**FAMILY COURT OF AUSTRALIA**

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| **RE: Baby D (NO. 2)** | **[2011] FamCA 176** |

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| FAMILY LAW - MEDICAL PROCEDURES – Application seeking orders and declarations for a “special medical procedure” on behalf of a child – Application brought by the parents on receipt of the opinion of the respondent hospital’s Clinical Ethics Committee – Where the medical practitioners involved supported the application – Where the procedure(s) sought included an extubation and then the administration of medication, sedation and palliative care if necessary – Whether the procedure(s) constituted a “special medical procedure” or a “special case”  FAMILY LAW - JURISDICTION – Matrimonial cause – Whether the Court had jurisdiction to hear and determine the parents’ application  FAMILY LAW - CHILDREN – Jurisdiction of Family Court – Whether the jurisdiction of the Court was invoked – Whether the Court had jurisdiction pursuant to the welfare jurisdiction provided in s 67ZC of the *Family Law Act* *1975* (Cth) to make the orders and declarations sought by the application  FAMILY LAW - CHILDREN – Parental responsibility – Whether Court authorisation was required for the procedure(s) sought on behalf of the child – Whether the child’s parents should have been able to consent and authorise the procedure(s)  FAMILY LAW - CHILDREN – Best interests – Whether the orders and declarations sought by the application are in the best interests of the child  FAMILY LAW - WORDS AND PHRASES – Special medical procedure and meaning of “Medical Procedure Application” in the Dictionary to the Family Law Rules 2004 (Cth)  FAMILY LAW - STATUTORY INTERPRETATION – Meaning of “Major long-term issues” in s 4 of the *Family Law Act* *1975* (Cth)  FAMILY LAW - CHILDREN – Independent Children’s Lawyer – Role of the Independent Children’s Lawyer  FAMILY LAW - PRACTICE AND PROCEDURE – Hearing – Appearance of the Office of the Public Advocate (‘OPA’) as *amicus curiae* – Role of the *amicus* in the proceedings and of the OPA pursuant to Practice Direction No. 9 of 2004 |

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| *Commonwealth Constitution* (Cth), ss 51, 76, 77  *Acts Interpretation Act* *1901* (Cth), s 15AA  *Equal Opportunity Act 1995* (Vic), s 16(1)(j)  *Family Law Act 1975* (Cth), ss 4, 60B(1), 60B(2), 60CA, 60CC(1), 60CC(2), 61B, 61C, 64B(2)(i), 65AA, 65C(c), 67ZC, 68L, 68LA, 69A, 69H, 69ZH, 92  *Guardianship and Administration Act 1986* (Vic), ss 1, 3, 4(1), 4(2), 15(c), 14, 16(1)(b), 16(1)(e), 16(1)(f),16(1)(k)  *Interpretation of Legislation Act 1984* (Vic), s 35  *Family Law Rules 2004* (Cth), rr 1.04, 1.06, 1.07, 1.08, 4.09, 4.10, 6.01, 6.05 |

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| *Airedale NHS Trust v Bland* [1993] AC 789; [1993] 1 All ER 821, cited  *Bropho v Tickner* (1993) 40 FCR 165; [1993] FCA 25, applied  *Church v S Overton* (2008) 40 Fam LR 357; [2008] Fam CA 952, cited  *DJL v Central Authority* (2000) 201 CLR 226; [2000] HCA 17 cited  *Fountain v Alexander* (1982) 150 CLR 615; [1982] HCA 16, cited  *Gillick v West Norfolk AHA* [1986] AC 112; [1985] UKHL 7, cited  *In the matter of the welfare of A (a child)* (1993) FLC 92-402; (1993) 16 Fam LR 715, discussed  *Levy v The State of Victoria* *& Ors* (1997) 189 CLR 579; [1997] HCA 31, applied  *Minister for Immigration and Multicultural and Indigenous Affairs v B & Anor* (2004) 219 CLR 365; [2004] HCA 20, applied  *P & P* (1995) FLC 92-615; (1995) 19 Fam LR 1, discussed  *R v Commonwealth Court of Conciliation and Arbitration; Ex parte Ozone Theatres (Aust) Ltd* (1949) 78 CLR 389; [1949] HCA 33, applied  *Re: Angela (Special Medical Procedure)* (2010) 43 Fam LR 98; [2010] FamCA 98, discussed  *Re Alex* (2009) 42 Fam LR 645; [2009] FamCA 1292, applied  *Re Baby A* [2008] FamCA 417, discussed  *Re Baby D* [2011] FamCA 14, related  *Re Brodie (Special Medical Procedure: Jurisdiction)* [2008] FamCA 334, discussed  *Re BWV: Ex Parte Gardner* [2003] 7 VR 487; [2003] VSC 173, cited  *Re GWW and CMW* (1997) FLC 92-748; (1997) 21 Fam LR 612, discussed  *Re Inaya* *(Special Medical Procedure)* (2007) 38 Fam LR 546; [2007] FamCA 658, applied  *Re J (a minor) wardship: medical treatment)* [1992] 4 All ER 614; [1993] Fam 15, cited  *Re Michael* (1994) FLC 92-471; (1994) 17 Fam LR 584, discussed  *Re: Sean and Russell* [2010] FamCA 948, applied  *Re: Sally (Special Medical Procedure)* [2010] FamCA 237, discussed  *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218; [1992] HCA 15, applied  *Re Medical Assessment Panel; ex parte Symons* (2003) 27 WAR 242; [2003] WASC 154, discussed  *United States Tobacco Co v Minister for Consumer Affairs & Ors* (1988) 20 FCR 520; [1988] FCA 213, applied |

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| 1. **APPLICANTS:** | The Parents |

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| 1. **RESPONDENT:** | 1. A Hospital |

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| 1. **Independent children’s lawyer:** | 1. Victoria Legal Aid |

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| 1. **AMICUS CURIAE:** | 1. Office of the Public Advocate |

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| 1. **DATE DELIVERED:** | 16 March 2011 |

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| 1. **FILE NUMBER:** By Court Order, file number is suppressed |

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| 1. **JUDGMENT OF:** | 1. Young J |

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| 1. **HEARING DATES:** | 1. 12, 13, 18, 19 & 25 January 2011 |

REPRESENTATION

By Court order the names of counsel and solicitors have been suppressed

# ORDERS DELIVERED ON 27 JANUARY 2011

**IT IS DECLARED**:

1. THAT the parents (the mother and father of Baby D) are permitted to authorise and give consent on behalf of their child to the hospital and its staff and medical practitioners:

(a) first to remove and not replace the endotracheal tube from the airway of Baby D; and

(b) secondly and if Baby D is in pain or develops respiratory distress or collapse suffered as a consequence of the removal or absence of the endotracheal tube, then to provide palliative care and administer such sedation or other medication as is necessary and proper.

1. THAT in the event the parents of Baby D permit and authorise the actions in paragraph 1(a) and (b) hereof then the hospital, its staff and medical practitioners may:

(a) remove and not replace the endotracheal tube from the airway of Baby D;

(b) provide palliative care to Baby D in the form of administering such sedation or other medication as is considered necessary and proper to relieve pain or distress exhibited by Baby D as a consequence of the removal or absence of the endotracheal tube; and then

(c) withhold treatment that would have the effect of artificially prolonging the life of Baby D.

1. THAT it is further declared that the actions and treatments identified in paragraphs 1 and 2 above are not *Special Medical Procedures*.

**IT IS FURTHER ORDERED**:

1. THAT the parents (the mother and father of Baby D) in the exercise of their parental responsibility forthwith jointly sign and have independently witnessed a written authority and consent document, prepared by their solicitors, sufficient and proper for them to authorise and permit the conduct and actions of the hospital, its staff and medical practitioners pursuant to paragraph (2) hereof.
2. THAT the appointment of the Independent Children’s Lawyer be otherwise discharged one (1) month after the delivery of the subsequent reasons for judgment.
3. THAT all extant applications be otherwise dismissed and the matter be removed from the list of cases awaiting hearing.
4. THAT for the purposes of publication of this order and judgment as authorised pursuant to s 121(9) of the *Family Law Act 1975* (Cth):

(a) this matter be known by and referred to as Baby D;

(b) the names of each doctor or medical specialist and the hospital referred to within the judgment be anonymised;

(c) the names of both parents be anonymised and the child be referred to only as Baby D;

(d) all references to any geographic locality be deleted;

(e) all references to the file number, Registry information and names and details of any of the legal representatives, barristers, solicitors and persons appearing by leave as a friend of the Court, be suppressed.

**IT IS CERTIFIED**

8. THAT pursuant to Rule 19.50 of the Family Law Rules this matter reasonably required the attendance of Counsel for the parents, Senior Counsel for the hospital and Counsel for the Independent Children’s Lawyer.

**IT IS NOTED**

A. THAT the reasons for judgment will be delivered as soon as practicable.

B. THAT these Orders and Declarations are largely in the form sought by the hospital and agreed to by the parents and the Independent Children’s Lawyer.

**IT IS NOTED** that publication of this judgment under the pseudonym *Re: Baby D* is approved pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

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| Family Court of Australia |

FILE NUMBER: By Court order, file number is suppressed

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| The Parents |

Applicant

And

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| **A Hospital** |

Respondent

And

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| Victoria Legal Aid |

Independent Children’s Lawyer

And

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| Office of the Public Advocate |

Amicus Curiae

REASONS FOR JUDGMENT

# ISSUE

1. In accordance with the written opinion and requirement of the respondent hospital’s Clinical Ethics Committee, and upon the recommendation of highly qualified medical professionals, the applicant parents sought orders and declarations for the medical procedure known as extubation to be performed upon their child and thereafter for artificial life prolonging treatment to be withheld. The issues considered in these reasons for judgment include a finding as to what was in the best interests of Baby D, whether the authorisation of the Court was required for the medical procedure(s) sought on Baby D’s behalf or whether the parents should have been able to legally consent and authorise the procedure(s) on the child’s behalf. In the course of the hearing other issues arose as to the role and responsibilities of various parties in the proceedings, including that of the Office of the Public Advocate. Those secondary issues have been addressed following the consideration of the primary issues in these reasons for judgment.

# APPLICATIONS FOR FINAL ORDERS SOUGHT

1. On 24 December 2010 the parents filed an Initiating Application seeking a declaration from this Court that it is lawful and in the best interests of Baby D that a medical procedure known as extubation be performed on her and thereafter life prolonging treatment be withheld.
2. By their Amended Initiating Application filed 6 January 2011 the final order sought by the parents was for the extubation to be performed on Baby D and that thereafter life prolonging treatment be withheld.
3. By a Response to the Amended Initiating Application filed with the leave of the Court on 12 January 2011 the hospital sought the following final orders:

(i) that it is lawful for the parents of Baby D to request and give permission to staff of the respondent hospital to remove and not replace an endotracheal tube inserted in the airway of Baby D, this course of action being in Baby D’s best interests;

(ii) that is lawful for the parents of Baby D to request and give permission to staff of the respondent hospital to administer such sedation or other medication as is considered necessary by staff of the respondent hospital to relieve pain and distress exhibited by Baby D as a consequence of removal of or the absence of an endotracheal tube, this course of action being in Baby D’s best interest;

(iii) a declaration that neither of the courses of action identified in each of the preceding orders amount to a “special medical procedure”;

(iv) that in the alternative, and if the Court finds that either or both of the courses of action referred to in orders 1 and 2 above do amount to a “special medical procedure” then the Court authorise staff of the respondent hospital to take those courses of action.

1. By an amended form of order filed with the Court by leave at the time of its final submissions the respondent hospital identified two additional orders that it sought and they were:

3. That it is lawful for the parents of Baby D to request and give permission to staff of the Respondent Hospital to withhold life prolonging treatment from Baby D, this course of action being in Baby D’s best interests.

4. In the event that the parents of Baby D request the courses of action referred to in 1, 2 and 3 above, then it shall be lawful for the Respondent Hospital and its staff to:

4.1 remove and not replace Baby D’s endotracheal tube; and

4.2 provide palliative care to Baby D in the form of administering such medication as is considered necessary by staff of the Respondent Hospital to relieve pain or distress exhibited by Baby D as a consequence of the removal or absence of the endotracheal tube; and

4.3 withhold life prolonging treatment from Baby D.

1. The Independent Children’s Lawyer (ICL) did not file a Response. In final submissions to the Court the ICL generally sought a form of order supportive of the parents and the hospital and that the ICL was satisfied was in the best interests of Baby D.
2. Upon being granted leave to participate in the first day of the hearing on an *amicus curiae* basis the Office of the Public Advocate (OPA) did not file a Response and likewise was then supportive of the orders sought by the parents, the hospital and the ICL. That position subsequently changed on the day after the hearing had concluded when Senior Counsel, with him Junior Counsel, were briefed to appear by the Principal Legal Officer of the OPA at a requested mention. The outcome and issues arising thereafter in the proceedings are subsequently considered in these reasons for judgment.

# REPRESENTATION OF CHILD’S INTEREST

1. The *Family Law Act 1975* (Cth) (‘the Act’) has been substantially amended to reflect the importance of independent representation of children’s interests and the role of the ICL.
2. Decisions in this Court that were handed down in the years prior to the commencement of the *Family Law Amendment (Shared Parental Responsibility) Act* *2006* (Cth) were written without the current emphasis and substantial formal input of the ICL.
3. The representation of a child’s interest was previously governed by s 65 of the Act (as it then was). Section 65 formerly provided that:[[1]](#footnote-1)

65. Where, in any proceedings under this Act in which the welfare of a child is relevant, it appears to the court that the child ought to be separately represented, the court may, of its own motion, or on the application of the child or of an organisation concerned with the welfare of children or of any other person, order that the child be separately represented, and the court may make such other orders as it considers necessary for the purpose of securing such separate representation.

1. As distinct from the legislation that applied on 30 June 1993[[2]](#footnote-2) or on 19 March 1996,[[3]](#footnote-3) which formed the basis of earlier decisions of the Full Court that are discussed later in these reasons, the current legislation as now amended provides for the separate representation of a child’s interests in s 68L and s 68LA.
2. Section 68L(2) provides for a court to order independent representation by a lawyer of the child’s interest, although the power is discretionary.
3. Section 68LA applies if an ICL is appointed and s 68LA(4)(a) stipulates that the ICL is not the child’s legal representative.
4. The ICL must form an independent view of what is in the best interests of the child and act at all times in the proceedings according to that best interest per s 68LA(2).
5. Specifically the duties of the ICL are recorded in s 68LA(5) which states that the lawyer for the child must:

(a) act impartially in dealing with the parties to the proceedings; and

. . .

(c) if a report or other document that relates to the child is to be used in the proceedings:

(i) analyse the report or other document to identify those matters in the report or other document that the Independent Children’s Lawyer considers to be the most significant ones for determining what is in the best interests of the child; and

(ii) ensure that those matters are properly drawn to the court’s attention; and

(d) endeavour to minimise the trauma to the child associated with the proceedings…

1. These are very substantial and very well defined powers encompassed within the role of the ICL.
2. In this case I am satisfied that the appointed ICL, both the solicitor appointed and Counsel briefed on behalf of the child’s interests, fully analysed all of the medical reports and opinions and reached an independent conclusion which aligned wholly with that of the parents and the hospital.
3. It is both timely and proper to reflect upon the substantially extended and very clearly defined role of the ICL in the context of the role undertaken by the amicus, by leave, in this hearing. This is a matter of some importance as at the time of earlier decisions of the Full Court that considered the powers and rights of the OPA in special medical procedure cases, the ICL had a narrower and more restricted basis of investigation.

# COURT HEARINGS

1. On 24 December 2010 and as a matter of urgency the parents’ Application was listed before Cronin J and his Honour made orders:

* adjourning the further hearing to 7 January 2011 before me; and
* requesting that Baby D be separately represented by an independent lawyer appointed by Victoria Legal Aid pursuant to s 68L(2) of the Act.

1. It was subsequently organised by my Chambers for the matter to be mentioned earlier than the adjourned date, and on 4 January 2011 the matter was listed before me with Counsel appearing for the parents, and the ICL appearing to represent the interests of Baby D. At that hearing I requested that the hospital be formally served with all documents filed with the Court and that they appear and be represented at the scheduled hearing later that week.
2. On 7 January 2011 Senior Counsel appeared for the hospital and Counsel appeared for each of the parents and the ICL. Orders were pronounced for the purposes of listing the matter for hearing on 12 January 2011 and also stated that:

(a) the matter be known and referred to as Baby D;

(b) the names of the parents, the hospital, the doctors and medical specialists be anonymised;

(c) all reference to the court file number, Registry information and names and details of all legal representatives be suppressed.

1. In accordance with Rule 4.10 of the *Family Law Rules 2004* (Cth) (‘the Rules’) I directed that a sealed copy of the Applications and supporting affidavits be served upon the relevant State welfare department (the Department) and otherwise the matter was adjourned for further pre-case mention before me on Monday 10 January 2011.
2. Upon service, the Department contacted this Court by letter dated 7 January 2011 and their principal solicitor advised that the Department would not seek to participate in the proceedings and would not be making any submissions on the various issues before the Court.
3. On 10 January 2011, at that further mention before me, Counsel for the parents and the ICL appeared and a solicitor represented the hospital. I ordered:

(a) that a sealed copy of the Amended Initiating Application and all supporting affidavits be served upon the OPA and that they be requested to advise my associate and the ICL if they wished to be heard and represented in the final hearing of these proceedings;

(b) that the medical professionals who had filed affidavits be identified only as Dr X and Dr Y;

(c) that the provider of the court transcript, Auscript, be directed at all times to ensure that the parents, Baby D, the hospital, the witnesses and the legal practitioners are not identified by name or position, but only as anonymised by the Court.

1. The OPA was required to be served pursuant to the Guidance and Protocol, Practice Direction No. 9 of 2004, (‘the Protocol’) applicable to all medical procedure applications for children in Victoria. That Protocol was entered into between the Family Court of Australia, Victoria Legal Aid and the OPA, and was supported by the Victorian Department of Human Services. However, the Protocol was directed only to the process of obtaining Court approval for a medical procedure for a child in Victoria, and in particular a child with intellectual disabilities.
2. The Guidelines and Protocol were expressed to:

(a) promote positive outcomes for children and young persons;

(b) promote the care, welfare and development of children and young persons;

(c) provide intending applicant/s and other interested parties with the opportunity to identify and discuss all relevant issues;

(d) assist in identifying, where appropriate, alternative options and strategies;

(e) encourage and support a cooperative and collaborative approach between the four participating organisations and medical and health professionals;

(f) ensure consistent and timely management of applications for a medical procedure for a child;

(g) ensure that a court hearing is of ‘last resort’, after all other options have been tested or considered and failed to or been assessed as unable to produce a satisfactory outcome;

(h) ensure that, if a matter proceeds to a court hearing, the Rules are followed and, in particular, all necessary evidence is available to the Court in compliance with Division 4.2.3 of the Rules.

1. Thereafter the Protocol deals with the role of the participants and the various options relating to dispute resolution and court hearings. The Protocol does not provide any right of appearance in a hearing to the OPA and primarily they are focused on pre-hearing support and discussions, and a careful consideration by all interested organisations of the suitability of the medical procedure, or alternatives available. There is no reference to or incorporation of the Protocol within the Rules.
2. On 11 January 2011 the OPA advised the ICL and the Court that they intended to be represented and to seek leave to appear and be heard as *amicus curiae*.
3. On the morning of the hearing the OPA elected to be represented by a senior manager. She had her instructions and sought leave to appear *amicus curiae*. That officer had prepared and handed to the Court a Notice of Address for Service. Thereafter, in the conduct of the proceedings, and with the leave of the Court, that officer participated in the cross examination of the two professional medical witnesses, made submissions to the Court and identified final orders and outcomes that she considered to be proper and in the best interests of Baby D. The hearing concluded.
4. I was then aware from disclosures made to the Court and proceedings in other matters before the Court that the officer had previously appeared, by leave or otherwise, for the OPA in other cases before judges of this Court.
5. I record that the following day, Thursday 13 January 2011, the   
   Principal Legal Officer of the OPA contacted my Chambers and requested that the proceedings be re-listed as a matter of urgency. I had the matter re-listed at 2.15p.m. on that day as requested. No applications were before the Court, though a letter from that legal officer at the OPA had been sent to the Registrar of the Family Court that morning and had been served upon all parties to this proceeding.
6. Senior Counsel appeared on behalf of the OPA at that hearing, as did Counsel for the parents, by telephone, Senior Counsel for the hospital, and Counsel for the ICL.
7. The Court was requested to order a full transcript of the proceedings of the earlier day and to otherwise structure a further Court timetable for written submissions on the substantive issues to be prepared and filed by the OPA, notwithstanding their earlier appearance by leave and involvement in the concluded proceedings and their support of the orders then sought by all parties.
8. I delivered an ex tempore judgment after Court hours and those reasons for judgment have now been published and I have not repeated the various reasons for then declining the further request of the OPA.[[4]](#footnote-4) Those reasons can and should be read in the context of this judgment and the orders sought and made in the best interests of Baby D.
9. I listed the matter to deliver Orders of the Court on the substantive issues on 18 January 2011 at 12.00pm. Each of the parties were represented by Counsel, and Senior Counsel, and Junior Counsel appeared for the OPA. Upon request of the parties the matter was stood down for out of court discussions and subsequently the Court was advised that a consent arrangement had been reached for a further independent medical specialist to be engaged by the OPA, with the agreement of all other parties, to consult with the hospital and its medical specialists, examine Baby D and prepare an updated report for the Court, the hospital and the parents.
10. With the consent of all parties I then adjourned the further hearing of this matter to Tuesday 25 January 2011. I withheld delivering the final Orders of the Court and that situation was requested by all parties, and the amicus, and was the subject of agreement.
11. At that point of the proceedings I raised with Senior Counsel for the OPA and those instructing him, including the Public Advocate herself who was in the body of the Court, the jurisdictional basis upon which they were at this Court and in particular their relevant and applicable powers and duties pursuant to the *Guardianship and Administration Act 1986* (Vic)[[5]](#footnote-5) within the ambit of these Federal proceedings.
12. After lengthy discussion between the Court and Senior Counsel and all other Counsel, I directed that written submissions as to the powers and duties of the OPA to be heard and participate in proceedings in this Court be filed within a specific short period, with replies from the parties to be also filed, and for the issues to be consolidated with the issues concerning Baby D and adjourned the matter to 25 January 2011.
13. I provided then to all parties and the amicus the transcript of evidence of Dr X and Dr Y, including their cross examination, from the hearing on 12 January 2011.
14. The written submissions of the Public Advocate were supplied on 21 January 2011. The written submissions of the respondent hospital were filed by leave of the Court at the recommencement of the Court hearing on 25 January 2011 and annexed to those submissions, and provided to the Court without objection from the parties or the amicus was a legal article.[[6]](#footnote-6) I have read and evaluated each of the written submissions.
15. Whilst ordered to do so neither the parents or the ICL, though their legal practitioners, filed any written legal submissions and each of them indicated to the Court that they were not instructed to further address those legal issues under consideration.
16. I have hereafter considered and commented upon the role of the OPA, its relevant and applicable powers and duties, the Protocol, its appearance before this Court on an amicus basis and the professional medical evidence which, by consent, it was permitted to adduce in this hearing.

