TISSUE TRANSPLANTATION FROM CHILDREN: DIFFICULTIES IN NAVIGATING STATE AND FEDERAL SYSTEMS

SHIH-NING THEN* AND GABRIELLE APPLEBY**

I INTRODUCTION

In Australia, mechanisms exist to offer support and protection to those who need it most, including children. Such safeguards are particularly important for children who do not have the competence to understand or make medical decisions for themselves due to their young age. This group is referred to as 'young children' throughout this article.[1] As a society, we arguably have a moral obligation to ensure this support and protection is offered to this vulnerable group.[2]

However, this article argues that the legal principles in each Australian jurisdiction governing some invasive medical procedures on young children fail to offer the necessary protection. Although the conclusions made in this article

* Lecturer in Law, Queensland University of Technology.
** PhD Candidate, University of Adelaide.
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1 This group lacks 'sufficient understanding and intelligence' to understand the nature and consequences of the particular medical treatment: *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218, 237 (Mason CJ, Dawson, Toohey and Gaudron JJ) ('*Marion's Case*'), referring to the test originally established in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189 (Lord Scarman) ('*Gillick*'). The development of this understanding and intelligence will vary from child to child.

2 M D A Freeman, *The Rights and Wrongs of Children* (Frances Pinter, 1983) 35.

may apply to a range of invasive medical procedures,[3] its focus is on tissue removal from a young child for the purpose of transplantation to another.

The removal of tissue for transplantation into another person is an invasive procedure that, in some Australian jurisdictions and subject to certain conditions, may lawfully be carried out on young children.[4] At common law, parents generally have the authority to make medical decisions on behalf of children. While *Gillick*-competent children who have sufficient intelligence and maturity to understand the nature and consequences of the particular medical treatment may legally consent to medical treatment,[5] this does not apply to young children who do not yet have the requisite 'understanding and intelligence' to provide consent.[6] Where parents have authority to make medical decisions on behalf of the child, this authority is limited by the need for the decision to be made in the best interests of the child. However, the Supreme Court, in the exercise of its *parens patriae* jurisdiction, can override decisions of parents if the Court considers it to be required by the best interests of the child.[7] For some special

3 The most obvious invasive medical procedure that is subject to differing regimes around Australia is that of sterilisation of children without capacity (usually by reason of disability). This difficult topic has been discussed at length in the literature: see, eg, Natasha Cica, 'Sterilising the Intellectually Disabled: The Approach of the High Court of Australia in *Department of Health v JWB and SMB*' (1993) 1 *Medical Law Review* 186; Ian Freckelton, 'Sterilisation of Intellectually Disabled Minors' (2007) 14 *Journal of Law and Medicine* 299; Jennifer Ford, 'The Sterilisation of Young Women with an Intellectual Disability: A Comparison between the Family Court of Australia and the Guardianship Board of New South Wales' (1996) 10 *Australian Journal of Family Law* 236; Alexandra George, 'Sterilisation and Intellectually Disabled Children: In the matter of *P & P*' (1996) 18 *Sydney Law Review* 218; Nahum Mushin, 'Special Medical Procedures, Sterilisation of Minors and the Role of the Family Court' (2007) 14 *Psychiatry, Psychology and Law* 199; Helen Rhoades, 'Intellectual Disability and Sterilisation – An Inevitable Connection?' (1995) 9 *Australian Journal of Family Law* 234; Linda Steele, 'Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability' (2008) 22 *Australian Journal of Family Law* 1; David Tait, Terry Carney and Kirsten Deane, 'Legal Regulation of Sterilisation: The Role of Guardianship Tribunals in NSW and Victoria' (1994) 8 *Australian Journal of Family Law* 141.

4 This article excludes from specific consideration the position of children without capacity by reason of disability. There are documented cases in the US of disabled children without capacity being used as tissue donors: David P T Price, *Legal and Ethical Aspects of Organ Transplantation* (Cambridge University Press, 2000) 348. However this scenario is likely to be rare. The legal position of such children in Australia may also be different due to the way the relevant tissue transplantation legislation around Australia has been drafted and the potential interaction with guardianship legislation in some jurisdictions.

5 *Gillick* [1986] AC 112, 189 (Lord Scarman).