# AFFIDAVITS

1. The parents relied upon:

(a) the affidavit of the mother filed by leave on 24 December 2010;

(b) the affidavit of the father, and annexures, filed by leave on 24 December 2010;

(c) the further affidavits of each of the mother and father filed by leave on 12 January 2011.

1. The hospital relied upon:

(a) the affidavit of Dr X filed 7 January 2011; and

(b) the affidavit of Dr Y filed by leave of the Court on 10 January 2011, and which annexed diagnostic imaging reports dated 23 November 2010 and 16 December 2010 under the signature of Professor Z;

(c) the further affidavit of Dr Y filed by leave of the Court on 12 January 2011;

(d) the affidavit of Professor Z and the annexed Magnetic Resonance Imaging (‘MRI’) brain scans of Baby D.

1. The Public Advocate, as amicus, and with the consent of all parties relied upon:
   1. the affidavit of Dr W and his annexed report filed 25 January 2011.
2. The ICL did not present any additional evidence to the Court, but relied, and addressed the Court upon, all of the above evidence.

# BACKGROUND FACTS

1. Baby D was a twin born at 27 weeks gestation in early August 2010 at the hospital. Both children required a long period of support in the neonatal intensive care unit with intubation and mechanical ventilation as a result of irregularity of breathing due to apnoea of prematurity.
2. The other twin has largely recovered and was in the special care nursery at the hospital but no longer required respiratory support.
3. The mother and father are the parents of Baby D. They are married and Baby D is a child of their marriage.
4. Baby D’s life was complicated by the development of an upper airway obstruction due to inflammation and narrowing of her larynx and the evidence before me was that situation was an uncommon but well recognised complication of prolonged endotracheal intubation. Several unsuccessful attempts were made to extubate Baby D and therefore a more formal examination of her airway was made by a medical specialist under anaesthesia in theatre and also while awake in neonatal nursery. Those findings then led to a further attempt being made to extubate Baby D with the aid of steroids to suppress inflammation.
5. Baby D had quite severe stridor and signs of significant airway obstruction. Initially the medical evidence indicated that her condition improved and the hospital and doctors were hopeful that as the inflammation subsided her symptoms would diminish in the days ahead. Unfortunately that positive outcome did not occur and her condition deteriorated approximately sixty hours after extubation and required the replacement of the endotracheal tube.
6. The evidence before me is that the replacement of the endotracheal tube proved to be an exceptionally difficult medical procedure. The laryngeal tissues of Baby D had become swollen and narrowed after the tube had been removed and the medical opinion was that this made it almost impossible to insert another tube. Her condition then deteriorated profoundly, necessitating prolonged resuscitation with cardiac compressions and adrenaline. Finally an endotracheal tube was inserted successfully after a delay of approximately 35 minutes.
7. After this event the medical specialists and the hospital were significantly concerned that Baby D may have suffered a major hypoxic injury to the brain. No seizures were subsequently observed but on clinical examination she displayed signs of mild encephalopathy with increased muscle tone and irritability. Ultrasound examination highlighted an unusual appearance, with abnormal echogenicity, in the occipital cortex on both sides of her brain.
8. A MRI was performed on 23 November 2010, six days after the initial event, and this showed abnormalities in the basal ganglia, internal capsules, rolandic tissues and occipital regions that were consistent with severe hypoxic ischaemic injury.
9. Baby D remained intubated to maintain patency on her airway. Otherwise she had no need for ongoing intensive care and support. She was able to breathe regularly, required no added oxygen and was stable from a cardiovascular perspective. Although her endotracheal tube remained connected to a mechanical ventilator, the medical evidence was that this was a prophylactic measure to avoid development of atelectasis in her lungs.
10. A second MRI was performed on 16 December 2010 for the purpose of evaluating the nature and extent of the brain injury. That imaging confirmed definite evidence of widespread and severe injury to the brain. That evidence was verbally reported to the Clinical Ethics Committee of the hospital by Professor Z, together with reports and assistance given them by both Dr X and Dr Y.
11. From the middle of November last year no further attempt has been made to electively remove Baby D’s endotracheal tube and thus the condition of her upper airway and the degree of airway obstruction has not been re-assessed. The evidence before me therefore was that there is uncertainty as to the degree of airway compromise and whether it has improved or deteriorated from that which pertained in mid November of last year.
12. Given the likely severity of the brain injury to Baby D the treating medical team at the hospital do not consider that the provision of ongoing intensive care support to be in the best interests of Baby D. Withdrawal of such support means the removal of the endotracheal tube and the consequences of that action remains uncertain.

# CLINICAL ETHICS COMMITTEE OF THE HOSPITAL

1. Annexed to the affidavit of the father is a referral form dated 13 December 2010 where the treating medical specialist and Director of Newborn at the hospital prepared a detailed report and identified the nature of the ethical issues to be listed on the agenda and considered by the hospital’s Clinical Ethics Committee at its meeting on Friday 17 December 2010.
2. That report, which is in evidence, identified and explained the ethical issues surrounding any likely withdrawal of intensive care from Baby D after full and proper discussions with the family. If and when that decision was taken within the hospital, in active discussion with the parents, the intensive care would be withdrawn with the expectation that the basic bodily functions would be unable then to support life and that death would occur over a few hours in a peaceful and controlled process.
3. Baby D does have evidence of serious hypoxic ischaemic injury as shown on the imaging but it was identified that, in other key respects, her case differed from the many other cases that come before hospital and ethical staff. Dr Y, and his medical support team believed that there were or could be, on the facts of this case, existing ethical dilemmas when considering the possibility of withdrawal of care. Baby D had no evidence of compromise to her brain stem reflexes or her cardio respiratory control. She was not dependent on mechanical ventilation and did not require any vasoactive drugs. Her support was limited only to the endotracheal tube which was required to prevent the swelling of her laryngeal tissues and consequent airway obstruction.
4. The key ethical issues that were summarised for discussion and determination by the hospital’s Clinical Ethical Committee were stated to be:

(i) Baby D has no underlying irrecoverable life-threatening problem;

(ii) her survival is temporarily dependent on a simple plastic tube, her endotracheal tube;

(iii) if that tube is removed and airway obstruction becomes symptomatic she will make vigorous efforts to breathe and be likely to experience intense distress; and

(iv) administration of medication to relieve that distress would be expected to have a very direct and instrumental impact on whether she were to succumb or survive following the removal of her tube.

1. The question posed by Dr X in his capacity as the Medical Director for consideration by the hospital Ethics Committee was:

Whether it would be ethically reasonable and legally acceptable to remove Baby D’s endotracheal tube with the expectation that it would not be replaced in the event that life- threatening airway obstruction develops.

1. By a written response dated 23 December 2010, exhibited to the affidavit of the father, the Deputy Chair of the Clinical Ethics Committee for and on behalf of that Committee advised that, at its meeting on Friday 17 December 2010, they had considered the matter of Baby D and offered the following advice or opinion for consideration:

1) It is appropriate for Baby D’s parents to apply to the Family Court of Australia to obtain a declaration that it is lawful for Baby D to be extubated and for life-prolonging treatment to be withheld as it is in her best interests. The parents can also apply for a declaration that it is lawful for them to refuse any life-prolonging treatment on behalf of their daughter Baby D as that course would be in her best interests. The hospital will support such an application.

2) Pending a declaration from the Family Court of Australia, if Baby D’s endotracheal tube falls out, she is to be re-intubated.

3) It is an appropriate ethical response to anticipate that clinical management in the best interest of Baby D by the paediatric team would proceed as follows, provided a supporting declaration from the Family Court of Australia is granted:

Extubation of Baby D:

(i) If she breathes on her own, no further intervention is required for her airway management; or

(ii) If she develops respiratory distress and struggles to breathe or suffers respiratory collapse, she will be provided with comfort palliative care by way of medication; however life-prolonging treatment is to be withheld as it is in her best interests.

4) A tracheostomy will not be offered in this case as it would be clinically and ethically inappropriate to subject Baby D to intrusive painful treatment, as she has a very poor prognosis and quality of life.

In considering the opinion(s) of the Clinical Ethics Committee, please note the following important information:

* The advice is not intended to constitute clinical or legal advice and that it constitutes ethical advice only (in the event that the CEC believes that there are legal considerations that need to be taken into account, it will assist the staff member in obtaining this advice by way of facilitating discussions with the Corporate Counsel);
* The advice does not replace the need for application of clinical judgment in relation to the continued treatment of the patient; and
* Acting in accordance with the ethical advice does not guarantee that the practitioner has acted in accordance with legal requirements.

It is requested that upon resolution of this matter, feedback be provided to the Clinical Ethics Committee, by way of a letter, notifying of the outcome of the matter. This feedback will assist the Committee in the provision of opinions on future cases considered for case consultation.

1. What then followed was that the following day the parents urgently applied to this Court for leave to file and have heard their Initiating Application which was made returnable before Cronin J on 24 December 2010 late in the afternoon.

# THE PARENTS’ EVIDENCE

1. The parents at all times had and continued to receive detailed information and advice from the hospital and the medical specialists. They recorded in each of their affidavits that they have accepted and relied upon such advice.
2. The position and instructions of the parents are expressed in paragraph 11 of the father’s most recent affidavit, filed 12 January 2011, endorsed by the mother which records that:

I am further convinced that it is in Baby D’s best interests for the medical procedures outlined in the letter from [the Deputy Chairman of the Clinical Ethics Committee], dated 23 December 2010, to be implemented.

1. His affidavit concluded with a request that the Court make the orders sought by the parents in his Amended Application filed 6 January 2011.

# DR Y

1. Dr Y is a very experienced medical practitioner, currently registered and holding substantial professional qualifications and appointments. He is a Fellow of the Royal Australasian College of Physicians (Paediatrics and Child Health Division). He holds a senior position with the hospital and has overall responsibility for the conduct of the neonatal intensive care unit and the special care nursery at the hospital. He holds honorary university appointments.
2. He knows and has consulted with the parents and Baby D is a patient in his hospital unit.
3. On 13 December 2010 Dr Y prepared a substantial report on the case history, issues and medical health of Baby D. That report was primarily prepared for the purposes of the Clinical Ethics Committee of the hospital, which had listed for discussion on 17 December 2010 matters of future treatment and possible outcomes for Baby D, as referred to above.
4. Subsequently a further MRI of Baby D’s brain was conducted and that has been reviewed both by the hospital, Dr X, Dr Y and Professor Z who is a specialist radiologist. That report and their professional opinions were annexed to Dr Y’s affidavit and the medical specialists were in agreement on the opinions expressed by each other.
5. Dr Y’s affidavit summarised the condition of Baby D as at 7 January 2011. It stated that:

* she remained in the neonatal intensive care unit at the hospital;
* she is intubated and connected to a mechanical ventilator but is able to breathe spontaneously and without mechanical support. The ventilation is continued only to avoid progressive deterioration of her lung function that was said to be likely over time as a consequence of the presence of the endotracheal tube. Dr Y’s professional opinion was that the presence long term of such a tube can have a progressive adverse effect on lung function because it prevents the larynx from playing its normal role in breathing and leads to the development of atelectasis (closure of air sacs in the lung);
* her nutrition is being maintained by providing milk through a nasogastric tube;
* she is in an open cot;
* she is conscious and aware. She responds to touch, feels pain and cries. She is comforted by being held and cuddled;
* it is uncertain at the moment whether her vision has been impaired.

1. Baby D was said to have clear evidence of severe brain injury as shown on her MRI.
2. The evidence of the hospital and Dr Y is that the neonatal intensive care unit commonly cares for infants who have suffered severe brain injury. However, such infants normally display a number of factors that impact upon their capacity to survive without intensive care. They often have compromised brain stem function with severe consequences for their capacity to maintain circulatory and respiratory stability. They may often also have damage to other major systems of the body so that when intensive care is withdrawn from such an infant it is generally done on the expectation that the basic functions of the brain, or of other major organ systems of the body, will be unable to support the child’s life and death would likely follow.
3. Baby D however, unlike so many other infants that have suffered severe brain injury, appears to have unimpaired brain stem function. The evidence of Dr Y is that she does not appear to have any compromise to the function of her other major organ systems. Her dependence upon intensive care support was limited to the need for an endotracheal tube.
4. The hospital has found Baby D to have been noticeably more irritable and harder to settle since the hypoxic event of mid November of last year. Since then no further attempts have been made to electively remove her endotracheal tube and the condition of her upper airway and the degree of airway obstruction has not been re-assessed. Thus it was somewhat unclear to Dr Y whether her degree of airway compromise is better, worse or the same as that which pertained in mid November. There have however been several occasions recorded by the hospital since that date when the endotracheal tube has needed to be replaced because it accidently or spontaneously dislodged. On each of those occasions the tube has been able to be replaced immediately by hospital staff and no difficulty had been encountered with its re-insertion.
5. The affidavit evidence of Dr Y was that such episodes of re-insertion which have been straightforward cannot be taken as an indication that the problem of the narrowing of the airway of Baby D has resolved as re-insertion of the tube is most usually performed immediately when it is discovered and therefore insufficient time had passed for the airway to close or to have become significantly compromised.
6. The evidence of Dr Y was that the removal of the endotracheal tube is the most efficient means to ascertain whether there remained potentially present a significant obstruction of her airway. His opinion was that the presence of the tube placing pressure upon the lining of the airway may, to an extent, limit the inflammatory swelling which would otherwise develop. It may therefore be found to be several hours following removal of such tube before the severity of the obstruction is clearly evident, if at all. The evidence before the Court was that visual inspection of the airway with a laryngoscope may be a possible alternative means of assessment but that is both difficult and poorly tolerated in an awake infant and would provide relatively little useful information upon which severity would be judged. More information would be gained by an examination of the airway under anaesthetic but the value of such investigation is limited by the fact that the swelling of the tissues may not have had time to develop in that intervening period.
7. Dr Y’s evidence canvassed the alternative medical option of the performance of a tracheostomy. His opinion however was that, with the severity of her brain injury, such an operation would not be in her best interests and would subject her to a significant surgical procedure to establish a secure airway and ensure her long term survival. Dr Y expressed his opinion that he, and the hospital, would not normally recommend such an intervention in the case of an infant that has suffered profound injury to the brain unless it was the firmly stated intention of the family and their express wish for their child to survive regardless of the gravity of the prognosis.
8. In paragraph 22 of his affidavit Dr Y carefully highlighted the dilemma confronting the hospital, the medical staff and the parents in deciding whether to remove and then not replace Baby D’s endotracheal tube. That dilemma was that if the airway obstruction developed the only way that the distress and suffering of Baby D would be alleviated would be to suppress her drive to breathe. That is in a palliative care setting where depression of breathing is a well accepted “double effect” of sedation with medication such as morphine administered to relieve pain and distress.
9. Dr Y highlighted what was so unusual in this case was that the source of distress to Baby D would be brought about by her intense desire to breathe in the presence of an obstructed airway and thus the relief and care would diminish her desire to breathe. The outcome of such palliative care to relieve her distress may be to suppress her breathing to the point that her life succumbs.
10. Dr Y concluded in the final paragraph of that first affidavit that he was, all matters carefully considered, prepared to act in accordance with the wishes of the parents, subject to the approval of the Court, to remove the endotracheal tube, and if Baby D then were to suffer distress and significant and ongoing breathing difficulties, to then administer palliative medication as required to relieve her distress. That is an extremely important fact and outcome which I wholly accept was reached by him after very careful reflection and consideration upon all possible options, with the background of his vast experience, and decided upon in the best interests of Baby D.

# FURTHER AFFIDAVIT OF DR Y

1. By leave of the Court Dr Y filed a further updated affidavit which was prepared with the background both of his extensive and specialist medical training and position and his appointment to a State Hospitals’ Neonatal Advisory Group.
2. Dr Y further advised the Court, in paragraph 14 of his second affidavit that:

14. The death of children in hospitals in Victoria is monitored by the Consultative Council for Obstetric and Paediatric Mortality and Morbidity… [This Council is established] by statute and is operated under the auspices of the Department of Health to look into the circumstances of individual obstetric and paediatric deaths. [Dr Y is] a current member of [that Council].

1. In that affidavit Dr Y deposed to, in more detail, his extensive paediatric and neonatal training and work experience. He has worked at the hospital as a specialist neonatologist for over two decades and as its Director for the past decade.
2. Dr Y deposed that it is not uncommon in the neonatal nursery at the hospital to provide palliative care to infants in a setting where their prognosis is poor and a decision had been reached with parents to cease active treatment of intervention.
3. The neonatal nursery at the hospital provides both intensive and special care services for newborns. It has a capacity of … beds designated for ventilator intensive care providing mechanical respiratory support for infants with breathing difficulties.
4. As background and factual information to the admissions in the neonatal nursery at the hospital, Dr Y advised that some 1200 infants are admitted each year of whom 400 require a period of ventilator intensive care. His evidence was that:

On average, amongst the babies that are admitted to the nursery, there are about 2 - 3 deaths each month. The total number of deaths in 2009 was 22 and in 2010 it was 33. I estimate that at least half of these deaths occurred in a setting in which a decision to withdraw intensive care or withhold further intervention had been reached after careful discussion with the parents.

1. Dr Y was a founding member of, and is a regular participant in, the Neonatal Advisory Group. The group is a partnership of the hospital and three other major hospitals who are predominantly involved with intensive care and tertiary perinatal services. As a further background to his significant experience and qualifications, Dr Y and the Advisory Group of the four major hospitals meet monthly to discuss common issues involving the care and treatment of, and advice for, infants requiring intensive and special care services.
2. Dr Y concluded by deposing that:

17. In Victoria, my experience is that neonatologists operate on the basis that parents generally have the authority to make end of life decisions in respect of very sick infants. In the neonatal nursery, decisions about withdrawal of treatment or withholding treatment, and initiation of palliative care, are generally made in a setting in which the infant is unlikely to survive or the child’s quality of life is expected to be poor. Such decisions are not normally regarded as being decisions that require permission from a Court.

18. Our Corporate Counsel has informed me that the term ‘special medical procedure’ includes, for example, invasive surgery such as gender reassignment or sterilisation, a situation where a child might be a donor for transplantation, or treatment of an experimental nature, and also informed me that in each of these situations the Court’s permission to proceed is required.

# ORAL EVIDENCE AND CROSS EXAMINATION OF DR Y

1. Dr Y was requested by the parties to be available to give oral evidence to the Court and to answer questions under cross examination. He therefore attended at Court, for the purpose of assisting the Court with further evidence and he remained for the duration of the proceedings.
2. Dr Y was asked by Senior Counsel for the hospital that, if and when the endotracheal tube of Baby D is removed, will she have a desire to breath. His answer that was:

She certainly will have a very strong desire to breathe, although a great deal of her brain has been damaged. Her brainstem which drives breathing appears to be unaffected by what has happened to them. She will have a very intense desire to breathe and she is able now to breathe without the aid of any mechanical support, other than the endotracheal tube. Although she is connected to a ventilator, that is not necessary in terms of maintaining regularity of her breathing.

1. Dr Y said that he did not think it totally unlikely that Baby D could manage without her tube. He thought it unlikely that she would have no symptoms of pain and distress at all. The palliative care would be required to relieve such symptoms and the preferred drug would be morphine. Dr Y’s evidence, in response to a question from the ICL, was that:

[M]orphine is one of the most effective agents in that setting and it is well recognised and accepted that in achieving the primary objective of relieving pain and distress a secondary consequence of the morphine may be to depress breathing and a further consequence of that may be to shorten further the patient’s life.

1. With that explanation Dr Y identified the particular dilemma in this case confronting the medical practitioners and the hospital. It was said that:

The dilemma that I think we may face with Baby D is that the source - the very source of her distress will be likely to be that desire to breathe. And whilst one would hope in that setting that it is possible to give her sufficient morphine to relieve the distress, but not to remove her desire to breathe, it is also possible in that setting that the two may prove to be inseparable. That the distress - the relief of the distress and the relief of the desire to breathe are inseparable and that I may not… [be] able to relieve her distress without depressing her breathing… [T]hat is the dilemma.

1. Subsequently, and in answer to a question from the officer of the OPA, Dr Y deposed that:

The circumstances that are unusual are a constellation of circumstances. It would - there would be many other occasions where the brain stem may be functioning reasonably in an infant in whom we’re withdrawing care, but in whom, for example, there is no prospect of the heart or lungs recovering. So it is not that on its own. It is the particular collection of circumstances that [Baby D] has a well preserved brain stem function, but she is in very unusual circumstances, where we’re having to contemplate withdrawal of care in an infant who will breathe, but who is going to be breathing with a very obstructed airway… [I]t’s a circumstance where the very withdrawal of the tube will result in significant stress to the infant.

1. Dr Y further explained, upon this constellation of circumstances that:

The thing which for me is unique, that is, that that constellation of factors puts me in a place that I am uncomfortable, that I don’t know where I sit in terms of the - it comes back to the morphine and the double effect versus the single effect of morphine.

1. He continued and further explained that:

The challenge and the thing that is making me feel gray about this and where I - and where the boundaries lie is the fact that it could be that the only way - it may not be but it could be that in this case the only way to relieve [Baby D’s] distress is with - is to relieve her of the - diminish her desire to breathe. But the relief of distress was the primary object that has become inseparable from diminishing the drive to breathe. Normally the diminishing of the drive to breathe is an acceptable, indirect by product of the relief of distress.

1. There was reference in the earlier affidavits of Dr Y to the tube being spontaneously dislodged on prior occasions and by explanation the witness said that:

It is an inevitable occurrence on occasions in infants who are intubated. The tube is held in place with tapes to the - with tapes to the cheeks and those tapes can come loose and the child may, by movement, cause the tube then to become dislodged.

1. Dr Y was asked about the effect or impact of a tracheostomy and his evidence was that such an operation was not the appropriate treatment for Baby D and that was an opinion shared by his medical colleagues. He highlighted the concern and difficulty of such an operation by stating that:

A tracheostomy is a surgical operation. It is, like all operations, a painful thing during the recovery from that operation. But a tracheostomy also presents an infant and an older child with added difficulties. It is impossible to cough effectively with a tracheostomy so secretions tend to be retained in the chest. The breathing is often rattling with those secretions. Because the child can’t cough those secretions out effectively they will need to be actively suctioned, a catheter placed through the tracheostomy and into the trachea. And such an appliance is meant to draw secretions out, which is quite an unpleasant procedure. That needs to be done multiple times a day in an infant with a tracheostomy.

1. When asked about his earlier report to the Clinical Ethics Committee Dr Y highlighted that the updated MRI was performed after the date of the preparation of his report, though the Ethics Committee had been orally advised of that outcome. Dr Y said that, with the benefit of time and the second MRI, his report would have been drafted in different terms and in stronger language but nevertheless would still have centred on the difficulty and dilemma confronting the medical professionals in their treatment of Baby D.
2. Specifically addressing the results of that second MRI and what was shown in that imaging Dr Y deposed that:

It is not so much the damage becomes greater. I mean, the source of the damage was hypoxia and that was done on 17 November. What happens over time is that the visible signs of that, of the damage that has been done, progressively evolve in changing appearances on investigations like an MRI. So I think that it is not that there was ongoing further injury to the brain, it is simply that the signs and physical appearance of that injury on the MRI became more conclusive.

1. Significantly the professional opinion of this witness was that the removal of the endotracheal tube was not a medical procedure. His evidence was that it occurred within the hospital on multiple occasions in each year and specifically and relevantly he said that:

Removal of an endotracheal tube as part of the withdrawal of care is thankfully not an everyday event but as I have indicated in my affidavit that it is not an uncommon circumstance though it be on multiple occasions each year that we did it.

1. When asked whether the administration of palliative care and assistance was a medical procedure the witness replied that it was not.
2. In the context of this application to the Court and the orders sought by the hospital and in his consideration of what is a special medical procedure Dr Y expressed his personal, but medically qualified opinion, that:

[I]t would be extraordinarily unfortunate if we needed to bring problems to a setting like this [a court] on a regular basis.

1. When asked if the major medical procedure for Baby D related to treatment for a bodily malfunction or disease, the evidence of Dr Y was that “Baby D has a very major organ that is malfunctioning”. He said that her airway problem was “undoubtedly a bodily malfunction” and that what had happened to her brain had left her with “a major bodily malfunction”.
2. That evidence is directly relevant and I have carefully considered it in the context of the definition of a “medical procedure application” in the Dictionary to the Rules. The Dictionary forms part of those Rules. The definition of that phrase is that it means:

[A]n Initiating Application (Family Law) seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease.

The Dictionary highlights, as an example, that a procedure for sterilising or removing the child’s reproductive organs is a major medical procedure.

# DR X

1. Dr X is a specialist paediatric neurologist and clinical geneticist. He is a Fellow of the Royal Australasian Collage of Physicians in the specialities of paediatrics, neurology and clinical genetics. He is a currently registered medical practitioner with specialist qualifications and is a part time Director of Paediatric Neurology at the hospital.
2. Dr X holds a position as a senior lecturer in the Department of Paediatrics and the Faculty of Medicine at a major university and is actively engaged in paediatric research and has national and international funding to pursue further studies in cerebral palsy research.
3. He is familiar with Baby D and was asked to provide an opinion on her current neurological condition, diagnosis and likely prognosis.
4. Dr X performed clinical examinations on Baby D on 15 December 2010 and 6 January 2011 and has reviewed both of her MRI scans.
5. In his opinion Baby D has clinical signs of increased tone affecting her legs and arms bilaterally. Specifically she has an adducted thumb on the right which extends easily with passive movement. She has trapezius reflexes present. She has increased tone in her right leg and eight beats of clonus on the left. Her reflexes are brisk and spread from ankle to knee jerks to the contralateral adductor group of muscles. Dr X holds concerns that the vision of Baby D is significantly impaired. His evidence is that she has a squint but that he is unable to obtain fixation with gaze.
6. Dr X reviewed the MRI scans taken on 16 December 2010 in consultation with Professor Z and they had earlier reviewed the scan of 23 November 2010. It is the opinion of Dr X that both scans demonstrate extensive neurological damage and significantly there is evidence of progressive worsening in the appearance of the neurological damage in the interval between both scans.
7. That most recent scan showed cystic changes particularly within the basal ganglia and the occipital regions. He believed that such damage was evident to the basal ganglia, the posterior frontal, parietal and occipital cerebral cortex involving both motor and visual areas.
8. As an overview of his clinical examinations and the review of the MRI scan Dr X expressed the professional opinion that the neurological damage which Baby D has sustained is severe and his clinical prognosis was that she will have significant and permanent ongoing disabilities. He found that Baby D already demonstrated neurological abnormalities upon his clinical examination.
9. The further evidence of Dr X was that if Baby D survived into childhood she would demonstrate the clinical signs and symptoms of cerebral palsy.
10. When asked to look forward to a period when Baby D would develop in early infancy the evidence of this witness was that he would expect the following to occur:

* she would have difficulty in moving all limbs and as a consequence she is unlikely to walk;
* she will most likely have severely impaired vision;
* she will need ongoing assistance with swallowing foods and liquid and at some future stage the placement of an enteral feeding device may be required;
* normal speech and language will not be obtained;
* there likely may be more ongoing complications resulting from her neurological condition such as seizures, decreased bone mineral density and pathological fractures.

# ORAL EVIDENCE AND CROSS EXAMINATION OF DR X

1. In response to a question from Senior Counsel for the hospital as to the extent of the brain injury caused to Baby D this witness said that it was “significant and profound”.
2. He subsequently added that:

Children who have the level of disability that I anticipate Baby D to have do not have a regular life. They are needing to be cared for multiple times a day. That care is often - causes discomfort. Their ability to participate in regular activities which we associate as being part of the normal child’s life are severely compromised because they are having such a high level of care. I think it is beyond the impact on just the family’s lifestyle… this has impact on the child itself.

1. Dr X offered the professional opinion that Baby D would not have any normal speech or language and would not be able to communicate in an effective manner with her carer or others. He said:

So many children who have just damage to the basal ganglia part of the brain, the central part of the brain, have difficulties with movement, difficulties with swallowing and difficulty with communication. Those children, if they communicate, often communicate as they go through life by using picture boards or using something else which they need vision to achieve. And I don’t believe that Baby D will have the vision to do that. Communication, again, is a subjective thing and people may communicate by crying or laughing, and so I don’t think it’s fair to say there will be no communication. She may be able to communicate distress or joy of something. But I think that communication would not be to an equivalent level of her peers or even other children with just basal ganglia changes.

1. When asked as to her risk of increased intellectual disability Dr X believed that there is evidence that may be the case with Baby D but qualified that assessment with his observation that:

[I]t’s difficult to assess what someone can understand if they can’t communicate back.

1. The officer of the OPA took up the issue of any intellectual disability of Baby D and asked, given that it is likely she will suffer cerebral palsy, would she also have an intellectual disability. The response of Dr X was that:

I’m glad you asked that question. The studies on children with basal ganglia changes show that children with significant basal ganglia changes have an increased rate of intellectual impairment associated with that. Baby D, in addition to the basal ganglia changes, has changes within her motor area, so the areas which can help control movement, which, on their own, I would say, were also associated with cerebral palsy and the areas at the back of her brain, as we mentioned, in the occipital lobe, which are relating to vision. While I can’t say with certainty that she would have intellectual disability, the evidence from the studies would suggest that children with her level of brain damage, a significant proportion of them go on to develop - to have intellectual disabilities, and part of those studies are compromised by how long they follow people out for. And so, following children for a short period of time, which is commonplace, rather than following them into their teenage years, the longer people are followed for the more apparent subtle intellectual disabilities becoming - become.

1. The oral evidence of this witness concluded with the Court asking his professional opinion as to whether the removal of the endotracheal tube and subsequent medication and palliative care was a medical procedure. The response of Dr X was that it was not and that “[i]t’s something which is commonplace within the hospital”.

# PROFESSOR Z

1. Professor Z is an experienced medical practitioner and Head of Paediatric Imaging at the Hospital. He has a special interest in MRI and neonatal imaging. He was asked to provide an opinion on the findings of the MRI scans performed on Baby D in both November and December 2010 and he provided an opinion upon her likely neurological prognosis. His report and evidence was summarised in his affidavit as follows:

8. The first of the two MRI scans was performed late in the day on 23/11/2010, and was reported the following day on 24/11/2010. It demonstrates severe acute damage (infarction) to the basal ganglia, corticospinal white matter tracts and cerebral cortex. The cortical involvement included the Rolandic cortex bilaterally (responsible for motor function) and occipital lobes bilaterally (responsible for vision).

9. The subsequent MRI scan was performed late in the day on 16/12/2010, and was reported the following day on 17/12/2010. It demonstrates evolution of the previously noted damage. The basal ganglia and thalami are small and cystic and the Rolandic cortex and posteromedial aspects of the occipital lobes completely destroyed with no remaining tissue in their place.

1. His evidence was accepted and relied upon by the medical professionals who have filed affidavits and given evidence in this hearing.

# DR W

1. Dr W is a very experienced medical practitioner and Consultant Neonatologist who is currently employed as a Clinical Director of the Department of Paediatrics and as a Staff Neonatologist at a major public hospital. He has had no involvement with the care, treatment or diagnosis of Baby D. He was engaged by the amicus to prepare an independent report and assessment on Baby D. Unlike each of the other specialist medical practitioners who gave oral evidence at Court, and were then subject to cross examination, Dr W was not required for cross examination.
2. Dr W has had discussions with each of the three medical practitioners involved with the care and treatment of Baby D, and whose evidence is previously recorded in this judgment, discussions with nursing staff, a review of the selected MRI images, a medical examination of the child herself on Friday 21 January 2011 and an interview with the parents on that same day.
3. At the commencement of his substantial and very helpful report which has been filed in evidence, annexed to his Affidavit of 25 January 2011, Dr W outlined the medical facts and his neurological prognosis for Baby D. This he found to be very poor, although qualified by the observation that the full extent of any deficits and of any compensating strengths cannot be assessed at this relatively early stage.
4. Dr W provided a succinct summary of the neurological issues and implications for management for Baby D as follows:

Baby D has sustained an overwhelming, generalised neurological insult.

Enough time has passed for the imaging findings to have stabilised and to provide considerable prognostic guidance.

She has emerging clinical signs of significant neurological abnormality.

There is very good evidence that she will be cortically blind.

There is very good evidence that she will suffer paralysis affecting all four limbs and all or most other volitional motor activity.

This will also be associated with contractures, joint complications and the need for repeated surgical procedures and ongoing physiotherapy.

There is very good evidence that she will have severe intellectual deficit, although the full extent of this is impossible to predict.

The severity of her other neurological deficits is such that it is very possible that her intelligence may never be able to be estimated, because of the barriers created by blindness and the lack of volitional activity.

She shows evidence of hearing.

She is very irritable and only able to be soothed by containment. The extent to which she is aware of and able to interact with others is unclear, as is her level of general awareness.

She is capable of experiencing pain.

1. Dr W concluded that Baby D has clearly suffered “a dreadful neurological insult”. He concluded that the severity of her neurological insult and imaging findings is at the outer end of the spectrum of severity seen in such situations.
2. The airway obstruction issues confronting Baby D were summarised on page 9 of the Report as follows:

Her upper airway obstruction is due to a combination of oedema and scarring related to the presence of an endotracheal tube. There may also be other components to her obstruction, such as tracheomalacia and airway collapse.

These processes will be being aggravated by the ongoing presence of an endotracheal tube, continually worsening the underlying pathology.

It is good medical management of the airway problem to attempt to remove the endotracheal tube, as no natural improvement of the underlying condition is possible without this step.

She has failed a number of attempts at extubation over some months. Should she fail again after an optimally conducted trial of extubation it would reinforce the view that she has a very significant functional obstruction.

Should she fail, tracheostomy would be the only way forward, ongoing endotracheal intubation being an unrealistic option.

The implications of tracheostomy in terms of qualify of life and the burden of care are such that it would be poor medical management to take this step without full exploration of whether it constituted burdensome and futile care in the particular context of the patient in question.

It would not be an automatic decision to offer a tracheostomy in all circumstances.

1. That identification above of the tracheostomy and in particular whether, within the medical and legal definition, it constituted “burdensome and futile care” is a matter upon which the Doctor was asked specific questions and which he subsequently answered at pages 30 and 32 of his report.
2. Dr W focused upon and provided very helpful observations upon the medical decision making process in difficult cases such as those presented by Baby D.
3. He highlighted and addressed the very difficult decision confronting both the parents and the medical treating team with Baby D. In particular he identified that “[i]nfants are peculiarly disadvantaged in situations such as end-of-life decision making or in decisions about burdensome treatment with an uncertain outcome as they cannot speak for themselves”.
4. With the background of his experience, with many like cases his starting point, Dr W highlighted that medical practitioners generally start with the principal that the parents are the most loving and highly motivated advocates for the child and are likely to give the best approximation of what the child’s wishes might have been. Both his evidence and his experience are that parents’ rights are essentially the rights needed to discharge their responsibility to the child, though there are situations where parents may become commonly conflicted and thus part of the task for neonatologists, as advocates for a child, is the need to make an assessment of the best interests of the child. Dr W cautioned that critical decisions must be carefully examined, particularly where issues in conflict with the best interests of the child may exist and may, of themselves, be matters of very real concern to parents. Therefore there is a required balancing of all competing factors, but subject always to the best interests of the child.
5. The further evidence of this topic of Dr W is most helpful, and in his report at pages 10 and 11, he records the following:

In working around end-of-life decision making the issues are sometimes clear, usually because there are no other choices. Sometimes the only choice available is not whether or not the child will die soon, but when and how. The choices then necessarily focus on how to salvage something from the wreckage for the child.

In more complex situations such as this other factors must be balanced. It is relatively common to be in a situation in which the child may not be in imminent danger of death, because of the level of support being given in intensive care, but faces a poor prognosis in the long term and a high burden of care.

In this situation the much more difficult calculation which must be made is whether the immediate burden of care is so great that it is not justified by what the child may gain from it, or whether the ongoing quality of life for the child is demonstrably so awful that it is legitimate to accept the death of the child concerned, regardless of the immediate burden of care.

In making such decisions about immediate care, the withdrawal of intensive care is most commonly undertaken with the logic that the immediate decision to move to palliative care to ameliorate the ongoing burden of care for the child is a withdrawal of care which is no longer serving a medically useful curative purpose and which is costing the child pain and suffering together with the more intangible but important depersonalisation inherent in a life on a ventilator. Any death which occurs as a consequence of this is accepted as a foreseeable but unintended consequence of good medical management.

Such balancing requires the humility needed to understand that we cannot cure everything and that just because a medical intervention is possible does not necessarily mean that it is good medical practice to offer it.

1. Dr W considered the use of sedation in terminal care and observed that this is a central issue in the management of this child who, on past occasions when she has been extubated has rapidly developed stridor and increased work of breathing and has become quite distressed. That situation is largely because of a reflex response to hypoxia and airway resistance. Dr W recorded that “[i]t would be fundamental to any humane medical management of this situation to provide assistance with sedation”.
2. On page 11 of his report and, both for Baby D and by way of an overview of the medical and ethical issues alive in this case he recorded that:

In such infants it is good, normal medical practice to use sedation and analgesia to ameliorate distress, just as is done in palliative care in adults and older children. The intent is to ease distress and pain. Attendant upon this may be some shortening of life due to the sedation, but this is not the primary intent and is regarded as optimal medical practice, providing the dosages used do not raise concerns about the intent of the sedation.

1. On page 12 of his report Dr W said:

Inherent in this is the need to consider the one effect of the intense desire to breathe is to help the baby cope with the obstruction by breathing hard. Sedation to reduce this distress will reduce this drive and may shorten her life. It is possible that very carefully titrated doses may provide the necessary relief without having this effect, but it will be a matter for nice judgement and it may well prove to be an inevitability that the price of the comfort achieved by such sedation would be a shortening of her life.

This is a classical “double effect” situation, which in medical logic turns on the intent of the sedation. It is very clear to me from the depositions and from discussion with [Dr Y] that the intent is entirely to relieve distress and that enormous thought has gone into the issues surrounding this.

It would be good, normal medical practice to use sedation and analgesia in this situation. It would be medically unacceptable to fail to do so.

1. In his engagement and preparation of the report on the request of the OPA Dr W was asked 41 specific questions, each of which he has answered in some detail in his extensive report which I have carefully read, considered and evaluated. Many of the answers to questions overlap his earlier comments and his endorsement of the treatment and conclusions of his medical colleagues at the hospital.
2. Dr W endorses the removal of the endotracheal tube which he describes as the cause of her airway problem and that “its presence is worsening that issue over time”. In the short term it is probably keeping her alive, but the price paid is a further oedema and scarring of the airway, thus worsening her fundamental problem. His conclusion is that the probability of Baby D being able to breathe independently and comfortably in the future is both low and becoming lower the longer the tube remains in place.
3. The various options for treatment including sedation, re-intubation and a tracheostomy have all been carefully considered by this expert and in particular it is important to record, and I am considerably helped by his response to question 38 (page 33 of the report). Dr W was there asked if he considered that in the event of extubation and Baby D being unable to breathe independently and comfortably was it in her best interest to have a tracheostomy. He replied, somewhat emphatically, “I do not” and continued:

This represents a significant increase in the burden of care to Baby D, who faces a life of considerable pain and discomfort, with none of the compensations of deep human contact and no ability for independent activity at her own volition, this complicated by blindness and mental retardation.

Her neuroimaging findings and her anticipated level of neurological disability are already at the outer limits of severity seen in the population of children with cerebral palsy.

Even without the airway issue, the severity of her neurological insult is such that it would have been normal practice in any Australian unit to offer a withdrawal of intensive care at the time of the second MRI, many would have offered it following the first MRI. The airway problem only further worsens her situation and anticipated burden of care. It also unfortunately greatly complicates decision making around palliative care.

To impose a tracheostomy on Baby D would be “striving officiously”, as she has little if anything, beyond pain, to gain from it. It would not be proportionate to her needs, condition and prognosis.

1. The questions drafted by the OPA partly focused upon an assessment of the future quality of life of Baby D, particularly whether it would be “burdensome”and also if the tracheostomy procedure would be regarded as “unduly burdensome”. The answers, as recorded by Dr W on pages 30 and 32 of his report (to questions 34 and 37), are direct and of very particular assistance to this Court.
2. When asked to describe if the tracheostomy could be classified as unduly burdensome in that the burden imposed by the procedure would outweigh the benefits to be achieved for Baby D, Dr W’s response was particularly clear and precise. His evidence was “Yes. Definitely”.
3. Again, in question 37, he was asked if, based upon his assessment of Baby D’s likely disabilities would he, and on what basis, would he consider her life to be burdensome. His response, which I wholly accept, was that “I believe that her life, should she survive, would be very burdensome.”
4. Later, and in further considered response to that question, Dr W said:

… but it is clear that her anticipated life could only be described as highly burdensome with few, if any, of the pleasures which we take for granted in our lives.

1. When asked in the current circumstances about the treatments and procedures that would be in the best interests of Baby D, Dr W provided a very clear, insightful and carefully considered response which I record in detail and wholly accept. At pages 33 to 35 of that report he said:

It is my view that treatment needs to move toward palliation, as the burden of care for her is high and her prospects of gaining anything from ongoing intensive care are very small.

There is a clear need to remove her endotracheal tube, as it is aggravating her basic airway pathology. It would be reasonable to structure this as a controlled extubation under steroid cover to maximise her chance of successful extubation and to provide greater certainty of the significance of any failure.

Part of the motivation for this would also be to provide some comfort to the treating team, in which there will be a spectrum of opinion concerning management and who are likely to have to support her through a time which is distressing for all.

Before moving to the next stage of treatment it would also be wise to take time with family to ensure that they have explored all options and have considered what would be important to them in the event of her approaching death.

This time would also be used to work with the treating team of nursing and junior medical staff to ensure a degree of comfort with the choices made and to allow staff some choice in their work assignments.

This done, my preferred management would be a controlled extubation, initially with mild sedation such as chloral hydrate. Should it become evident that she were in distress carefully titrated does of intravenous morphine would be added to ameliorate this.

This stage of care should ideally be conducted in a private area of the nursery in which parents could spend undisturbed time with her and be private through a very distressing time. The focus of management would shift very much to maximisation of the quality of her time with her family and to ensuring her comfort as best possible.

She will probably deteriorate toward death over the time after extubation, although the time course is uncertain. Should she reach a stage at which it were obviously necessary to reintubate her or to provide tracheostomy if she were to survive I do not believe that this should be offered. Efforts to ease her distress should continue, but with an acceptance of her death.

1. The above evidence of Dr W is of significant importance and of great assistance to the Court. It is very supportive of the concerns and approach of the hospital and its medical professionals and staff. It is a particularly sensitive and humane assessment of the life and struggles of Baby D. That eventual acceptance of her death is no doubt both difficult and distressing to parents and all professionals but at that stage the very best of effort and medical knowledge had been available to Baby D and there is a point in time where her best interests do require efforts to ease her distress with the knowledge and acceptance of her death.
2. The consensus amongst all of the very experienced and qualified medical practitioners, supported by Dr W, is that any future life for Baby D must, with certainty, be seen to be one that is, at the least, very burdensome and futile with no expectation of any enjoyment of life and without sight and any meaningful brain capacity.
3. I have not made any assessment on a moral judgment of the quality of life of Baby D but I am particularly attracted to the sensitive, humane and knowledgeable evidence of Dr W at page 36 of his report where he stated that:

It is most unlikely that [Baby D] would be able to have an interactive relationship with another, except at the most basic, or most reflex level, nor would she have the vision and probable intellectual capacity to appreciate and explore the world around.