6 See above n 1 and accompanying text.

7 See, eg, *Re Heather* [2003] NSWSC 532 (12 June 2003).

medical procedures parental consent will be insufficient and court authorisation is required.[8]

Tissue transplantation is also subject to state and territory legislative regimes, the common law *parens patriae* jurisdiction and the federal jurisdiction under the *Family Law Act 1975* (Cth) ('*FL Act*'). Therefore, this issue offers a good example of the overlap, inconsistency and general confusion the law has created for young children, their parents and the medical practitioners involved.

Framed within children's vulnerability and this diffuse constitutional context, this article considers the operation of the specific state and territory regimes relating to tissue transplantation in young children before setting out the operation of the *parens patriae* jurisdiction, and finally turning to the effect of the federal jurisdiction under the *FL Act* on these. This analysis of the law will highlight the inconsistency between the current legal position and Australia's obligations created through it being a signatory to the *Convention on the Rights of the Child*.[9] The *CRC* places obligations on member states to give effect to the principle of the best interests of the child;[10] in addition, it highlights the need to allow children to participate in decisions affecting them.[11] Although the Australian government has stated that 'a determination of the best interests of the child is the key principle in most legislation concerning children in Australian, state and territory jurisdictions',[12] this article aims to show that this has not occurred in relation to removal of tissue from children for the purposes of transplantation.

This article concludes by considering avenues for reform and suggesting a system modelled on the UK regime, which allows different jurisdictions to coexist while empowering a centralised body to authorise the procedures.

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8 For example, sterilisation, sex change operations and abortions require court authorisation prior to these procedures being carried out on children without capacity to make their own decisions: Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218, 249–54 (Mason CJ, Dawson, Toohey and Gaudron JJ) (*Marion's Case*); *Re Alex* (2004) 180 FLR 89, 124 (Nicholson CJ); *Queensland v B* [2008] 2 Qd R 562, 565 [17] (Wilson J). There is conflicting Federal Court authority as to whether a transplantation procedure is such a 'special procedure': *Re Inaya* (2007) 213 FLR 278, 288, 290 (Cronin J); *Re W* (1997) 136 FLR 421, 425–6 (Hannon J). See below Part II(A). There exist other limiting factors on the parents' right to consent, including where a child is *Gillick*-competent (that is, the child has sufficient intelligence and maturity to understand the nature and consequences of the particular medical treatment): see above n 1 and accompanying text.

9 Convention on the Rights of the Child, signed 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) ('*CRC*').

10 *CRC* art 3, which provides: 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.'

11 *CRC* art 12. See also UNICEF, *Implementation Handbook for the Convention on the Rights of the Child* (UNICEF, 3rd ed, 2007) 149.

12 Australian Government, *Fourth Report under the Convention on the Rights of the Child* (Attorney-General's Department, 2009) 15 citing *Family Law Act 1975* (Cth) s 60CA, which provides that the best interests of a child are the paramount consideration in making parenting orders concerning a child.

II TISSUE TRANSPLANTATION

The removal of tissue from a child for transplantation into another is a procedure fraught with ethical uncertainties.[13] Questions arise as to whether such a medically invasive procedure should be carried out when it is of no physical benefit to the child providing tissue.[14] While recognising that difficult ethical issues arise, the focus in this article is on the legality of these transplantation procedures.

The following case study is used as the basis for our examination of the jurisdictional overlap and inconsistencies that arise in Australia:

Tina is seven years old and lives with her mother, Sandra. Tina has a brother, Nathan, who is three years old. Sandra separated from her husband, Frank, two years ago. Since then, Sandra and Tina have lived together, and Frank and Nathan have lived together in a town two hours away. Nathan has a hepatoblastoma (a malignant liver tumour) that has been unsuccessfully treated with chemotherapy. His doctor now advises that the best treatment would be for him to receive a liver transplant. However, as this will need to be carried out soon, the chances of a deceased donor liver becoming available are slim. Sandra, Frank and other close relatives are tested but ruled out as potential donors due to pre-existing medical conditions. Tina is tested and found to be a suitable match. Tina hates going to the doctors and becomes distressed when examined. Sandra and Frank have tried to explain the procedure to her but she does not understand. Sandra and Frank wish to proceed with the removal of liver tissue from Tina to be donated to Nathan.

The case of Tina raises several legal issues that Sandra and Frank, Tina, and the medical practitioner must navigate. At common law, can Sandra and Frank consent to such a procedure, or does it require court authorisation? Even if they can consent, does the procedure fall within the tissue transplantation regimes in specific state and territory legislation? Can they bypass the state regimes and seek an order from the Supreme Court or under the welfare jurisdiction of the *FL Act*?