It can be seen that this would be life without any of the things that enrich our lives and allow us to develop and express our humanity. It would be life in a “vitalist” sense - she would have a pulse, respiration, circulation and some neurological activity, but little if anything in the way of a higher neurological functions.

Whilst reluctant to leap to judgement about quality of life… I find it hard to see that the future holds anything for her but life which could legitimately be described as “demonstrably awful”.

1. Dr W concluded his report by recording the fact that he had been impressed by the care and thought which had gone into Baby D’s care at the treating hospital. He then said:

It is very clear to me that the issues have been deeply felt and have been agonised over in way which shows high emotional intelligence and ethical sensitivity. I have real confidence that the treating team and the parents have between them made an extremely honest and effective attempt to judge [Baby D’s] best interests and to pursue them. I fully support their management.

1. Senior Counsel for the hospital made particular reference to the answer of Dr W provided to question 39, and in particular, where he said:

There is a clear need to remove her endotracheal tube, as it is aggravating her basic airway pathology. It would be reasonable to structure this as a controlled extubation under steroid cover to maximise her chance of successful extubation and to provide greater certainty of the significance of any failure.

1. Subsequently and arising out of discussions between Senior Counsel for the hospital and the OPA and after obtaining further instructions from Dr W, a qualification to his above evidence was agreed upon and read into the transcript of the Court evidence, as follows:

[Dr W] believes that it is sound medical practice not to give steroids to Baby D as has been foreshadowed by [Dr Y].

1. I accept that further evidence and its outcome is to neutralise any limited disagreement in the ongoing professional approach and treatment between each of the highly respected and qualified medical specialists.

# ACCEPTANCE OF PROFESSIONAL MEDICAL EVIDENCE

1. I have carefully considered and accepted the affidavit and oral evidence of Dr W, Dr X, Dr Y and Professor Z, including their expert opinions, the medical history given of Baby D, their assessment of the current health issues and prognosis, and their recommendations that I have found to be in the best interests of Baby D.

# PARENTAL RESPONSIBILITY AND JURISDICTION

1. I have hereafter in these reasons for judgment considered and evaluated in some detail the meaning of parental responsibility within the facts of this difficult and complex case, the jurisdiction of this Court and the welfare provisions within the Act*,* together with the constitutional basis of such powers and the assistance derived from previous reported decisions. Subject to that evaluation of all of these issues, a concise summary of the issues concerning Baby D in this judgment include:
   * + 1. Is court authorisation required for the performance of the proposed medical procedure(s); and
          1. Do the proposed medical procedure(s) constitute a “special medical procedure” pursuant to the Act and Rules, or a “special case” in accordance with the reasoning in *Secretary, Department of Health and Community Services v JWB and SMB*;[[7]](#footnote-7) and
          2. Has the welfare jurisdiction of the Court, provided for in s 67ZC of the Act, been invoked?; and
          3. Does the scope of the welfare jurisdiction under s 67ZC empower the Court to make orders in relation to the performance of the medical procedure(s) on Baby D?; and
          4. Does the scope of the welfare jurisdiction under s 67ZC empower the Court to make the further orders and declarations sought by the Hospital?;

Or otherwise:

* + - 1. Are the parents of Baby D able to consent on the child’s behalf to the proposed medical procedure(s);
         1. Does the scope of parental responsibility provided for in the Act include the decision to consent to medical procedure(s) on behalf of Baby D?; and
         2. Does the definition of “Major long-term issues” in s 4 of the Act include issues in relation to the health of Baby D?; and
         3. Are the parents required to jointly approach the Court for the orders or declarations sought by the hospital’s Clinical Ethics Committee?

**RIGHTS OF PARENTS TO MAKE DECISIONS ABOUT THEIR CHILD**

1. The objects and principles of Part VII of the Act are provided for in s 60B. The objects are directed towards ensuring children have the benefit of the meaningful involvement of both their parents in their lives; protection from any form of abuse, neglect or family violence; and adequate and proper parenting so as to achieve their full potential. Specifically subparagraph (d) is directed to ensuring that “parents fulfil their duties, and meet their responsibilities, concerning the care, welfare and development of their children”.
2. The principles underlying the objects include (unless contrary to a child’s best interests), that “parents jointly share duties and responsibilities concerning the care, welfare and development of their children” per s 60B(2)(c), and “agree about the future parenting of their children” per s 60B(2)(d).
3. These objects and principles were included in amendments to the Act.[[8]](#footnote-8) These amendments, as and from 1995, substantially highlight and give legal effect to the rights, duties and responsibilities of parents. That is the fundamental basis upon which I have approached the decision making process, based upon the best medical opinions, in determining the best interests of Baby D.
4. I record that great caution must be adopted when considering earlier reported cases dealing with the best interests of children in like circumstances to Baby D where the Act that was then operative was vastly different in content and focus.
5. The Court must regard the best interests of the child as the paramount consideration as provided for in s 60CA. How the best interests of the child are determined, both as to the primary considerations and additional considerations are identified within s 60CC(1) and (2). For the purposes of the determination of the best interests of Baby D I have had particular regard to (in summary):

Primary Considerations

1. the need to protect the child from physical or psychological harm from being subject to, or exposed to, abuse, neglect or family violence.

Additional Considerations

(f) the capacity of each of the child’s parents, or any other person to provide for the emotional needs of the child;

(g) the maturity, lifestyle and background of the child;

(i) the attitude to the child and to the responsibilities of parenthood demonstrated by each of the parents;

(m) any other fact or circumstance that the Court thinks relevant.

1. The meaning of “parental responsibility” is very clearly defined in s 61B of the Act and in relation to a child:

means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

1. Each of the parents of a child who has not attained 18 years of age has parental responsibility for that child pursuant to s 61C. A notation to this section identifies the legal position provided by s 61C prevails in relation to parental responsibility to the extent which it is not displaced by a parenting order made by the Court. Such responsibility can be affected by court order, and s 61C(3) provides that parental responsibility has effect, but only subject to any order of a court for the time being in force.
2. A parenting order is defined in s 64B(1) and the matters dealt with by such an order pursuant to s 64B(2) include:

(i) any other aspect of care, welfare or development of the child or any other aspect of parental responsibility for a child

1. Parents have responsibility for “major long-term issues”[[9]](#footnote-9) and within s 4 of the Act that term is defined to mean, in relation to a child:[[10]](#footnote-10)

issues about the care, welfare and development of a child of a long-term nature and includes (but is not limited to) issues of that nature about:

(c) the child’s health

1. Parenting orders are further explained within Division 6, Part VII of the Act and significantly s 65AA emphasises the best interests of a child in making a parenting order and redirects attention to s 60CA.
2. Pursuant to s 65C either or both of a child’s parents may apply for a parenting order, as may a child, or a grandparent, or by subparagraph (c) “any other person concerned with the care, welfare or development of the child”.
3. It was the parents in this case, at the request or direction of the Clinical Ethics Committee of the hospital, that were effectively required to apply for the orders regarding Baby D and for the purposes of these reasons for judgment it is not necessary to consider what other person could have applied pursuant to s 65C(c) of the Act.

# WELFARE OF CHILDREN

1. Part VII, Division 8 of the Act enables orders to be made about children and in particular in relation to the welfare of children.
2. Section 67ZC(1) states that “[i]n addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children”.
3. In deciding whether to make an order under s 67ZC(1) in relation to a child, a court must regard the best interests of a child as the paramount consideration pursuant to s 67ZC(2). The extension, application and additional operation of Part VII is considered within Division 12, subdivision F of the Act, which includes s 69ZH.[[11]](#footnote-11)
4. That confirmation of the applicable and additional jurisdiction of the Court under s 67ZC is established in this case where the parents are married and Baby D is a child of that marriage. These issues are more fully discussed in my consideration of the limitations upon and scope of parental powers informed by law.

# LIMITATIONS ON PARENTAL RESPONSIBILITY AND THE SCOPE OF PARENTAL POWER

1. In *Marion’s Case* the majority discussed the scope of parental power.[[12]](#footnote-12) In their reasons for judgment Mason CJ, Dawson, Toohey and Gaudron JJ cited *Gillick v West Norfolk AHA*[[13]](#footnote-13) as authority for the proposition that a parent’s power to consent to medical treatment on behalf of a child diminishes over time as “parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child”.[[14]](#footnote-14) The majority reasoned that when a child is not capable of giving informed consent to medical treatment, as is the case with Baby D, an issue arises as to “whether there are kinds of intervention which are, as a general rule, excluded from the scope of parental power”.[[15]](#footnote-15)
2. The majority in *Marion’s Case* held that the decision to authorise the sterilization of an intellectually disabled minor fell outside the ordinary scope of parental powers under the Act and that court authorisation was necessary as a “procedural safeguard” to ensure the “best protection of the interests of a child”.[[16]](#footnote-16) The majority discussed a number of first instance decisions that permitted sterilization procedures to be performed on minors.[[17]](#footnote-17) The distinction adopted by Nicholson CJ of therapeutic[[18]](#footnote-18) and non-therapeutic procedures was noted, but the majority hesitated to apply such an approach due to the uncertainty of the terms involved.[[19]](#footnote-19) However, it was recognised that some distinction was necessary, irrespective of how unclear the dividing line may be. In discussing the procedure of sterilization in the context of *Marion’s Case* the majority noted that:[[20]](#footnote-20)

As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child’s present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.

1. The majority noted that the factors contributing to the significant risk of a wrong decision being made in the context of a sterilization case are (in summary):

(a) the complexity surrounding the question of consent; and

(b) the fact that the consequences of a sterilization procedure are not merely medical or biological but social and psychological; and

(c) the decision of a parent to sterilise an intellectually disabled child may involve the interests of the child but also the potentially conflicting interests of the parents and other family members.

1. The majority emphasised that “court involvement ensures that, in the case of conflict, that the child’s interests prevail”.[[21]](#footnote-21) However, importantly their Honours acknowledged that “it is not possible to formulate a rule which distinguishes these cases… [g]iven the widely varying circumstances, it is impossible to apply a single rule to determine what are… the “clear cases” ”.[[22]](#footnote-22)
2. It is apparent from *Marion’s Case* that there are limitations on parental power in circumstances where the child is not able to consent and where the medical intervention proposed comes within the ambit of a “special case”.

**IS COURT AUTHORISATION REQUIRED?**

1. In *Marion’s Case* the procedure of sterilization was highlighted as a “special case” outside the scope of ordinary parental power and thereby requiring court authorisation. One of the significant questions posed in the matter before the Court is whether factors exist that have the combined effect of “marking out” the decisions to:
2. perform the medical procedure of extubation on Baby D; and
3. administer palliative care, sedation or other medication as necessary and proper if Baby D is in pain or respiratory distress due to the extubation;

as decisions involving medical procedure(s) that would constitute a “special case”.

1. If the procedure(s) constitute a “special case”, first due to the significant risk of a wrong decision being made about what is in the best interests of Baby D (as a child who cannot consent), and secondly due to the grave consequences that may follow from a wrong decision being made, then court authorisation may be required. This raises the issue of whether the Family Court has jurisdiction in relation to this matter and is empowered to authorise the medical procedure(s) proposed.

**DOES THE FAMILY COURT HAVE JURISDICTION?**

1. In *Marion’s Case*[[23]](#footnote-23)the majority of the High Court noted that any limitation on the jurisdiction of the Family Court conferred by the Actmust be constitutional. The majority determined that the Act is limited by the constitutional powers set out in section 51 of the Constitution,[[24]](#footnote-24) specifically s 51(xxi) “Marriage” and s 51 (xxii) “Divorce and matrimonial causes; and in relation thereto, parental rights, and the custody and guardianship of infants”.[[25]](#footnote-25)
2. In *DJL v Central Authority*[[26]](#footnote-26) the High Court stated, in relation to the jurisdiction and powers of the Family Court, that:

The Family Court is a statutory court, being a federal court created by the Parliament… [a] court exercising jurisdiction or powers conferred by statute “has powers expressly or by implication conferred by the legislation which governs it” and “[t]his is a matter of statutory construction”; it also has “in addition such powers as are incidental and necessary to the exercise of the jurisdiction or the powers so conferred”.

. . .

However, the powers conferred upon the Family Court by statute may be exercised only within the range of jurisdiction conferred upon it by laws made by the Parliament under s 77 of the Constitution.

1. Gleeson CJ and McHugh J in *Minister for Immigration and Multicultural and Indigenous Affairs v B & Anor*[[27]](#footnote-27) agreed that, as a federal court established by Parliament, the Family Court’s authority to decide is defined pursuant to sections 76 and 77 of the Constitution.[[28]](#footnote-28) Their Honours stated that one of the matters detailed in s 76 of the Constitution is a matter arising under a law made by the Parliament.[[29]](#footnote-29) Section 76 of the Constitution provides that:

The Parliament may make laws conferring original jurisdiction on the High Court in any matter:

1. arising under this Constitution, or involving its interpretation;
2. arising under any laws made by the Parliament;
3. of Admiralty and maritime jurisdiction;
4. relating to the same subject-matter claimed under the laws of different States.
5. Section 77 of the Constitution states that:

With respect to any of the matters mentioned in the last two sections the Parliament may make laws:

1. defining the jurisdiction of any federal court other than the High Court;
2. defining the extent to which the jurisdiction of any federal court shall be exclusive of that which belongs to or is invested in the courts of the States;
3. investing any court of a State with federal jurisdiction.
4. Their Honours concluded that the Family Court is only vested with the jurisdiction provided by the Parliament as defined in a law “with respect to one of the “matters” mentioned in… s 76 of the Constitution”.[[30]](#footnote-30) However, Gleeson CJ and McHugh J stated that the High Court had “long recognised that the requirements of s 77 of the Constitution may be satisfied even though jurisdiction in respect of a matter is defined or invested only inferentially”.[[31]](#footnote-31) Gummow, Hayne and Heydon JJ in their separate reasons for judgment identified that the Family Court is created by s 21 of the Act, is a superior court of record and has the authority to make decisions “as to the existence of its jurisdiction in a matter”.[[32]](#footnote-32) Further, s 31 of the Actsets out the original jurisdiction of the Family Court and states that:

(1) Jurisdiction is conferred on the Family Court with respect to:

(a) matters arising under this Act or under the repealed Act in respect of which matrimonial causes are instituted or continued under this Act; and

. . .

(d) matters (other than matters referred to in any of the preceding paragraphs) with respect to which proceedings may be instituted in the Family Court under this Act or any other Act.

1. From the reasoning of the majority in *Marion’s Case*, and that of Gleeson CJ and McHugh J, and Gummow, Heydon and Hayne JJ in *MIMIA v B*, I am comfortable in concluding that the Family Court has jurisdiction with respect to “matters” relating to the “marriage” and “divorce and matrimonial causes” powers, as provided for in s 76 and s 77 of the Constitution. However, this raises the question of whether the scope of the jurisdiction provided by the Act empowers the Court to make orders in relation to Baby D.

**THE WELFARE JURISDICTION AND SECTION 67ZC**

1. The question of whether the Family Court has an independently vested “welfare jurisdiction” was discussed in *Marion’s Case* and *MIMIA v B*.[[33]](#footnote-33) In *Marion’s Case* the majority held that the 1983 amendments to the Act were intended to confer on the Family Court jurisdiction similar to the *parens patriae* jurisdiction.[[34]](#footnote-34)
2. The majority reasoned that s 64(1)(c) of the Act “does not in terms confer jurisdiction on the Court but it confers power to make orders and presupposes jurisdiction” and that it was “clear that the welfare of a child of a marriage is a “matter” which arises under Pt VII for the purposes of s 63(1) and is, therefore, an independent subject which may support proceedings before the Family Court”.[[35]](#footnote-35) The majority affirmed the reasoning of McCall J[[36]](#footnote-36) who argued that the Court was able to exercise “the general *parens patriae* power with respect to children”, noted that modern conceptions of the supervisory power accepted there is no limitation on the jurisdiction,[[37]](#footnote-37) and held that therefore “courts can exercise the jurisdiction in cases where parents have no power to consent to an operation, as well as in cases in which they have the power”.[[38]](#footnote-38)
3. The majority further relied on the statement of Gibbs CJ in *Fountain v Alexander*[[39]](#footnote-39) in confirming that “the power of Parliament to make laws with respect to marriage does not extend to laws for the protection or welfare of the children of a marriage except in so far as the occasion for their protection or welfare arises out of, or is sufficiently connected with, the marriage relationship.”[[40]](#footnote-40) However, their Honours noted that the welfare jurisdiction was very wide and that “[s]o long as an order of the Family Court is constitutional, there can be no limitation on the Court’s powers”.[[41]](#footnote-41) The majority concluded that the question of the sterilization of a child of a marriage arises from the marital relationship and therefore from the custody and guardianship of the child and that the jurisdiction to authorise a sterilization procedure was within the ambit of the power vested in the Commonwealth.[[42]](#footnote-42)

**THE SCOPE OF THE WELFARE JURISDICTION AND SECTION 67ZC**

1. In *MIMIA v B* the High Court discussed the scope of and limitations on the welfare power provided for in s 67ZC[[43]](#footnote-43) in the context of proceedings brought before the Family Court for orders directing the Minister to release children from immigration detention[[44]](#footnote-44) on the grounds that their continued detention was harmful to their welfare.[[45]](#footnote-45) Gleeson CJ and McHugh J concluded that s 67ZC did not confer jurisdiction on the Family Court to impose obligations on third parties except as expressly provided for, and that otherwise Part VII was confinedto the relationship between parents and children. Further, their Honours held that Chapter III of the Constitution confined the Family Court’s jurisdiction and powers with respect to the welfare of children in the same manner as s 69ZH(2) and (3) of the Act.[[46]](#footnote-46) Gummow, Hayne, Callinan and Heydon JJ held that the Family Court did not have jurisdiction as s 67ZC must be read subject to Part VII, Division 12, Subdivision F which did not confer the jurisdiction to decide a matter involving the Minister.[[47]](#footnote-47)
2. In their separate reasons for judgment Gleeson CJ and McHugh J noted that s 67ZC did not expressly give jurisdiction in relation to a “matter” and that the “welfare of children” was not a matter mentioned within ss 51 or 76 of the Constitution.[[48]](#footnote-48) However, their Honours noted that s 77 of the Constitution may be satisfied if the jurisdiction in relation to a matter can be inferred.[[49]](#footnote-49) It was said that s 67ZC, unlike other sections considered by the Court in previous authorities,[[50]](#footnote-50) does not confer liabilities, duties, rights or privileges on a person and does not therefore “confer jurisdiction in respect of a “matter” arising under a law of the Parliament because it does not confer rights or impose duties on anyone” and “unless it were supported by the external affairs power… or was read down to refer to the parties to a marriage, it could not constitutionally confer any rights or impose any duties in respect of the welfare of children”.[[51]](#footnote-51)
3. Gleeson CJ and McHugh J considered the reasoning of the majority in *Marion’s Case* and posited that the effect of that decision was not to establish that the Family Court had a welfare jurisdiction at large or that the jurisdiction could be relied on to authorise orders that “are divorced from the determination of “some immediate right, duty or liability” of the parties to a controversy or that are not analogous to those exceptional orders traditionally made by courts exercising judicial power”.[[52]](#footnote-52) Their Honours argued that when construed as a whole the Divisions and Subdivisions of Part VII of the Actindicate that the main object of the Part is to ensure that parents act to advance the best interest of their children and no provisions in the Part suggest an intention to give the Family Court “a general jurisdiction over children with the power to make an order against individuals whenever the best interests of a child require such an order to be made” and that except where expressly stated the Part is concerned with the obligation of parents to their children and proceedings between parents of children.[[53]](#footnote-53) In determining the scope and effect of s 67ZC and the welfare jurisdiction as constrained by Part VII, Gleeson CJ and McHugh J stated that:[[54]](#footnote-54)

Section 67ZC is contained in subdiv E of Div 8. Thus, s 69ZH gives s 67ZC an “effect” as if the references to “children” and “child” in that section were “confined to a child of a marriage” (s 69ZH(2)) and the section made “provision with respect to the parental responsibility of the parties to a marriage for a child of the marriage” (s 69ZH(3)).

. . .

[T]he parents of a child may seek an order under s 67ZC whether the operation of that section is confined by s 69ZH(2) and (3) or whether it has an operation independently of those subsections. The right to seek that order arises from various provisions in Pt VII, but particularly from ss 60B, 61B and 61C…

. . .

By necessary implication, the Family Court may also make an order under s 67ZC that is binding on a parent. Under that section it may also make orders such as those made in *Marion’s Case* or those analogous to orders traditionally made by courts exercising *parens patriae* jurisdiction. Nothing in that section or in the rest of Pt VII, however, suggests that the Family Court has jurisdiction to make orders binding on third parties whenever it would advance the welfare of a child to do so.

1. Gummow, Hayne and Heydon JJ in their separate reasons for judgment also concluded that the welfare jurisdiction conferred on the Family Court was limited and that s 69ZH “confines the operation of s 67ZC to the parental responsibilities of the parties to a marriage for a child of the marriage”.[[55]](#footnote-55) In discussing s 69A, in Division 12 of Part VII, and in particular, subsections “(b) jurisdiction of courts” and “(e) the places and people to which this Part extends and applies”, their Honours reasoned that those subsections conjointly conferred jurisdiction on the Court in relation to “matters” for “the conferral of federal jurisdiction and the creation of rights and liabilities in the exercise of legislative powers found in s 51 of the Constitution”.[[56]](#footnote-56) Their Honours argued that “[j]urisdiction is conferred by s 69H(1) on the Family Court “in relation to matters arising under [Pt VII]””[[57]](#footnote-57) and that “s 69ZH confines the operation of s 67ZC to the parental responsibilities of the parties to a marriage for a child of the marriage”.[[58]](#footnote-58) Ultimately Gummow, Hayne and Heydon JJ held that “[s]ection 67ZC… must be read in the manner indicated earlier in these reasons, with the provisions of Div 12, in particular s 69ZH.”
2. The reasoning in *MIMIA v B* was applied by Chief Justice Bryant in *Re Alex*[[59]](#footnote-59) in holding that “parental responsibility is a “matter” concerning the welfare of a child under s 76(ii) of the *Constitution* and it provides a sufficient basis upon which to make orders pursuant to section 67ZC”.[[60]](#footnote-60) It is clear from the reasoning of Gleeson CJ and McHugh J, and Gummow, Hayne and Heydon JJ in *MIMIA v B*,[[61]](#footnote-61)the reasoning of the majority in *Marion’s Case*, and the application of *MIMIA v B* in subsequent decisions of this Court, that s 67ZC is limited by s 69ZH to the parental responsibilities of the parties to a marriage for a child of the marriage.[[62]](#footnote-62) As stated in paragraph 49 the applicant parents of Baby D are parties to a marriage and Baby D is a child of that marriage. It is therefore unnecessary to consider the application of s 67ZC in other circumstances.

**SECTION 67ZC OR PARENTAL RESPONSIBILITY: HAS JURISDICTION BEEN INVOKED**

1. In *Re: Sean and Russell (Special Medical Procedures)*[[63]](#footnote-63) Murphy J commented that due to the “unclear dividing line” discussed in *Marion’s Case* parents may seek to obtain court authorisation in relation to decisions falling within the ambit of parental responsibility.[[64]](#footnote-64) Similarly, his Honour noted that medical practitioners may seek certainty in relation to the authorisation of procedures where the consequences of proceeding without a proper authority are significant.[[65]](#footnote-65) In *R v Commonwealth Court of Conciliation and Arbitration; Ex parte Ozone Theatres* the majority of the High Court held that where “a jurisdiction is created for the public benefit or for the purpose of conferring rights or benefits upon persons the court upon an application properly made is under a duty to exercise its jurisdiction and is not at liberty to refuse to deal with the matter”.[[66]](#footnote-66) His Honour reasoned in *Re: Sean and Russell* in reliance on *Ozone Theatres* that if a proceeding for a proper purpose invokes the jurisdiction of the Family Court then the Court has a duty to exercise its jurisdiction.[[67]](#footnote-67)
2. Murphy J then referred to the statement in *Marion’s Case* where the majority were satisfied that the courts can exercise jurisdiction in “special cases” where parents do not have the power to consent to an operation, as well as in circumstances where they do,[[68]](#footnote-68) and emphasised that:[[69]](#footnote-69)

Where a decision properly falls within the ambit of parental responsibility, the authorisation or consent to a procedure is a parental decision.

. . .

Where parents are properly and appropriately exercising parental responsibility as the Act and the law contemplate that they will and should; where there is no disagreement between them and there is no “solely therapeutic” element to the proposed procedure, the dilemmas and decisions for parents and doctors alike are predominately medical.

. . .

In my view, the law should tread very lightly in seeking to intrude in, or impose itself upon, those decisions. It would in my respectful view be sad indeed if the courtroom was to replace a caring, holistic environment within which approach by parents and doctors alike could deal with (admittedly extremely difficult) medical and other decisions that need to be made.

1. I respectfully agree with the reasoning and comments of Murphy J. Importantly his Honour noted that even if court authorisation is not required, the Court has the jurisdiction and power to make orders in relation to “any other aspect of parental responsibility”.[[70]](#footnote-70) Parental responsibility comprises “*all* duties powers and responsibilities and authority, which, by law… parents have in relation to… children” including orders which “seek to define or clarify the limits of parental responsibility”.[[71]](#footnote-71) Murphy J noted that the applications in the matter of *Re: Sean and Russell* had not be brought in avoidance of parental responsibility, or for an ulterior motive, and that as the jurisdiction of the Court had been properly invoked and the orders and declarations sought were within power,[[72]](#footnote-72) the determination of an issue relating to the limits of parental responsibility could be said to be in the best interests of the child.[[73]](#footnote-73)
2. Section 69Hof the Act provides that the Court is vested with jurisdiction in relation to matters arising under Part VII.[[74]](#footnote-74) This includes the power to make parenting orders pursuant to s 65C and in accordance with s 64B. Section 64B(2)(i) provides that an order may deal with “any aspect of the care, welfare or development of the child or any other aspect of parental responsibility for a child”, including “major long-term issues” relating to the child’s health.[[75]](#footnote-75) The jurisdiction conferred by s 67ZC states that it is provided “in addition to the jurisdiction that a court has” under Part VII.[[76]](#footnote-76)
3. The applicant parents have, pursuant to the request of the Clinical Ethics Committee of the hospital, made an application to this Court seeking orders either for Court authorisation of the proposed procedure(s) or for declarations that the authorisation of the proposed procedure(s) are properly within the ambit of parental responsibility. Those orders relate to the determination of an issue relating to the limits of parental responsibility. Further, the determination of those issues in all of the circumstances can be said to be in the best interests of the child, Baby D. It follows that as the applications have been made properly, not in avoidance of parental responsibility or for an ulterior or improper purpose, and as the jurisdiction of the Court has been properly invoked, the Court has a duty to exercise its jurisdiction and hear and determine this matter.

**ARE THE PROCEDURE(S) A “SPECIAL MEDICAL PROCEDURE” OR “SPECIAL CASE”**

1. Since the decisions of the High Court in *Marion’s Case* and *MIMIA v B* there have been significant amendments to the Act. As Murphy J noted, the legislature has not amended s 67ZC since its insertion by the *Family Law Reform Act* *1995* (Cth), and the subsequent *Family Law Amendment (Shared Parental Responsibility) Act 2006* (Cth) did not change its form or effect.[[77]](#footnote-77) This suggests that the decision in *Marion’s Case* would continue to apply until it is overturned, and that parents are required to seek court authorisation for medical interventions involving procedures that are “special cases” outside the scope of parental power.[[78]](#footnote-78) Importantly, in *Marion’s Case* the Court held that the Act does not empower the Family Court to “enlarge the powers” of a parent to consent to medical interventions deemed to be outside the scope of parental power.[[79]](#footnote-79) This raises the question of whether the proposed procedure(s) are a “special medical procedure” pursuant to the Act or a “special case” within the category described by the High Court in *Marion’s Case*.
2. A “Medical Procedure Application” is defined in the Dictionary of the Rules and means “an Initiating Application (Family Law) seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease”. The example notated in the Rules of a “major medical procedure” for a child, that is not for the treatment of a bodily malfunction or disease, is a procedure for the sterilization or removal of a child’s reproductive organs. This definition suggests that *special* medical procedure applications as defined relate only to medical treatments that are not performed primarily for the treatment of a bodily malfunction or disease.
3. In *Marion’s Case* the majority noted that “in speaking of sterilization in this context, we are not referring to sterilization *which is a by-product of surgery appropriately carried out to treat some malfunction or disease*”[[80]](#footnote-80) thereby distinguishing between sterilization procedures required for the treatment of a bodily malfunction and disease and sterilization procedures not primarily for that purpose.[[81]](#footnote-81) In *Re: Sean and Russell* Murphy J noted that “it is not possible, or in my view, in any event desirable, to further define or list those procedures, treatments, or the like which require court authorisation”[[82]](#footnote-82) and although I respectfully agree with his Honour I will briefly canvass relevant Family Court authorities.

**RELEVANT AUTHORITIES**

1. Special medical procedure authorities have involved applications for sterilization procedures,[[83]](#footnote-83) treatments and medical procedures relating to gender identity,[[84]](#footnote-84) and a variety of medical procedures outside of those discrete categories.[[85]](#footnote-85)

*RE: ANGELA (SPECIAL MEDICAL PROCEDURE)*

1. Recently, in *Re: Angela (Special Medical Procedure)*[[86]](#footnote-86)the child, who was 12, had Retts Syndrome, which is a progressive neurological disorder that results in epilepsy and physical and intellectual impairment. The parents of Angela brought an application seeking the performance of a hysterectomy on the child, which was supported by Angela’s treating medical practitioners. The evidence of the medical practitioners, and Angela’s mother, indicated that during heavy menstruation Angela was more likely to suffer epileptic seizures.[[87]](#footnote-87) Expert evidence before the Court stated that a number of other treatments had been pursued in attempts to control Angela’s menstruation prior to bringing the application, but that none had been effective in reducing the severity of the menstruation or the occurrence of seizures during heavy menstruation.[[88]](#footnote-88)
2. In discussing whether Court authorisation was required, Cronin J highlighted that the procedure in *Marion’s Case* was deemed to be a special case as it was a “major invasive medical procedure” with irreversible effects.[[89]](#footnote-89) His Honour went on to comment that:[[90]](#footnote-90)

There is a fine line in this case between the decision falling within normal parental responsibility and outside of it because of the fact that [the doctor] says that this is not a procedure for sterilization purposes. However, it is clear that it is invasive and irreversible. To the extent that it is necessary to find therefore that this decision is outside the scope of the parental responsibility of the mother and father, I do so on the basis of the invasive nature and irreversible effect of the procedure.

1. After identifying that s 67ZC of the Act provides the Court with jurisdiction to make orders relating to the welfare of the children, and that any orders made must be in the best interest of the child,[[91]](#footnote-91) his Honour noted rule 4.09 of the Rules and concluded that the procedure was in Angela’s best interests.[[92]](#footnote-92)

*IN THE MATTER OF THE WELFARE OF A (A CHILD)*

1. *In the matter of the welfare of A (a child)*,[[93]](#footnote-93) the child who was 14 years old, was born with a condition known as congenital adrenal hyperplesia. The disorder resulted in the over-production of androgens in the adrenal glands of the child as a foetus, causing the masculinisation of the child’s genitalia. The application brought by the mother sought the authorisation of procedures to be performed on A, including a bilateral mastectomy, a hysterectomy and oopherectomy and surgery to unfold A’s clitoris, close A’s labia and create the appearance of a scrotum.[[94]](#footnote-94)
2. Mushin J found that although it was not a “sterilization case” the procedures involved “extensive surgical intervention” and “invasive, irreversible and major surgery”.[[95]](#footnote-95) His Honour concluded that the procedures required Court authorisation, were necessary and in the best interests of the child based substantially on the expert evidence of A’s treating psychologist.[[96]](#footnote-96) His Honour made orders in the form of declarations that the mother be authorised to consent to the procedures being performed on the child, and further for the medical practitioners and other professionals to be authorised to conduct such operations and procedures as a result of the consent of the mother.[[97]](#footnote-97)

*RE: SALLY (SPECIAL MEDICAL PROCEDURE)*

1. Similarly, in Re: *Sally (Special Medical Procedure)*[[98]](#footnote-98) a hospital applied for orders that the child’s parents be authorised to consent on her behalf to the performance of a gonadectomy so that she would be able to “live more normally as a female”.[[99]](#footnote-99) Expert evidence determined that Sally was genetically male, did not have a uterus, and had gonads present in her pelvis due to a 5-alpha-reductase deficiency, which is a sexual development condition. Sally, who was 14 and a half, affirmed that she identified as female and wanted the procedure to be the performed. Her parents supported the application. Importantly, Murphy J noted that Sally was not diagnosed with gender identity dysphoria and her condition was not psychological, but one requiring treatment that involved an “invasive and irreversible medical procedure”.[[100]](#footnote-100)
2. His Honour held that the Court had jurisdiction to hear and determine the application pursuant to s 67ZC of the Act.[[101]](#footnote-101) After discussing at length the risk of psychiatric harm if the procedure was not performed, as well as the long term ramifications of the procedure on Sally, Murphy J concluded that the procedure was in the best interests of the child.[[102]](#footnote-102) In coming to this conclusion his Honour applied the s 60CC primary and additional considerations.[[103]](#footnote-103) Murphy J ordered that pursuant to s 67ZC of the Act the procedure and necessary consequential procedures be performed on Sally. His Honour further ordered that the written authority of Sally’s parents be sufficient to authorise medical practitioners and other professionals to conduct the operations and procedures authorised by the orders.[[104]](#footnote-104)

*RE: SEAN AND RUSSELL*

1. Recently, Murphy J also heard the aforementioned matter of *Re: Sean and Russell*.[[105]](#footnote-105) The applications were brought by a health authority and the parents of both children joined the authority in seeking the orders and declarations sought. The applications sought the Court’s consent on behalf of the children or a declaration that the parents of Sean and the parents of Russell were authorised to consent to a gonadectomy and consequential procedures related to the effective treatment of Denys-Drash Syndrome.[[106]](#footnote-106) The syndrome is incredibly rare and is associated with the development of ambiguous genitalia and male psuedohemaphroditism.[[107]](#footnote-107) As both Sean and Russell were genetically male, the procedure would render each child infertile. However, the medical evidence suggested that it was almost certain that each child would be rendered infertile due to the effects of the syndrome without the proposed procedures. The concern that gave rise to the application was the increased risk of the development of testicular cancer which could be prevented by the procedures.
2. It was reasoned that the procedures fell within the scope of parental powers encompassed by parental responsibility as the procedures were for the “treatment of a “bodily malfunction or disease”” despite being procedures that would result in sterilization.[[108]](#footnote-108) His Honour noted that although Court authorisation was not required, the Court had the jurisdiction and power to make the orders and the question was therefore if the terms of the orders sought were “in the best interests of each of these children – that being the ultimate determinant of whether a parenting order of any type should be made”.[[109]](#footnote-109)

*RE: ALEX*

1. Comparatively, in *Re Alex*,[[110]](#footnote-110) Alex was diagnosed with gender identity dysphoria.[[111]](#footnote-111) Alex had affirmed his male sex, expressed a desire to become male in appearance and orders were made in 2004 authorising the department, who had guardianship of Alex, to consent to medical treatment including the administering of hormones and continuous psychiatric treatment.[[112]](#footnote-112) The department made a further application in 2007 for authorisation to perform a bilateral mastectomy procedure on Alex, who had continued to express a desire to be male and live as a man.[[113]](#footnote-113)
2. Chief Justice Bryant held that due to the interventionist nature of the procedure it was appropriate for “the court’s permission to be sought for a bilateral mastectomy to be performed”.[[114]](#footnote-114) However, in considering whether the purpose of the procedure was to correct a disease or malfunction the her Honour adopted Nicholson CJ’s finding and stated that:[[115]](#footnote-115)

There is no suggestion that Alex’s diagnosis of gender identity dysphoria has changed in the intervening period and thus the earlier findings remain apposite. Nicholson CJ said at [195] and [197]:

The current state of knowledge would not, in my view, enable a finding that the treatment would clearly be for a “malfunction” or “disease” and thereby not within the jurisdiction of this Court as explained by the majority in Marion’s case. To my mind, their Honours were seeking in that case to distinguish medical treatment which seeks to address disease in or malfunctioning of organs. In the context of sterilisation for example, they would seem to have had in mind a malignant cancer of the reproductive system which required an intervention that was medically indicated for directly referable health reasons. The present case does not lend itself to such a comparison.

1. The application in *Re Alex* sought a declaration pursuant to s 67ZC of the Act.[[116]](#footnote-116) The evidence of medical practitioners, departmental staff and the submissions of the Independent Children’s Lawyer all strongly supported the application. Her Honour held that s 67ZC provided the Court with jurisdiction to hear the application and make a declaration authorising the performance of the double mastectomy.[[117]](#footnote-117) In determining that it was in the best interests of the child for the procedure to be performed the Chief Justice discussed the objects and principles in Part VII of the Act and applied the primary and additional considerations set out in s 60CC(2) and (3).[[118]](#footnote-118)

*RE BRODIE (SPECIAL MEDICAL PROCEDURE: JURISDICTION)*

1. In an earlier authority where the proposed procedures related to gender identity, the child, who was 11 years old, affirmed his male sex and expressed a desire to be identified as male. In *Re Brodie (Special Medical Procedure: Jurisdiction)*[[119]](#footnote-119)the child’s mother brought an application seeking authorisation to consent to hormone treatment for the child. The child’s father opposed the application. The expert evidence reinforced that the child was diagnosed with a gender identity disorder and proposed that the child should be treated with hormones to suppress the onset of puberty. In discussing whether the procedure was a special medical procedure Carter J noted that the treatment was fully reversible.[[120]](#footnote-120) However, as the authorisation of the medical treatment related to an aspect of parental responsibility and was related to the care, welfare and development of the child, her Honour concluded that the Court had jurisdiction to hear the application.[[121]](#footnote-121) Carter J ultimately did not determine whether the proposed treatment was a special medical procedure.[[122]](#footnote-122)

*RE GWW AND CMW*

1. Conversely, in *Re GWW and CMW*[[123]](#footnote-123)the parents of the B, who was 9 years old, applied for a declaration or order authorising the performance of a bone marrow harvest to collect marrow, cells or peripheral blood stems from the child, for the child’s maternal aunt. The child’s Aunt was diagnosed and suffering from leukaemia. The expert evidence given indicated that the transplant needed to occur within a month or it was probable that the Aunt would die within six months. The child was the only relative that fully matched the Aunt and the evidence provided to the Court suggested that her chances of survival increased significantly with a transplant from a related donor.
2. Hannon J reasoned that the Court had jurisdiction to hear the application due to s 31(1)(d) of the Act and concluded s 67ZC invoked the welfare jurisdiction of the Court.[[124]](#footnote-124) His Honour noted that the proposed procedure was invasive but not irreversible, and involved a surgical procedure, albeit of less gravity than that involved in a sterilization or organ transplant.[[125]](#footnote-125) However, his Honour concluded that the procedure constituted a “special case” as it would have an immediate adverse effect on B and was for the purpose of providing “tissue to a third party without any physical benefit to the donor”.[[126]](#footnote-126) Despite this, after considering B’s understanding of the proposed procedure, B’s desire to be a donor for his Aunt, the relationship between B and his Aunt, the close relationship between all members of B’s extended family, and the physical and psychological risks to B, his Honour concluded that the risks of the procedure were outweighed by the psychological benefit to B in allowing him to assist his Aunt.[[127]](#footnote-127)
3. Hannon J determined that permitting B to be a donor was in his best interests. His Honour ordered the authorisation of the procedures and declared that B’s parents were authorised to consent to the procedures on behalf of the child.[[128]](#footnote-128)

*RE INAYA (SPECIAL MEDICAL PROCEDURE)*

1. More recently, in *Re Inaya* *(Special Medical Procedure)*[[129]](#footnote-129)the parents of Inaya, who was just over one year old, sought an order authorising the performance a bone marrow harvest on the child for transplant to her cousin Mansour.[[130]](#footnote-130) Mansour was suffering from infantile osteoporosis and was likely to die within one to five years without a transplant. As in *Re GWW and CMW* Inaya was the closest donor match to Mansour of his relatives. Inaya and Mansour were part of a close knit family within an Islamic community. The community and Inaya’s parents were supportive of the application.
2. Cronin J determined the Court had jurisdiction to hear the application due to the welfare power in s 67ZC.[[131]](#footnote-131) His Honour discussed the reasoning in *Re GWW and CMW*, and relevant State legislation applicable to bone marrow transplants, and held that the procedure was not a “special case” but a medical procedure within the scope of parental responsibility.[[132]](#footnote-132) In particular Cronin J emphasised that “Major long-term issues” are defined to be issues in relation to the “care, welfare and development of the child” pursuant to s 64B(2)(i), and include issues relating to the child’s health.[[133]](#footnote-133)
3. Cronin J found that it was in Inaya’s best interests for the procedure to be performed due to the relationship between Inaya and Mansour, the closeness of their families, and the risk of psychological harm to Inaya due to the potential loss of an important familial relationship if the procedure was not performed.[[134]](#footnote-134) His Honour made orders that the child’s parents were authorised to consent to the performance of the procedure and that the medical practitioners were able to rely upon that consent.[[135]](#footnote-135)

*RE BABY A*

1. In a further authority, which is in some respects factually similar to the matter of Baby D, the parents of the child brought an urgent application seeking Court authorisation to enable the administration of an unapproved therapeutic drug on the child. In *Re Baby A*[[136]](#footnote-136)the child was five weeks old at the date of the hearing and was diagnosed with a fatal metabolic disorder called molybdenum cofactor deficiency type A which results in the build up of toxins in the body causing irreparable neurological damage. The medical practitioners treating the child supported the application and the treatment plan was approved by the hospital’s clinical ethics committee.
2. Dessau J concluded that the treatment proposed for the child was within the ambit of parental responsibility despite the difficult ethical issues arising from the proposed treatment.[[137]](#footnote-137) However, in circumstances where the medical practitioners sought the “clarity and certainty” of a Court order, her Honour proposed to consider the matter as if it were a “special medical procedure”.[[138]](#footnote-138) Dessau J considered the expert evidence as required by r 4.09 of the Rules[[139]](#footnote-139) and made orders authorising the parents to consent to the treatment on behalf of the child or in the alternative declaring that it was lawful for the parents to consent to the treatment on behalf of the child.[[140]](#footnote-140)

**OVERVIEW OF THE RELEVANT AUTHORITIES**

1. In the majority of the authorities outlined above that have been decided after *Marion’s Case* the medical procedures in question have fallen outside the scope of parental responsibility and have required Court authorisation due to their invasive and irreversible nature. The procedures in the authorities are varied suggesting that the categories of medical procedures and treatments that may be deemed a “special case” or a “special medical procedure” are not closed. It is clear from these authorities that the Court has exercised jurisdiction under Part VII or s 67ZC even where the procedure in question is not determined to be a “special case” or a “special medical procedure”.
2. In both *Re: Sean and Russell* and *Re Inaya (Special Medical Procedure)* Murphy J and Cronin J respectively concluded that the Court’s authorisation of the medical procedures was not required as the procedures fell within the scope of parental responsibility. In coming to this conclusion Cronin J identified that the procedure related to major long-term health issues and therefore were issues relating to the care, welfare and development of the child within s 64B(2)(i) of the Act. Equally, Murphy J noted that as the procedures in *Re: Sean and Russell* were for the treatment of a bodily malfunction or disease they fell within the scope of parental responsibility. Significantly, his Honour noted that even if Court authorisation was not required, the Court had jurisdiction to make orders as long as the orders were in the best interests of the child.
3. Further, in *Re Baby A* Dessau J considered a procedure a “special medical procedure” and exercised jurisdiction to make orders in circumstances where her Honour considered that the treatment was within the scope of parental responsibility but where the certainty and clarity of a Court order was required for the procedure to proceed in the child’s best interests. As to the form of the order which her Honour pronounced I would comment only that, for myself, I would not be open to persuasion to pronounce a declaration as to “what actions may be lawful”.[[141]](#footnote-141) Orders should be refined and specific to the matters in dispute.[[142]](#footnote-142)