A Liver Transplantations and Parental Consent

Few cases such as Tina's have come before the courts and these have been limited to the situation where a young child is being considered as a potential

13 See, eg, Mark Sheldon, 'Guest Editorial: Children and Organ Donors: A Persistent Ethical Issue' (2004) 13 *Cambridge Quarterly of Healthcare Ethics* 119; Lainie Friedman Ross, 'Moral Grounding for the Participation of Children as Organ Donors' (1993) 21 *Journal of Law, Medicine and Ethics* 251; James Dwyer and Elizabeth Vig, 'Rethinking Transplantation between Siblings' (1995) 25(5) *Hastings Center Report* 7; Price, above n 4, 334–47.

14 In addition, medical advances have created the ability to select and implant embryos for the specific purpose of future tissue donation from the child conceived. This issue has been discussed in Shih-Ning Then, 'The Legality of Tissue Transplants for the Benefit of Family Members in the UK and Australia: Implications for Saviour Siblings' (2009) 10 *Medical Law International* 23. Although beyond the scope of this article, this highlights the complex ethical issues involved in this area.

bone marrow donor.[15] These cases have debated whether that type of tissue transplantation from one child for the benefit of another is a 'special medical procedure', taking it outside the realm of parental consent and requiring authorisation from the courts.

In *Marion's Case*, it was concluded that 'non-therapeutic' sterilisation was a 'special medical procedure'.[16] This was because the procedure required 'invasive, irreversible and major surgery', there was a significant risk of a wrong decision being made (due to the complexity of the question of consent, the social and psychological as well as medical effects of consent and the conflicts of interests that may occur for the parent), and the grave consequences of making the incorrect decision.[17]

The most recent authority, *Re Inaya,* suggests that, unlike sterilisation, consenting to the removal of bone marrow tissue is within the scope of the parental authority, although subject to any legislative regulation or prohibition.[18] However, it is unlikely that removal of a section of the liver is the same as removing bone marrow. Like the removal of bone marrow, the procedure is one that creates an inherent conflict of interest for parents, as it will often involve weighing up the interests of both their donor child and the family member recipient.[19] However, unlike a bone marrow transplant, a liver resection is likely to be considered major surgery and is not a 'routine operation with minimal risks commonly performed on young children'.[20] In any case, a court order is necessary, as in *Re Inaya*, if the matter is otherwise prohibited by state or territory legislation.

B The Law Relating to Tissue Removal from a Child for the Benefit of Another

To determine the legal position of Sandra, Frank, any medical practitioners involved, and of course Tina, an examination of the relevant state, territory and federal legislation and the common law is required.

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15 *Re W* (1997) 136 FLR 421; *Re Inaya* (2007) 213 FLR 278. Note also *E v E* [1999] FamCA 2403, where an application was made to allow a *Gillick*-competent child to donate bone marrow or undergo peripheral blood collection.

16 (1992) 175 CLR 218, 250–2 (Mason CJ, Dawson, Toohey and Gaudron JJ).

17 Ibid.

18 (2007) 213 FLR 278. Although Cronin J qualifies this statement that this is the case to the extent that legislation expressly provides that parental consent is sufficient, and subject to certain requirements being fulfilled: at 288. *Contra Re W* (1997) 136 FLR 421, 425–6 (Hannon J); *E v E* [1999] FamCA 2403.

19 See, eg, *Queensland v B* [2008] 2 Qd R 562, 565, where Wilson J considered that a decision as to termination of pregnancy was outside ordinary parental consent because there was potential for the parents to make a decision which 'favours other and possibly conflicting interests of the family as a whole'. See also World Health Organization Executive Board, *Human Organ and Tissue Transplantation,* 62nd World Health Assembly, Provisional Agenda Item 12.10, A62/15, Annex 'WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation', Guiding Principle 4 Commentary (29 March 2009). Conflict of interest is discussed further at Part II(F).

20 *Re Inaya* (2007) 213 FLR 278, 287 (Cronin J).