**CONCLUSION: PARENTAL RESPONSIBILITY**

1. The Court was referred to a significant number academic articles, texts and literature that discussed the jurisprudence surrounding artificial life prolonging treatment.[[143]](#footnote-143) Those extrinsic materials have been useful in my consideration of the evidence of Doctors W, Y and X with regard to the procedures of extubation and the administering of medication, sedation and palliative care. In my respectful view the procedure of extubation and the foreshadowed procedure to administer medication, sedation or palliative care are not special cases within the category discussed by the High Court in *Marion’s Case*.
2. Although the procedure of extubation may be invasive, it was very clear from the evidence of Doctors X and Y that both practitioners considered extubation a routine medical procedure as opposed to a procedure involving major or irreversible surgery. Further, both practitioners strongly emphasised that they did not consider extubation to be a “special medical procedure” as defined in the Rules. Similarly, the foreshadowed procedure of administering medication, sedation or palliative care, based on the evidence of Doctors X and Y, does not involve invasive or major irreversible surgery.
3. There are a number of distinguishing features between the procedure in *Marion’s Case* and the procedure(s) proposed in the matter of Baby D. The medical procedure of extubation and the foreshadowed administering of palliative care, sedation or medication in the current circumstances are for the treatment of a bodily malfunction or disease, namely Baby D’s upper airway obstruction.[[144]](#footnote-144) My respectful conclusion is that, in the particular factual context of this matter, this places the procedures within the ambit of parental responsibility as procedures that relate to major long-term issues in respect of the health of Baby D and her care, welfare and development per s 64B(2)(i) of the Act.
4. The long term parental responsibility for the health of a child as enshrined within s 4 of the Act (as highlighted in paragraph 165) focuses the intention of the Parliament upon parental responsibility, significantly for major long-term issues. As the definition in s 4 was inserted into the Act by the 2006 amendments[[145]](#footnote-145) it is clear that this change was intended to emphasise that long-term issues in relation to the health of a child come within the ambit of parental responsibility provided for in Part VII. That is a factor which I have carefully assessed in my overall consideration of parental responsibilities in the best interests of Baby D and in the context of post 2006 decisions of this Court in relation to medical procedure applications.
5. In so far as it is necessary to exercise the jurisdiction of this Court under Part VII or alternatively under the welfare jurisdiction provided by s 67ZC, I have done so on the basis that it is in the best interests of Baby D and necessary to allow the procedure(s) to be performed in circumstances where medical practitioners would not or may not be prepared to proceed without the clarity and certainty of a Court order. In doing so I have had regard to the primary and additional considerations outlined in s 60CC of the Act, referred to in paragraph 161 of these reasons for judgment, and to the considerations outlined in r 4.09 of the Rules.
6. Furthermore, it should be understood that the circumstances of this matter, and in particular, the precarious medical situation of Baby D, was unusual and exceptional. In concluding that the medical procedure(s) in question are not a “special medical procedure” or a “special case” requiring court authorisation, I have focussed upon the particular facts and circumstances of this case. Other similar medical procedures within a different factual context may require court authorisation.
7. In arriving at my conclusions that parents, a hospital or medical practitioners may properly seek court authorisation for decisions that are within the ambit of the “unclear dividing line” discussed in *Marion’s Case* I strongly reiterate the sentiments of Murphy J in *Re: Sean and Russell* that the law should tread lightly in seeking to intrude or impose itself upon these extremely difficult decisions. In that context, however, it is important to ensure that the Court continues to have a role in circumstances where “Court authorisation is necessary and is, in essence, a procedural safeguard”[[146]](#footnote-146) for the performance of medical interventions considered to be a “special medical procedure” or “special case”, particularly where issues in conflict with the best interests of the child may exist and may be a matter of real concern.
8. Thus where there is a real and genuine issue or concern in relation to a medical treatment or procedure that is to be performed on a child, and an application is brought pursuant to the Act, for a proper purpose, and not in avoidance of parental responsibility, if the Court’s jurisdiction is invoked then the Court has a duty to hear and determine the application according to law.

**THE ROLE OF THE PUBLIC ADVOCATE AS AMICUS CURIAE**

1. In the circumstances of this case where the Court accepted the appearance of the amicus, with the consent of all parties, it is proper to set out the main purpose and general powers of the Family Court derived from the Rules. Following that discussion I have considered the role of the amicus in the particular facts of this case and with its related legal issues and matters likely to be of some public interest.

# FAMILY LAW RULES 2004 (“RULES”)

1. The main purpose of the Rules is to ensure that each case is resolved in a just and timely manner at a cost to the parties and the Court that is reasonable in the circumstances of the case per r 1.04. The way in which that main purpose is promoted and achieved is described in rr 1.06 and 1.07. The responsibility imposed upon the parties and lawyers in achieving the main purpose is clearly identified in r 1.08.
2. The Court’s powers in all cases are established in Part 1.3 of the Rules and specifically:

(a) a Court may make such orders as it considers necessary in all cases if it is satisfied that a difficulty arises, or a doubt exists, in relation to a matter of practice or procedure per r 1.09; and this is a matter identified by the amicus in paragraph 3 of their written submissions, filed 21 January 2011;

(b) the Court may make an order on application or on its own initiative in relation to any matter mentioned in these Rules per r 1.10;

(c) the Court may dispense with the Rules, on application or on its own initiative and may dispense with compliance with any of the Rules at any time, before or after the occasion for compliance arises per r 1.12.

1. The Rules for and concerning Parties are provided for in Chapter 6 and define that parties include an intervener in a case, but by omission not an amicus curiae pursuant to r 6.01. The Court has the discretion to add or remove a party in proceedings and the requirements of intervention by a person seeking to become a party are dealt with in r 6.05, and intervention in s 92 of the Act.
2. The Case Guardian provisions of the Rules are identified in Chapter 6, Part 6.3. However, there has been no application in the proceedings before me, and nor should there have been, for the appointment of any independent person as a Case Guardian for Baby D. The parents have and retain parental responsibility. The interests of the child are otherwise represented by the appointed ICL, and by the Notice previously required to be given to the Department of Human Services of the State of Victoria to intervene or otherwise show an interest in the proceedings.

# THE ROLE OF AN AMICUS CURIAE

1. The Family Court performs a judicial function and it has an inherent or implied power to ensure that it is properly informed of matters which it ought to take into account in reaching its decision. This is particularly central to judgments which may affect or impact upon children including those who are disadvantaged or living under a disability within our community. If it is considered to be in the best interests of a child, and generally in the interests of the justice of the case, the Court may hear submissions from an *amicus curiae*, if available, on a discretionary basis.
2. The traditional approach of the courts has been that an amicus would be allowed to appear if that organisation or individual could assist the court in being properly informed of material relevant to reaching its decision. Most usually this is achieved through oral submissions. An amicus is not a party or an intervener. Usually they are not permitted to inspect documents, examine or cross examine witnesses or appeal from a decision. As they are not a party any decision of the court is not binding upon the amicus.
3. Often leave is given for the appearance of an amicus in proceedings to ensure that all relevant submissions are before the court for its consideration. Traditionally the appearance of an amicus is a safeguard to ensure that the relevant legal arguments would be both submitted and tested before the court. *Amici Curiae* often play the proper and necessary role of a contradictor.
4. I record that on the first day of the hearing before me on 12 January 2011 I had the appearance of experienced Counsel, including Senior Counsel for the hospital, to provide assistance on both an informed and independent basis. Additionally the Court was offered a further level of assistance from the amicus, and with the consent of all parties, I allowed the ongoing involvement of the officer from the OPA in that one day defended hearing. That decision did not cause any further costs or delay in the proceedings.
5. As I have earlier outlined in the history of the Court proceedings before me on the day following the conclusion of that defended hearing, different personnel from the OPA sought to have the matter relisted for the purpose of reopening and hearing further submissions. The OPA then introduced legal representation to the hearing on their behalf. Their instructing solicitor briefed Senior Counsel, who appeared with Junior Counsel. Thereafter, and by consent of the parties, the further evidence of Dr W was obtained and admitted into evidence and subsequent further written submissions were filed in compliance with my further orders.
6. It is necessary and proper to now examine the role of the *amicus curiae* in this Court, within the facts of this case, and to consider generally the proper actions, powers and involvement of the OPA in accordance with the existing Protocol of this Court.
7. In *Levy v the State of Victoria* *& Ors*,[[147]](#footnote-147) Brennan CJ said:

The hearing of an amicus curiae is entirely in the Court’s discretion. That discretion is exercised on a different basis from that which governs the allowance of intervention. The footing on which an amicus curiae is heard is that that person is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would not otherwise have been assisted. In Kruger v The Commonwealth (Transcript of 12 February 1996, at 12), speaking for the Court, I said in refusing counsel’s application to appear for a person as amicus curiae:

“As to his application to be heard as amicus curiae, he fails to show that the parties whose cause he would support are unable or unwilling adequately to protect their own interest or to assist the Court in arriving at the correct determination of the case. The Court must be cautious in considering applications to be heard by persons who would be amicus curiae lest the efficient operation of the Court be prejudiced. Where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application”.

It is not possible to identify in advance the situations in which the Court will be assisted by submissions that will not or may not be presented by one of the parties nor to identify the requisite capacities of an amicus who is willing to offer assistance. All that can be said is that an amicus will be heard when the Court is of the opinion that it will be significantly assisted thereby, provided that any cost to the parties or any delay in consequent on agreeing to hear the amicus is not disproportionate to the assistance that is expected.

1. In *United States Tobacco Co v Minister for Consumer Affairs & Ors*[[148]](#footnote-148)the Full Court of the Federal Court, per Davies, Wilcox and Gummow JJ said:

The general principle is that the parties are entitled to carry on their litigation free from the interference of persons who are strangers to the litigation. But there is an overriding right of the court to see that justice is done. An amicus may be heard if good cause is shown for doing so and if the court thinks it proper. Nothing in these reasons should be understood to delimit or restrict the availability of or effectiveness of this valuable tool.

1. In *Bropho v Tickner*[[149]](#footnote-149) Wilcox J said:

An amicus curiae has no entitlement to lead evidence: see Corporate Affairs Commission v Bradley [1974] NSWLR 391 at 399. The role which he or she may play is a matter entirely within the discretion of the court: see United States Tobacco Co v Minister for Consumer Affairs (1988) 20 FCR 520 at 534-535. In Australia, as distinct from the position in the United States, the intervention of an amicus curiae is a relatively rare event; the amicus’ role normally being confined to assisting the court in its task of resolving the issues tendered by the parties by drawing attention to some aspect of the case which might otherwise be overlooked. I do not dispute that it may sometimes be appropriate to allow an amicus curiae to complete the evidentiary mosaic by tendering an item of non-controversial evidence; although I would prefer to reserve my opinion whether this should be permitted to be done over the objection of one or more of the parties. But it is another matter where the proposed evidence would be complex and controversial. To allow the tender of that type of evidence may be to allow the amicus curiae effectively to hijack the parties’ case, taking it off into new factual issues which may greatly extend its length and thereby impose significant additional costs and disadvantages upon the parties.Rarely, if ever, should this course be permitted.

1. In their written submissions the OPA referred to the decision of the Western Australian Supreme Court in *Re Medical Assessment Panel; ex parte Symons*[[150]](#footnote-150) where Heenan J said:

However, an amicus curiae does not become a party to the proceedings and may not appeal: Day v Day [1957] P 202; Corporate Affairs Commission v Bradley [1974] 1 NSWLR 391 at 396 and 399. The latter decision was cited, with evident approval, by Dawson J in Levy v The State of Victoria (1997) 189 CLR 579 at 604 - 605. As there is no right of appearance it is entirely for the court to decide whether or not an amicus curiae should be heard and, if so, to what extent and on what aspects of the case: Brandy v Human Rights and Equal Opportunity Commission (1995) 183 CLR 245 at 258.

1. In *Re BWV: Ex Parte Gardner*[[151]](#footnote-151)the Victorian Supreme Court had before it in an appeal from the Victorian Civil and Administration Tribunal, a case which involved a consideration of the lawfulness of withholding or withdrawing life-sustaining medical treatment from an adult who lacked capacity. The facts of that case involved an elderly woman in the terminal stages of a progressive and fatal form of dementia who was receiving artificial hydration and nutrition through a tube inserted directly into her stomach. The Public Advocate, on behalf of BWV, and after consulting BWV’s immediate family members, sought declarations for the withdrawal of that tube. The Attorney-General of the State of Victoria was granted leave to intervene, other special interest groups and individuals also sought leave to intervene and were ultimately granted the status of *amicus curiae*.
2. Morris J stated that:[[152]](#footnote-152)

It is unusual for the status of an amicus curiae to be given to a person in a hearing before the Trial Division of this court. However, it struck me that the nature of the proceeding, the novelty of the issues raised, the possible implications of any decision and the uncertainty about the precise role that the Attorney-General may play in the proceedings all justified this course.

1. Morris J granted leave to ensure that all relevant and different submissions would be placed before the Court. It is of interest that his Honour had specific regard to the comments of Brennan CJ and Kirby J in *Levy v Victoria* and their individual judgments with the differing emphasis on the reasons for and occasions which might require the appointment of an amicus.
2. In summary, my decision to accept the request of the OPA as amicus both initially and then on an ongoing basis, was for a combination of reasons, primarily as it was with the consent of all parties, as it was provided for in the existing Protocol, and to ensure that all submissions and matters of importance concerning Baby D and her best interests were fully articulated. At the time of my acceptance of the amicus I then did not anticipate any additional delay or expense to the parties in the proceedings.
3. Subsequently, upon further submissions and again by consent, I permitted further evidence to be obtained and put before the Court by the OPA from Dr W. The amicus had no entitlement to introduce such evidence and the general principal from reported case law is that parties are entitled to carry on their litigation without interference from others.
4. Putting aside the welfare jurisdiction of this Court pursuant to s 67ZC of the Act, all parties agreed to pursue that course of action, and on balance, it was in the best interests of Baby D that such additional evidence be considered. However, the adoption of such a course of action must always be subject to any real delay, cost, and consequential disadvantage to the parties to a proceeding. Such evidence may be complex and different, and may come at significant emotional cost to the parents, but ultimately the overriding actions and concerns of this Court must be undertaken in the best interests of Baby D. Had the parties not agreed I may well have been somewhat reluctant to further delay the decision of this Court given the substantial medical evidence that was then available, and given the consensus reached by the parties and the amicus at the concluded hearing of 12 January 2011. However, the facts of this case are unique as they dealt with the best interests of Baby D, including all questions surrounding both her life and its quality.
5. I was conscious from the direction of the oral submissions of Counsel for the parents, and subsequently from their written submissions, that they feel that there had been an “effective hijacking” of their case by the amicus. That submission must be considered in the context of their consent to the proposed further medical examination and evidence, and the best interests of Baby D.

# THE PUBLIC ADVOCATE

1. The OPA in Victoria is an independent statutory body established in accordance with the *Guardianship and Administration Act 1986* (Vic) (‘Guardianship Act’). The OPA sits within the Department of Justice, Victoria, but reports to the State Parliament of Victoria (‘State Parliament’). The Public Advocate is appointed by the Governor in Council for a period of seven years in accordance with Schedule 3 of the Guardianship Act.
2. The stated purpose of the Guardianship Act is defined in s 1 which provides:

1 Purpose

The purpose of this Act is to enable persons with a disability to have a guardian or administrator appointed when they need a guardian or administrator.

It is also the purpose of this Act to enable the making of administration orders and temporary administration orders in respect of the estate of a missing person.

1. The objects of the Guardianship Actare expressed in s 4 and are:

(b) to provide for the appointment of a Public Advocate; and

1. to enable the making of guardianship orders and

administration orders; and

(ca) to enable the making of administration orders and temporary administration orders in respect of the estate of a missing person; and

1. to ensure that persons with a disability and represented persons are informed of and make use of the provisions of this Act; and
2. to provide for the appointment of enduring guardians; and
3. to provide for consent to special procedures, medical research procedures and medical and dental treatment on behalf of persons incapable of giving consent to those procedures or treatment; and
4. to provide for the registration of interstate guardianship orders and administration orders.
5. The intention of the State Parliament is recorded in s 4(2):

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

* 1. the means which is the least restrictive of a person’s freedom of decision and action as is possible in the circumstances is adopted; and
  2. the best interests of a person with a disability are promoted; and
  3. the wishes of a person with a disability are wherever possible given effect to.

1. At issue, in the proceedings before me, was the forceful submission, made orally and in writing on behalf of the OPA in undertaking its role as amicus, that s 16(1)(f) of the Guardianship Act applied to or extended the OPA’s powers to make representations on behalf of or to act for a person (including a child under 18 years of age) with a disability in a Federal jurisdiction and in proceedings under the Act.
2. By s 14 of the Guardianship Act the Public Advocate is duly appointed and its powers and duties are as described in s 16(1) and (2). Those sections provide that the Public Advocate may:

16 Powers and duties of the Public Advocate

(1) The Public Advocate may—

(a) where appointed by the Tribunal be—

(i) a guardian (whether plenary or limited); or

(ii) an alternative guardian (whether plenary or limited); and

\* \* \* \* \*

(b) make an application to the Tribunal for the appointment of a guardian or administrator or the rehearing or reassessment of a guardianship order or an administration order; and

\* \* \* \* \*

(d) submit a report to the Tribunal on any matter referred to the Public Advocate for a report by the Tribunal; and

(e) seek assistance in the best interests of any person with a disability from any government department, institution, welfare organization or service provider; and

(f) make representations on behalf of or act for a person with a disability; and

(g) give advice to any person as to the provisions of this Act and in respect of applications for guardianship or administration; and

(h) investigate any complaint or allegation that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship; and

(ha) for the purposes of—

(i) an investigation under paragraph (h); or

(ii) the provision of a report under clause 35, 42 or 48 of Schedule 1 to the Victorian Civil and Administrative Tribunal Act 1998—

require (subject to subsection (1A)) a person, government department, public authority, service provider, institution or welfare organisation to provide information; and

(i) provide information for persons who are or propose to be guardians; and

(j) report and make recommendations to the Tribunal on behalf of any person with a disability in any proceeding under the Equal Opportunity Act 1995; and

(ja) make recommendations to the Tribunal with respect to guidelines proposed to be issued by the Tribunal about consent to a special procedure or medical research procedure and any other medical or dental treatment under Part 4A.

(k) perform any other function and exercise any other power conferred on him or her by this or any other Act.

(1A) It is a reasonable excuse for a person to refuse or fail to provide information that the person would otherwise be required under subsection (1)(ha) to provide if providing the information would tend to incriminate the person.

(2) Where the Public Advocate is appointed as the guardian of a represented person—

(a) the person for the time being holding the office or performing the functions of the Public Advocate is the guardian of that represented person; and

(b) the Public Advocate must use his or her best endeavours to find an appropriate person to be appointed as the guardian.

1. The functions of the Public Advocate are set out in s 15 of the Guardianship Act and primarily are:

a. to promote, facilitate and encourage the provision, development and coordination of services and facilities provided by government, community and voluntary organisations for persons with a disability – and in particular to promote the development of the ability and capacity of persons with a disability to act independently, to minimise restrictions on their rights, to ensure maximum utilization of services and facilities, and to encourage the involvement of voluntary organisations, relatives, guardians, friends in the provision and management of such services and facilities;

b. to support the establishment of organisations involved with persons with a disability, relatives, guardians and friends for the purpose of instituting citizen advocacy and community education programs and promoting family and community responsibility for guardianship;

c. to arrange, coordinate and promote informed public awareness and understanding by disseminating information with respect to the Act, the OPA, the role of the Victorian Civil and Administrative Tribunal, the duties, powers and functions of guardians and administrators under the Guardianship Act, and the protection of persons with a disability from abuse and exploitation and of their rights; and

* 1. to investigate, report and make recommendations to the Minister on any aspect of the operation of the Guardianship Act.

1. The functions of the OPA are not expressed to encompass any role as an amicus in proceedings in the Family Court of Australia, and more particularly so where parents are actively and properly involved with their child, and have parental responsibility, and where the child is independently represented by a Court requested lawyer.
2. The word “Tribunal” is described in the Dictionary in s 3 of the Guardianship Act as meaning:

Victorian Civil and Administrative Tribunal established by the Victorian Civil and Administrative Tribunal Act 1998.

1. The phrase “special procedure” is also described in the Dictionary of that Act as meaning:

(a) any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out; or

\* \* \* \* \*

(c) termination of pregnancy; or

(d) any removal of tissue for the purposes of transplantation to another person; or

(e) any other medical or dental treatment that is prescribed by the regulations to be a special procedure for the purposes of Part 4A;

# WRITTEN SUBMISSIONS OF THE PUBLIC ADVOCATE

1. The written submissions of the Public Advocate were filed 21 January 2011 and their primary submission is summarised in paragraph 2 which read as follows:

The Public Advocate submits that the court has jurisdiction to hear from the Public Advocate as amicus curiae in this case, that nothing in the Guardianship and Administration Act 1986… prevents this, and in fact the Act specifically permits this. In any event it is appropriate to permit the Public Advocate to continue to participate.

1. The submissions addressed two separate and distinct issues, being:

* that the Public Advocate can and should continue to be heard as amicus curiae regardless of the absence of any express or implied power in the Guardianship Act; and
* that Act does empower the Public Advocate to appear, intervene and become a party.

1. As to the first issue, the OPA was heard and did give assistance to the Court as an amicus throughout the hearing. The evidence obtained and submitted from Dr W, with the consent of all parties, was of very considerable importance and assistance to the Court.
2. It was highlighted in paragraph 7 of the submissions that it has been the practice of the Family Court, on occasion, to permit the attendance and participation of the OPA in appropriate proceedings. The Protocol was acknowledged and followed and reference is made to “special medical procedure applications” under s 67ZC of the Act.
3. I pause to record the substantial difference in the definition of the phrase “special procedure” for the purposes of the Guardianship Act as contrast with the Dictionary definition contained within the Rules where a medical procedure for a child is defined as “not for the purpose of treating a bodily malfunction or disease”.
4. Whilst an example was identified of a reported decision where the Public Advocate appeared as a party in proceedings in this Court, *Re: Baby A*,[[153]](#footnote-153) and without commenting upon the particular facts of that case, I was not asked to consider any scenario where the OPA could or would be a party in proceedings in this Court.
5. The more contentious submission of the Public Advocate was that the Guardianship Act directly empowers the OPA to make representations in the Family Court and to appear, intervene and become a party.
6. It was submitted that s 16(1)(b) must be read expansively and purposively. In support of that submission reference was made to the Second Reading Speech, of the then Minister, in the State Parliament on 28 November 1985.
7. I have read the extract of the speech as recorded in the submission filed, but substantially it is an explanation provided by the Minister of the State Government in relation to the establishment of the OPA. There are no Federal implications or references to appearances in this Court in that extract.
8. The OPA did not make any submission to or refer to or rely upon s 16(1)(e) of the Guardianship Act.
9. The submission was predicated substantially upon the power prescribed in s 16(1)(f) of the Guardianship Act which, on its face, was said to authorise the OPA to commence proceedings, join proceedings or seek leave to appear amicus curiae on behalf of a person with a disability. Whilst initially I was inclined not to read that subsection with that width and impact on proceedings of this Court and in Federal legislation, I withhold that conclusion in light of the reported Full Court decision of *Re Michael*.[[154]](#footnote-154)
10. I concur with the part of the written submission that asserts that nothing within s 16 of the Guardianship Act requires there to be any limitation or reading down of the powers conferred pursuant to subparagraph (1)(f). The operation of subsection (1)(f) is independent of any appointment made by the Tribunal pursuant to subparagraph (1)(a).
11. Finally it is submitted that, in the alternative, the power prescribed in subsection (1)(k) to perform any other function and exercise any other power conferred by the Guardianship Act or any other Act would validly permit and authorise the OPA to appear, intervene or become a party. I do not accept that submission and am not persuaded that the subsection independently authorises the appearance or intervention of the Public Advocate and it certainly does not support their involvement as a party in the proceeding in this Court. As I have discussed hereafter, s 16(1)(k) was not referred to or considered by this Court in *Re Michael*.[[155]](#footnote-155)
12. Within that context and accepting the role of the amicus which has been played by the Public Advocate in this hearing, I reject the submission contained within paragraph 18 that:

Under s 15(c), the Public Advocate has the function of arranging, coordinating and promoting informed public awareness and understanding by the dissemination of information with respect (inter alia) of the protection of Baby D from abuse and to the protection of her rights, including the right to life she enjoys at law. The means by which this is to be done are not circumscribed, and must extend to interventions upon the request of a Court to the Public Advocate to appear as *amicus curiae* to perform that very function.

1. I do not agree with that submission. Section 15(c) is a function of, but not a power of, the OPA.
2. The best interests of Baby D have been substantially considered and represented in the proceedings due to the role played by the parents as applicants under the umbrella of parental responsibility, with the appointment of the ICL, and specifically with the Notice given to the Victorian Department of Human Services.

# WRITTEN SUBMISSIONS ON BEHALF OF THE HOSPITAL

1. The submissions of the hospital, filed by leave on 21 February 2011, emphasised that the Public Advocate is a creature of statute and its rights to appear and be heard in the Family Court, if any, must be interpreted in the context of the Guardianship Act.
2. It was said that the objects and intentions of the Guardianship Act, as provided for in s 4(1) and (2) does not confer jurisdiction and does not favour a reading permitting, or more importantly empowering, the Public Advocate to appear as amicus, intervener or as a party. Those sections set out the basis upon which the functions, powers, authority, discretion and jurisdiction, otherwise conferred by the State Act are to be exercised.
3. The submission made by the Public Advocate that it had appropriate powers and duties pursuant to s 16(1)(f) was rejected by the hospital but again without any reference to or discussion of the current relevance of *Re Michael*.[[156]](#footnote-156)
4. It was submitted that the purpose of that State Act was clear and related primarily to the appointment of guardians and administrators for adult persons with a disability, or otherwise as appointed by the Tribunal. It was said that a correct reading of that section, within the ambit of s 15AA of the *Acts Interpretation Act* *1901* (Cth) and its corresponding State legislation, s 35 of the *Interpretation of Legislation Act 1984* (Vic)would support that outcome.
5. The submissions identified that, in the State of Victoria, the *Children Youth and Families Act* *2005* (Vic)was introduced with respect to the guardianship of children and the purpose and intent of that State Act was to provide that guardianship orders are administered by the Secretary of the Department of Human Services, and not the OPA. Thus it was submitted that, if for any reason parents are not the appropriate guardians of children in Victoria (and there is no suggestion of that fact in this case) then it would be the Secretary of that Department who would be appointed guardian and not the OPA.
6. The respondent hospital supported by both the parents and the ICL submitted that s 16(1)(f) of the Guardianship Act must be read within the context of the purposes and objects of that Act and within the proper meaning of the whole of that section. As such the powers of the Public Advocate were said to include, inter alia, the power to make an application to the Tribunal for the appointment of a guardian or administrator, the power to submit a report to the Tribunal or give advice to any person as to the provisions of the Guardianship Act on related issues.
7. It was submitted that, properly read, the powers and functions of the OPA are directed to making decisions of, and representations concerning, adults with a disability within the jurisdiction of the Tribunal or within the context of the Guardianship Act,but not otherwise in any Federal Court or Commonwealth jurisdiction. My initial position was to substantially accept the submission of the respondent hospital but again that was not founded upon a careful reading of the Full Court decision of *Re Michael*[[157]](#footnote-157) and I have expressed my considered position at the conclusion of this judgment.
8. The respondent further submitted that the demonstration of such a limited and specific referral of power is supported by a consideration of s 16(1)(j) of the *Equal Opportunity Act 1995* (Vic).
9. The submissions on behalf of the hospital responding to the existing Protocol, and actions required pursuant to the Protocol asserted that “such a protocol does not vest jurisdiction to so appear upon the OPA. The protocol appears to be inconsistent with the statutory role of the OPA”. The hospital further called for a revision of the Protocol to clarify that the OPA should not be involved, as of right, in cases about a medical procedure for a child with a disability in Victoria.
10. Highlighting the legislative changes in Victoria over the past decade or thereabouts it was submitted on behalf of the hospital that:

21. A further consideration supporting the need to revise the Protocol is that relevant legislation in Victoria has changed significantly since the Protocol was created in 2004. The *Children Youth and Families Act* 2005 (Vic) has repealed and replaced its predecessor statute. Disability discrimination legislation, both at Commonwealth and State levels, has substantially changed in the intervening period. Since 2008, under section 40 of the *Charter of Human Rights and Responsibilities Act* 2006 (Vic) (‘the Charter’), the Victorian Equal Opportunity and Human Rights Commission (‘the Commission’) has had the right to intervene in certain court proceedings. The Commission has the right to be heard and intervene in any proceeding before any court or tribunal, including in relation to a child. The term ‘*child*’ is defined in the Charter.

22. Whilst the OPA’s role does include advocating in a broad public policy sense for the rights of all disabled persons, section 16(1)(f) does not provide the OPA with the power to commence proceedings, or to seek to join proceedings in any court, and in this case the Family Court, advocating the rights of a particular child.

1. The written submissions on behalf of the hospital responded to the role of amicus curiae performed in this case by the OPA. The submissions contained in paragraph 25 was that:

25. It is submitted that the assistance of the OPA can provide to the Court is proscribed by the functions and the powers which are vested in the OPA by statute. This does not extend to the role of contradictor. In the case of a child it is the Department of Human Services which is the prescribed welfare authority not the OPA.

1. In paragraphs 26 and 27 the hospital submitted that:

26. The discretion [to allow the involvement of an amicus] must also be exercised in the context of the facts and circumstances of each particular case. The parents in this case have the responsibility for making decisions for the welfare of Baby D and there is no evidence which would suggest they would not appropriately exercise their obligation to act in her best interests.

27. Baby D is also separately represented and the Court has the assistance of submission made by the Independent Children’s Lawyer on behalf of Baby D.

1. The particular issues and concerns in this case, after the concluded first hearing day of 12 January 2011 are very clearly identified on behalf of the hospital in a somewhat challenging submission contained in paragraph 28 where it was asserted that:

Whilst the Respondent [hospital] did not take issue with the involvement of the OPA in the proceedings on the first day of the hearing, the conduct of the proceedings since that date are of significant concern and it is submitted that ultimately the best interests of Baby D and the efficient operation of the Court should not be unnecessarily prejudiced by the involvement of the OPA as amicus curiae, particularly in circumstances where the parties to the case have provided all relevant assistance necessary to the Court to identify the relevant issues and to arrive at a correct decision.

1. It was apparent from my observations and the conduct of the hearing that Counsel and legal representatives of all the parties, and their clients, were concerned by the actions and submissions of the OPA. I have highlighted these matters but have elected not to address the more difficult issue of the subjective approach adopted by the amicus in raising the concerns of the Public Advocate, or those submitted to the Court on her behalf.

**THE REPORTED DECISION OF RE: MICHAEL**

1. The decision of the Full Court of the Family Court in *Re Michael*[[158]](#footnote-158) was unfortunately not identified in either of the written submissions or by Senior Counsel in their oral argument. Given the positive findings and the outcome of that case for the OPA, on balance, I decided against re-listing this issue for further legal argument or extended written submissions. Additionally, I did not consider it to be in the interests of justice to require the applicant parents and respondent hospital to appear once again in these proceedings, at further cost to those parties, in order to discuss matters of law secondary to the main issues concerning Baby D. I do not believe that my decision caused any injustice to any party.
2. In *Re Michael* the Full Court, constituted by Nicholson CJ, Fogarty and Joske JJ, had as the only issue for determination in that case the question of the standing of the Public Advocate to make an application in proceedings. The Public Advocate relied upon its powers under the Guardianship Actas the source of his standing and power to so act. The trial judge had held that s 16(1)(e) and (f) did permit the Public Advocate to institute such proceedings and it had been held at first instance that the Public Advocate was a person who had an interest in the welfare of the child within the meaning of s 63C(1)(c) of the Act(as it then was).
3. The facts of that case were that Michael, an 11 year old child, suffered from a congenital heart abnormality where his main blood vessels to and from the heart were transposed. Evidence was that most infants born with that condition die as a consequence. Medical experts were convinced of the necessity for surgery but Michael’s parents were opposed to that course of medical action and the matter had been referred to the Public Advocate in the context of such parental opposition.
4. The equivalent in the current Actto what was s 63C(1)(c) is now to be found in s 65C(c) in that, who may now apply for a parenting order includes:

(c) any other person concerned with the care, welfare or development of the child.

1. The Full Court adopted a very broad approach and generously endorsed the objects of the Guardianship Actas set out in s 4 and in particular the express parliamentary intention of the State Government recorded in s 4(2), that every function, power, authority, discretion, jurisdiction and duty conferred or imposed by the Guardianship Act is to be exercised or performed so that (inter alia), the best interests of a person with the disability are promoted.
2. The Full Court read the powers and functions of the Public Advocate, as defined within ss 15 and 16 of the Guardianship Act in an extremely expansive manner and said that:

[I]t is important to appreciate that the powers of the Public Advocate extend well beyond a support function to the Guardianship Board.

1. With the background of their consideration of Second Reading Speech to the Legislative Council, given by the then Attorney-General of the State of Victoria, the Full Court considered the powers provided for in s 16(1)(e) and (f) and concluded:

In our view, the power conferred by sub-para (f) is more than sufficient to provide a basis for the Public Advocate to commence these proceedings. In this regard, we reject the argument of senior counsel for the parents that the Public Advocate is not, in taking these proceedings, either making representations on behalf of, or acting for, a person with a disability. That submission, we think, involves a far too narrow construction of what these concepts involve. In this case, whether rightly or wrongly, the parents are not prepared to seek or consent to the relevant surgical treatment for the child. For the purposes of considering this application only, and without in any way determining the issue, we must approach the matter upon the basis that the parents’ attitude is unjustified. This is so because the issue has not yet been determined and the welfare of the child requires us to approach the matter upon the basis that it may be determined in favour of the Public Advocate as there is medical evidence which, if accepted, supports that position. The child himself is unaware of the matter and is, in any event, too young to form a valid appreciation of his condition and assess whether action should be taken to remedy it.

. . .

As we have pointed out, although adversary in form, these are not strictly adversarial proceedings and the mere fact that the Public Advocate appears as an applicant does not in any way change the basis upon which he does so, which is to invoke the Court’s protection on behalf of the child. It matters not, in our opinion, whether some other person or persons could have done so, because the real issue is whether the sub-paragraph confers the power upon him to so act. We are satisfied that it does.

We note that the trial Judge founded his decision upon sub-para (f), that is, the Public Advocate’s power to make representations on behalf of a person under a disability. We agree with his Honour in this regard and see no reason to limit this power to the making of representations to persons or bodies other than courts. However, we consider that this construction is further supported by the power to “act for” such persons contained in that sub-paragraph.

We do not think that this power should be narrowly construed, as senior counsel for the parents argued, to confine it to acting for a person under a disability as if the Public Advocate were a next friend, solicitor or counsel for that person. We consider that a person who commences *parens patriae* proceedings in circumstances such as this is doing so on behalf of the child and is effectively acting for that child in the sense contemplated by the legislation by reason of the very nature of *parens patriae* proceedings.

1. The Full Court further considered and endorsed the findings of the trial judge, although for different reasons, and said that:

…that sub-para (e) provides a basis for the actions of the Public Advocate. The key words of that sub-paragraph empower the Public Advocate to “seek assistance in the best interests of any person with a disability”. This assistance may be sought from any “government department, institution, welfare organization or service provider”.

Given the broad context in which we consider these powers should be construed, we consider that “institution” in this context includes a court. It is difficult to imagine that it could be otherwise for there are forms of assistance which only a court can provide, for example an injunction against a particular course of treatment (*In re Jane* (1989) FLC ¶92-007) or the protection that comes from an application in the *parens patriae* jurisdiction.

We are fortified in this view by the broad range of bodies covered by sub-para (e). Although a court is not a department of government it is, we think, an institution of government, and we consider that the expression “institution” as used in the sub-paragraph is clearly intended to cover an institution of government.

# THE REPORTED DECISION OF P & P

1. *P & P*[[159]](#footnote-159) is a reported decision of the Full Court of the Family Court, constituted by Nicholson CJ, Fogarty and Finn JJ, delivered on the 3 May 1995. Again this reported case was not referred to in argument or in submissions before me in these proceedings.
2. The child in this case was an intellectually disabled teenager who suffered from epilepsy. Her mother filed an application seeking authorisation for the child to undergo a hysterectomy for the prevention of menstruation and risk of pregnancy. The application was fully supported by the father and the appointed child’s separate representative. The Human Rights and Equal Opportunity Commission intervened, but confined its submissions to legal principles and procedures for the determination of applications of this kind. The trial judge had dismissed the mother’s application at first instance and she appealed from that decision.
3. The Full Court confirmed that the Family Court has jurisdiction to authorise performance of a medical procedure if it is in the best interest of a child and in circumstances where that child is incapable of giving informed consent.
4. For matters relevant to the proceedings before me the procedural safeguards, which were the concern of the intervener in that reported decision, were considered by the Full Court in the context of their concern that eight sterilisation cases had been before the Court and there appeared not to have been a consistent approach to the issue of legal representation of the child, although it was accepted that in all cases, except perhaps one, there had been some degree of independent advocacy of the child’s interest.[[160]](#footnote-160)
5. The Full Court said:[[161]](#footnote-161)

Secondly, it is not correct to say there was no representation of the child’s interest in one of those cases. The Commission asserts that this was the case in Re A (1993) 16 Fam LR 715, but in fact the child’s interests were represented by the Public Advocate of Victoria, which is a statutory office set up under the Victorian Guardianship and Administration Board Act 1986 and, pursuant to s 16(1)(f) of that Act, the Public Advocate is empowered to represent the interests of a person under a disability.

In fact, the Public Advocate has been a party in all Victorian cases before the court and has performed the role of representing the interests of the child in each of those cases. In the case of Re Michael (1994) FLC 92-471 a separate representative of the child was appointed as well, because the Public Advocate had brought proceedings, seeking to be substituted for the parents as the party who could give consent to the performance of a medical procedure. In particular circumstances, the trial judge, correctly we think, thought it appropriate for the child to be separately represented.

In all other cases, the Public Advocate has performed an independent role on behalf of the child and has put the child’s position before the Court. It has been particularly well suited to doing so because of the professional expertise that has been developed within that office.

1. The Full Court continued thereafter and said:[[162]](#footnote-162)

Re a Teenager (1989) FLC 92-006, Re Elizabeth (1989) FLC 92-023, In re Jane (supra) and In re S (1990) FLC 92-124 were all cases where there was a natural contradictor seeking an injunction to restrain the procedure being carried out. Marion’s Case was the first in which the parent’s sought the Court’s permission to carry out the procedure and the Court was careful to ensure that the child’s interests were represented.

In the later cases of Sarah (supra), Re Michael (supra) and Re A (supra) separate representatives have been appointed, as was the situation in this case.

In the case of Re A, to which the Commission refers, the Public Advocate was of the view that the application should succeed. It therefore did not assume the role of contradictor, nor in our view should it have done so. The parens patriae jurisdiction is not an adversary jurisdiction – (see Marion’s case at CLR 258-9; In Re P (a child); Separate Representative (1993) FLC 92-376) and we do not think it appropriate for there to be opposition to such an application for the sake of it.

It is true that in Re A, Mushin J at 721 expressed a preference for hearing a contrary argument and it also true that this makes the task of a trial judge easier, but we do not think that this is a good reason to unnecessarily complicate proceedings of this sort when the outcome is relatively clear cut.

The Commission submitted that here there should be a contradictor, not only for the above reasons but also because of the serious and irreversible nature of sterilisation and because in the absence of a contradictor, the child’s appeal rights would be rendered nugatory.

We do not accept these submissions. As to the former, it is the serious and irreversible nature of the procedure which led to the High Court in Marion’s Case to hold that this Court’s consent is required before the procedure can be performed upon a child. We do not regard this as a valid reason for converting every application into a forensic contest.

1. A more recent reference to the decision of *Re Michael* was in *Church v S Overton*,[[163]](#footnote-163) a decision of Benjamin J where his Honour observed that:[[164]](#footnote-164)

62. An example of the court’s approach to overriding a joint parental decision about a child is Re Michael (1994) FLC 92-471. Michael was 12 years old and suffered from a serious cardiac condition. His parents appealed Treyvaud J’s decision enabling the Public Advocate to seek a declaration that he be authorised to consent to a medical procedure for Michael. Whilst a Full Court of Nicholson CJ, Fogarty and Joske JJ were focussed on the standing of the Public Advocate, during the course of the judgment their Honours made it clear that it was for the Public Advocate to establish by way of medical evidence that the parent’s decision was unjustified (at page 80, 893).

63. If a court is satisfied that an approach to the upbringing of a child by a parent or parents in whatever way is contrary to that child’s best interests, then the court should interfere by putting in place appropriate orders. In the absence of substantive issues as to the child’s best interests, it is not the role of a court to peer over the shoulders of functional parents and second guess the decisions they make regarding the upbringing of their children. A court should only intervene in such decision-making in a cautious, careful and thoughtful manner and consider whether a better approach is to make no order at all.

# OVERVIEW OF THE ROLES OF THE AMICUS

1. The decision of the Full Court of the Family Court in *Re Michael*, and as endorsed by a slightly differently constituted Full Court in *P & P* is, of course, binding upon a single judge of this Court on that identical issue and I have recognised and accepted that fact.
2. I again observe that it was unfortunate that these reported cases were not identified and argued in this hearing but that perhaps is now somewhat academic in this particular case as the OPA was present at and actively involved in all hearings, including the calling of its expert evidence.
3. However, it may now be an appropriate time for this very significant (and in this case somewhat concerning) issue of the continuation of the Protocol and its benefits, if any, to children in this Court and any role to be played by the OPA to be reconsidered, particularly having regard to the many significant changes implemented since 1995 and including:

* The substantially redrawn Part VII of the Act and the current focus upon parental responsibility established in that Part;
* The strong and developing acceptance of the rights, duties and obligations of parents;
* The increased role, importance and professional standing of the ICL;
* The nomination of the prescribed child welfare authority (in Victoria the Department of Human Services) in r 4.10 of the Rules for service of all medical procedure applications;
* State Legislation enacted since the revision of the Protocol including the *Children Youth and Families Act 2005* (Vic), the *Equal Opportunity Act 1995* (Vic), and the *Charter of Human Rights and Responsibilities Act* *2006* (Vic);
* The emphasis on the best interests of the child pursuant to Part VII in the context of the 2006 amendments to the Act;
* The State (only) based powers and jurisdiction of the OPA pursuant to the *Guardianship and Administration Act 1986* (Vic);
* The public interest in the just and timely resolution of cases before the Court at a cost reasonable to the parties;
* The increasing recognition of international instruments in judgments of this Court, particularly the *United Nations Convention of the Rights of the Child*;[[165]](#footnote-165)
* The s 4 definition of “major long-term issues” and the parental responsibility for the health of a child provided for in that section.

1. In the absence of any appeal in this case on this subsidiary issue (and in respect of which I have pronounced no orders) the role of the OPA and the continuance or variation of the Protocol may now be best dealt with by informed discussion between the Chief Justice of this Court, the OPA and other interested or affected groups or persons. My views are perhaps clear but I leave any decision on these matters to others and as such these issues remain open to reflection and debate.

I certify that the preceding three hundred and fifteen (315) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Young delivered on 16 March 2011.

Legal Associate:

Date: 16 March 2011

1. *Family Law Act 1975* (Cth) as at 30 June 1993, including amendments up to Act No. 229 of 1992. [↑](#footnote-ref-1)
2. Supra. [↑](#footnote-ref-2)
3. *Family Law Act 1975* (Cth) as at 19 March 1996, including amendments up to Act No. 167 of 1995. [↑](#footnote-ref-3)
4. See *Re Baby D* [2011] FamCA 14. [↑](#footnote-ref-4)
5. Act No. 58 of 1986, version 74, in force from 28 October 2010. [↑](#footnote-ref-5)
6. Cooper, D., Willmott, L., White, B., ‘Interveners or Interferers: Intervention in Decisions to Withhold and Withdraw Life Sustaining Medical Treatment’ (2005) 27 *Sydney Law Review* 597. [↑](#footnote-ref-6)
7. *Marion’s Case* (1992) 175 CLR 218. [↑](#footnote-ref-7)
8. See the *Family Law Reform Act 1995* (Cth), Act No. 167 of 1995, and the *Family Law Amendment (Shared Parental Responsibility) Act* *2006* (Cth), Act No. 46 of 2006. [↑](#footnote-ref-8)
9. See *Chappell & Chappell* (2008) FLC 93-382 at [50], [60] and [115] to [116]; *Langmeil & Grange* (2010) FLC 93-427 at [305] to [306]; *Cales & Cales* (2010) FLC 93-459 at [68]. [↑](#footnote-ref-9)
10. It should be noted that this definition was inserted into the Act by the *Family Law Amendment (Shared Parental Responsibility) Act* *2006* (Cth), Act No. 46 of 2006. [↑](#footnote-ref-10)
11. As inserted by the *Family Law Reform Act 1995* (Cth), Act No. 167 of 1995, and subsequently amended by the *Family Law Amendment (Shared Parental Responsibility) Act* *2006* (Cth), Act No. 46 of 2006. [↑](#footnote-ref-11)
12. (1992) 175 CLR 218 at 236 to 239. [↑](#footnote-ref-12)
13. [1986] AC 112. [↑](#footnote-ref-13)
14. [1986] AC 112 at 183 to 184. [↑](#footnote-ref-14)
15. *Marion’s Case* (1992) 175 CLR 218at 239. [↑](#footnote-ref-15)
16. *Marion’s Case* (1992) 175 CLR 218at 249. [↑](#footnote-ref-16)
17. *Marion’s Case* (1992) 175 CLR 218at 241 citing *Re a Teenager* (1988) FLC 92-006; *Re Jane* (1989) FLC 92-007*; Re Elizabeth* (1989) FLC 92-023; *Attorney-General (Q) v Parents (“In re S”)* (1989) FLC 92-124. See also the discussion of authorities relating to sterilization procedures in common lawjurisdictions including New Zealand at 244, England at 244 and United States at 246. [↑](#footnote-ref-17)
18. Where therapeutic was employed to mean “treatment of some malfunction or disease”, as cited in *Marion’s Case* (1992) 175 CLR 218at 243. [↑](#footnote-ref-18)
19. *Marion’s Case* (1992) 175 CLR 218at 250. [↑](#footnote-ref-19)
20. *Marion’s Case* (1992) 175 CLR 218at 250. [↑](#footnote-ref-20)
21. *Marion’s Case* (1992) 175 CLR 218at 252. [↑](#footnote-ref-21)
22. *Marion’s Case* (1992) 175 CLR 218at 253. [↑](#footnote-ref-22)
23. (1992) 175 CLR 218. [↑](#footnote-ref-23)
24. *Commonwealth Constitution* (Cth). [↑](#footnote-ref-24)
25. *Marion’s Case* (1992) 175 CLR 218 at 261 per Mason CJ, Dawson, Toohey, Gaudron JJ. [↑](#footnote-ref-25)
26. (2000) 201 CLR 226 at 241 per Gleeson CJ, Gaudron McHugh, Gummow and Hayne JJ. [↑](#footnote-ref-26)
27. (2004) 219 CLR 365. For further commentary see: Chisholm, R, ‘Immigration and the Family Court: The High Court speaks’, (2004) 18 *Australian Journal of Family Law*, 1. [↑](#footnote-ref-27)
28. *MIMIA v B* (2004) 219 CLR 365 at 377. [↑](#footnote-ref-28)
29. *MIMIA v B* (2004) 219 CLR 365 at 377. [↑](#footnote-ref-29)
30. *MIMIA v B* (2004) 219 CLR 365 at 379. [↑](#footnote-ref-30)
31. *MIMIA v B* (2004) 219 CLR 365 at 379. [↑](#footnote-ref-31)
32. *MIMIA v B* (2004) 219 CLR 365 at 393 applying the reasoning of the High Court in *Re Macks; Ex parte Saint* (2000) 204 CLR 158. [↑](#footnote-ref-32)
33. It should be noted that s 67ZC was not inserted into the Act until the enactment of the *Family Law Reform Act* *1995* (Cth) after the High Court decided *Marion’s Case.* [↑](#footnote-ref-33)
34. *Marion’s Case* (1992) 175 CLR 218 at 256. [↑](#footnote-ref-34)
35. *Marion’s Case* (1992) 175 CLR 218 at 257. [↑](#footnote-ref-35)
36. *Marion’s Case* (1992) 175 CLR 218 at 257 citing *Re Marion* (1990) 14 Fam LR at 480. [↑](#footnote-ref-36)
37. *Marion’s Case* (1992) 175 CLR 218 at 258. [↑](#footnote-ref-37)
38. *Marion’s Case* (1992) 175 CLR 218 at 259. [↑](#footnote-ref-38)
39. (1982) 150 CLR 615at 627 in *Marion’s Case* (1992) 175 CLR 218 at 261. [↑](#footnote-ref-39)
40. *Marion’s Case* (1992) 175 CLR 218 at 261. [↑](#footnote-ref-40)
41. *Marion’s Case* (1992) 175 CLR 218 at 261. [↑](#footnote-ref-41)
42. *Marion’s Case* (1992) 175 CLR 218 at 261 and 263. [↑](#footnote-ref-42)
43. As inserted into the Act by the *Family Law Reform Act* *1995* (Cth). [↑](#footnote-ref-43)
44. In which the children were held under provisions of the *Migration Act* *1958* (Cth). [↑](#footnote-ref-44)
45. *MIMIA v B* (2004) 219 CLR 365. [↑](#footnote-ref-45)
46. Supra. [↑](#footnote-ref-46)
47. Supra. [↑](#footnote-ref-47)
48. *MIMIA v B* (2004) 219 CLR 365 at 379. [↑](#footnote-ref-48)
49. *MIMIA v B* (2004) 219 CLR 365 at 379. [↑](#footnote-ref-49)
50. See *R v Commonwealth Court of Conciliation and Arbitration; Ex parte Barrett* (1945) 70 CLR 141, cited in *MIMIA v B* (2004) 219 CLR 365 at 379, in which the High Court held that Parliament had inferentially conferred jurisdiction in relation to a “matter” mentioned in ss 75 and 76. Dixon J’s argued that s 58E of the *Commonwealth Conciliation and Arbitration Act 1904* (Cth) imposed a liability and that “the liability accordingly supplies an appropriate subject or ‘matter’ upon which ‘judicial power’ or jurisdiction’ may operate”. [↑](#footnote-ref-50)
51. *MIMIA v B* (2004) 219 CLR 365 at 380. [↑](#footnote-ref-51)
52. *MIMIA v B* (2004) 219 CLR 365 at 383. [↑](#footnote-ref-52)
53. *MIMIA v B* (2004) 219 CLR 365 at 385. [↑](#footnote-ref-53)
54. *MIMIA v B* (2004) 219 CLR 365 at 388 to 390. [↑](#footnote-ref-54)
55. *MIMIA v B* (2004) 219 CLR 365 at 396. [↑](#footnote-ref-55)
56. *MIMIA v B* (2004) 219 CLR 365 at 402 to 403. [↑](#footnote-ref-56)
57. *MIMIA v B* (2004) 219 CLR 365 at 403. [↑](#footnote-ref-57)
58. *MIMIA v B* (2004) 219 CLR 365 at 407. [↑](#footnote-ref-58)
59. (2009) 42 Fam LR 645; [2009] Fam CA 1292. See in particular reference to the reasoning of Gleeson CJ and McHugh J at [116] to [118] and to the separate reasons for judgment of Gummow, Hayne and Heydon JJ at [119] to [120]. [↑](#footnote-ref-59)
60. *Re Alex* (2009) 42 Fam LR 645 at [130]. [↑](#footnote-ref-60)
61. (2004) 219 CLR 365. [↑](#footnote-ref-61)
62. See for example *Secretary of the Department of Health and Human Services & Ray* [2010] FamCAFC 258 and the discussion from [86] to [92] of the Full Court per Bryant CJ, Finn and Ryan JJ. [↑](#footnote-ref-62)
63. [2010] FamCA 948. [↑](#footnote-ref-63)
64. *Re: Sean and Russell* [2010] FamCA 948 at [67] to [68]. [↑](#footnote-ref-64)
65. *Re: Sean and Russell* [2010] FamCA 948 at [67] to [68]. [↑](#footnote-ref-65)
66. *R v Commonwealth Court of Conciliation and Arbitration; Ex parte Ozone Theatres (Aust) Ltd* (1949) 78 CLR 389 at 398 per Latham CJ, Rich, Dixon, McTiernan and Webb JJ. [↑](#footnote-ref-66)
67. *Re: Sean and Russell* [2010] FamCA 948 at [69]. See also *R v Commonwealth Court of Conciliation and Arbitration; Ex parte Ozone Theatres (Aust) Ltd* (1949) 78 CLR 389 at 398, 401. [↑](#footnote-ref-67)
68. *Re: Sean and Russell* [2010] FamCA 948 at [70]. [↑](#footnote-ref-68)
69. *Re: Sean and Russell* [2010] FamCA 948 at [84], [90] and [91]. [↑](#footnote-ref-69)
70. *Re: Sean and Russell* [2010] FamCA 948 at [102]. [↑](#footnote-ref-70)
71. *Re: Sean and Russell* [2010] FamCA 948 at [103], citing s 61B and s 64B(2)(i) of the Act. [↑](#footnote-ref-71)
72. See *Re: Sean and Russell* [2010] FamCA 948 at [104] where the orders sought were declarations, Murphy J determined the declarations were “parenting orders” as per s 64B(1). [↑](#footnote-ref-72)
73. *Re: Sean and Russell* [2010] FamCA 948 at [105] to [107]. [↑](#footnote-ref-73)
74. *Re: Sean and Russell* [2010] FamCA 948 at [71]. [↑](#footnote-ref-74)
75. See paragraph 165 of these reasons and the definition in s 4 of “major long term issues”. [↑](#footnote-ref-75)
76. *Re: Sean and Russell* [2010] FamCA 948 at [71]. [↑](#footnote-ref-76)
77. *Re: Sean and Russell* [2010] FamCA 948 at [54] to [55]. [↑](#footnote-ref-77)
78. *Marion’s Case* (1992) 175 CLR 218at 249. [↑](#footnote-ref-78)
79. *Marion’s Case* (1992) 175 CLR 218, see (2). [↑](#footnote-ref-79)
80. *Marion’s Case* (1992) 175 CLR 218at 250. My emphasis. [↑](#footnote-ref-80)
81. See for example the reasoning of Murphy J in *Re: Sean and Russell* [2010] FamCA 948 at [62] where his Honour noted this distinction and commented that the High Court reasoned it was not sterilization *per se* that required authorisation but the procedure of sterilization in circumstances where it was not a by-product of the treatment of a disease or bodily malfunction. [↑](#footnote-ref-81)
82. *Re: Sean and Russell* [2010] FamCA 948 at [65]. [↑](#footnote-ref-82)
83. See for example *Marion’s Case* (1992) 175 CLR 218 and *Re Marion (No 2)* (1992) 17 Fam LR 336; *P v P* (1994) FLC 92-462; but note also *Re: Angela (Special Medical Procedure)* [2010] FamCA 98 and *In the matter of the welfare of A (a child)* (1993) FLC 92-402. [↑](#footnote-ref-83)
84. See for example *Re Brodie 2007 (Special Medical Procedure: Jurisdiction)* [2007] FamCA 776 and more recently *Re:Rosie (Special Medical Procedure)* [2011] FamCA 63 and *Re: O (Special Medical Procedure)* [2010] FamCA 1153. See in relation to special medical treatment and children, but also in respect of the limitations of DSM-IV diagnosis of gender identity: Chief Justice Bryant (2009) ‘It’s my body, isn’t is? Children, Medical Treatment and Human Rights’, *The Costello Lecture*, Thursday 23 July 2009, at pp 16-19. [↑](#footnote-ref-84)
85. See for example *Re GWW and CMW* (1997) FLC 92-748; *Re Inaya* *(Special Medical Procedure)*[2007] FamCA 658; *Re: Sean and Russell* [2010] FamCA 948; *Re Baby A* [2008] FamCA 417. [↑](#footnote-ref-85)
86. [2010] FamCA 98. [↑](#footnote-ref-86)
87. [2010] FamCA 98 at [11]. [↑](#footnote-ref-87)
88. [2010] FamCA 98 at [12], [32]. [↑](#footnote-ref-88)
89. [2010] FamCA 98 at [44] to [45]. [↑](#footnote-ref-89)
90. [2010] FamCA 98 at [48]. [↑](#footnote-ref-90)
91. [2010] FamCA 98 at [46],[49]. [↑](#footnote-ref-91)
92. [2010] FamCA 98 at [51] to [60]. [↑](#footnote-ref-92)
93. (1993) FLC 92-402. [↑](#footnote-ref-93)
94. (1993) FLC 92-402 at [80,113]. [↑](#footnote-ref-94)
95. (1993) FLC 92-402 at [80,115]. [↑](#footnote-ref-95)
96. (1993) FLC 92-402 at [80,116]. [↑](#footnote-ref-96)
97. (1993) FLC 92-402 at [80,117]. [↑](#footnote-ref-97)
98. [2010] FamCA 237. [↑](#footnote-ref-98)
99. [2010] FamCA 237 at [33] to [34]. [↑](#footnote-ref-99)
100. [2010] FamCA 237 at [36] to [37]. [↑](#footnote-ref-100)
101. [2010] FamCA 237 at [24] to [26]. [↑](#footnote-ref-101)
102. [2010] FamCA 237 at [65] to [72]. [↑](#footnote-ref-102)
103. [2010] FamCA 237 at [65]. [↑](#footnote-ref-103)
104. [2010] FamCA 237, see Order 1 a) and b). [↑](#footnote-ref-104)
105. [2010] FamCA 948. [↑](#footnote-ref-105)
106. *Re: Sean and Russell* [2010] FamCA 948. [↑](#footnote-ref-106)
107. *Re: Sean and Russell* [2010] FamCA 948 at [14] and [15]. [↑](#footnote-ref-107)
108. *Re: Sean and Russell* [2010] FamCA 948 at [96] to [102]. [↑](#footnote-ref-108)
109. *Re: Sean and Russell* [2010] FamCA 948 at [108]. [↑](#footnote-ref-109)
110. (2009) 42 Fam LR 645. [↑](#footnote-ref-110)
111. However, please note the Chief Justice’s comments in relation to gender identity dysphoria in *Re Alex* (2009) 42 Fam LR 645 at [151] to [153]. [↑](#footnote-ref-111)
112. *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175. [↑](#footnote-ref-112)
113. See the discussion in Wallbank, R, ‘Re Kevin In Perspective’, (2004) 9 *Deakin Law Review* 2, at pp 5, 15, and 27 to 33. [↑](#footnote-ref-113)
114. *Re Alex* (2009) 42 Fam LR 645 at [130]. [↑](#footnote-ref-114)
115. *Re Alex* (2009) 42 Fam LR 645 at [151]. [↑](#footnote-ref-115)
116. *Re Alex* (2009) 42 Fam LR 645 at [21]. [↑](#footnote-ref-116)
117. *Re Alex* (2009) 42 Fam LR 645 at [131]. [↑](#footnote-ref-117)
118. *Re Alex* (2009) 42 Fam LR 645 at [155], [156] and [157] to [186]. [↑](#footnote-ref-118)
119. [2008] FamCA 334. [↑](#footnote-ref-119)
120. [2008] FamCA 334 at [48] to [50]. [↑](#footnote-ref-120)
121. [2008] FamCA 334 at [46] to [47]. [↑](#footnote-ref-121)
122. [2008] FamCA 334 at [52]. [↑](#footnote-ref-122)
123. (1997) FLC 92-748. [↑](#footnote-ref-123)
124. (1997) FLC 92-748 at [84,106]. [↑](#footnote-ref-124)
125. (1997) FLC 92-748 at [84,108]. [↑](#footnote-ref-125)
126. (1997) FLC 92-748 at [84,109]. [↑](#footnote-ref-126)
127. (1997) FLC 92-748 at [84,110]. [↑](#footnote-ref-127)
128. (1997) FLC 92-748. [↑](#footnote-ref-128)
129. (2007) 38 Fam LR 546. [↑](#footnote-ref-129)
130. Monsour was roughly 8 months old at the time of hearing. [↑](#footnote-ref-130)
131. (2007) 38 Fam LR 546 at [50]. [↑](#footnote-ref-131)
132. (2007) 38 Fam LR 546 at [57] to [62], see in particular [60] and [76]. [↑](#footnote-ref-132)
133. (2007) 38 Fam LR 546 at [77] to [82]. [↑](#footnote-ref-133)
134. (2007) 38 Fam LR 546 at [88] to [90] [↑](#footnote-ref-134)
135. (2007) 38 Fam LR 546 at [91] to [92], see orders (1) and (2). [↑](#footnote-ref-135)
136. [2008] FamCA 417. [↑](#footnote-ref-136)
137. [2008] FamCA 417 at [16]. [↑](#footnote-ref-137)
138. [2008] FamCA 417 at [17] to [18]. [↑](#footnote-ref-138)
139. [2008] FamCA 417 at [19]. [↑](#footnote-ref-139)
140. [2008] FamCA 417 at [38], see orders (2), (3) and (4). [↑](#footnote-ref-140)
141. See paragraph 5 in which the amended form of order sought by the respondent Hospital is set out, note the use of the terms “that it is lawful” and “then it shall be lawful” in the proposed orders 3 and 4. [↑](#footnote-ref-141)
142. In relation to order 2(c) and the use of the term “artificial”see *Re BWV; Ex parte Gardner* [2003] 7 VR 487 at [90] to [91] and the authorities discussed therein; *Airedale NHS Trust v Bland* [1993] 1 All ER 821 at 822, 837 to 838 in reference to *Re J (a minor) wardship: medical treatment)* [1992] 4 All ER 614. See also generally in relation to the withdrawal of life prolonging treatment: *Re Wyatt* [2004] 4 All ER 1325; *Re Wyatt (a child) (medical treatment: continuation of order)* [2005] EWCA Civ 1181; *Re Wyatt (No 3) (a child) (medical treatment: continuation of order)* [2005] EWHC 693 (Fam); *Re Wyatt (a child) (medical treatment: parents’ consent)* [2004] EWHC 2247 (Fam); *Northbridge v Central Sydney Area Health Service* [2000] NSWSC 1241; *Isaac Messiha (by his Tutor) v South East Health* [2004] NSWSC 1061. [↑](#footnote-ref-142)
143. See Thiagarajan, M., Savulescu, J., Skene, L., ‘Deciding about life-support: A perspective on the ethical and legal framework in the United Kingdom and Australia’, (2007) 14 *Journal of Law and Medicine* 583, at 592 to 593 in particular; Skene, L., ‘The Schiavo and Korp cases: Conceptualising end-of-life decision-making’, (2005) 13 *Journal of Law and Medicine* 223, at 226; Freckelton, I., ‘Editorial: Withdrawal of Artificial Life Support’, (2004) 11 *Journal of Law and Medicine* 265, at 266; and Skene, L., *Law and Medical Practice*, 3rd ed, LexisNexis Butterworths, Sydney, 2008, see in particular Chapter 11, 346 to 362, and Chapter 10, 311 to 328, 334 to 336. [↑](#footnote-ref-143)
144. Described in Dr W’s report as “airway narrowing due to upper airway oedema, glottic and subglottic stenosis, with tracheomalacia” and supported by the evidence of Dr Y and Dr X. [↑](#footnote-ref-144)
145. *Family Law Amendment (Shared Parental Responsibility) Act* *2006* (Cth), Act No. 46 of 2006. [↑](#footnote-ref-145)
146. *Marion’s Case* (1992) 175 CLR 218at 249. [↑](#footnote-ref-146)
147. (1997) 189 CLR 579 at 604. [↑](#footnote-ref-147)
148. (1988) 20 FCR 520 at 536, see also 533 to 538. [↑](#footnote-ref-148)
149. (1993) 40 FCR 165 at 172 to 173. [↑](#footnote-ref-149)
150. [2003] WASC 154 at [18]. [↑](#footnote-ref-150)
151. [2003] 7 VR 487. [↑](#footnote-ref-151)
152. [2003] 7 VR 487 at 491. [↑](#footnote-ref-152)
153. [2008] FamCA 417, at [9]. [↑](#footnote-ref-153)
154. (1994) FLC 92-471. [↑](#footnote-ref-154)
155. Supra. [↑](#footnote-ref-155)
156. (1994) FLC 92-471. [↑](#footnote-ref-156)
157. (1994) FLC 92-471. [↑](#footnote-ref-157)
158. (1994) FLC 92-471. [↑](#footnote-ref-158)
159. (1995) FLC 92-615; (1995) 19 Fam LR 1. [↑](#footnote-ref-159)
160. (1995) FLC 92-615 at [82,154]. [↑](#footnote-ref-160)
161. (1995) FLC 92-615 at [82,154]. [↑](#footnote-ref-161)
162. (1995) FLC 92-615 at [82,155]. [↑](#footnote-ref-162)
163. (2008) 40 Fam LR 357; [2008] Fam CA 952. [↑](#footnote-ref-163)
164. (2008) 40 Fam LR 357 at [62] to [63]. [↑](#footnote-ref-164)
165. See, for example, the discussion in *Re Alex* (2009) 42 Fam LR 645 at [178] to [185]. [↑](#footnote-ref-165)