1 *State and Territory Statutory Regimes for Regenerative Tissue*[21]

Each Australian jurisdiction has a separate regime for the removal of blood,[22] regenerative tissue and non-regenerative tissue.[23] For the purposes of assessing Tina's situation – which relates to a liver transplant – the regimes relating to removal of *regenerative* tissues from children are most relevant. All jurisdictions, with the exception of the Northern Territory, have specific provisions relating to children.[24]

Tissue is commonly defined as including an organ, or part, of a human body and a substance extracted from, or from a part of, the human body.[25] Regenerative tissue generally means 'tissue that, after injury or removal, is replaced in the body of a living person by natural processes of growth or repair'.[26] The definition of regenerative tissue includes bone marrow, one of the most common types of transplantable tissue.[27] With recent advances in transplant techniques, liver tissue also arguably comes within the scope of regenerative transplantable tissue.[28] However, removal of liver tissue is an invasive procedure – in that respect more akin to the removal of non-regenerative tissue – with a

21 The relevant legislation are: *Transplantation and Anatomy Act 1978* (ACT); *Human Tissue Act 1983* (NSW); *Human Tissue Transplant Act 1979* (NT); *Transplantation and Anatomy Act 1979* (Qld); *Transplantation and Anatomy Act 1983* (SA); *Human Tissue Act 1985* (Tas); *Human Tissue Act 1982* (Vic); *Human Tissue and Transplant Act 1982* (WA).

22 For the legal framework regarding blood removal generally see: *Transplantation and Anatomy Act 1978* (ACT) pt 2 div 2.5; *Human Tissue Act 1983* (NSW) pt 3 div 2; *Transplantation and Anatomy Act 1979* (Qld) pt 2 div 4; *Transplantation and Anatomy Act 1983* (SA) pt 2 div 5; *Human Tissue Act 1985* (Tas) pt 2 div 5; *Human Tissue Act 1982* (Vic) pt 3; *Human Tissue and Transplant Act 1982* (WA) pt 2 div 5.

23 In all jurisdictions except the ACT, the removal of non-regenerative tissue from children is expressly or impliedly prohibited in all jurisdictions: see below n 32; *Transplantation and Anatomy Act 1983* (SA) s 12; *Human Tissue Act 1982* (Vic) s 14(1); *Human Tissue and Transplant Act 1982* (WA) s 12(2). In the ACT, removal of non-regenerative tissue from a child is allowed in circumstances where parental consent is given, the child understands the nature and effect of the procedure and agrees, and a Minister appointed committee authorises the procedure: *Transplantation and Anatomy Act 1978* (ACT) s 14.

24 The legislation in the Northern Territory has no specific provisions for removal of regenerative tissue from children, but provides that any removal not in accordance with the Act is an offence: *Human Tissue Transplant Act 1979* (NT) s 27(1).

25 *Transplantation and Anatomy Act 1978* (ACT) s 2; *Human Tissue Act 1983* (NSW) s 4(1); *Transplantation and Anatomy Act 1983* (SA) s 5(1); *Human Tissue Act 1985* (Tas) 3(1); *Human Tissue Act 1982* (Vic) s 3(1); *Human Tissue and Transplant Act 1982* (WA) s 3(1). In Queensland, the definition is more explicit: *Transplantation and Anatomy Act 1979* (Qld) s 4(1).

26 *Transplantation and Anatomy Act 1978* (ACT) s 2; *Human Tissue Act 1983* (NSW) s 4(1); *Transplantation and Anatomy Act 1983* (SA) s 5(1); *Human Tissue Act 1985* (Tas) 3(1); *Human Tissue Act 1982* (Vic) s 3(1); *Human Tissue and Transplant Act 1982* (WA) s 3(1); *Transplantation and Anatomy Act 1979* (Qld) s 4(1).

27 The exception to this is Western Australia, where the definition of blood includes bone marrow: *Human Tissue and Transplant Act 1982* (WA) s 3(1). This means that bone marrow harvests will come under the statutory regime for blood, see *Transplantation and Anatomy Act 1978* (ACT) pt 2 div 2.5; *Human Tissue Act 1983* (NSW) pt 3 div 2; *Transplantation and Anatomy Act 1979* (Qld) pt 2 div 4; *Transplantation and Anatomy Act 1983* (SA) pt 2 div 5; *Human Tissue Act 1985* (Tas) pt 2 div 5; *Human Tissue Act 1982* (Vic) pt 3; *Human Tissue and Transplant Act 1982* (WA) pt 2 div 5.

28 The liver of a donor typically regenerates to a median 89 per cent of the original liver size: Silvio Nadalin et al, 'Current Trends in Live Liver Donation' (2007) 20 *Transplant International* 312, 325.

higher risk of adverse outcomes than kidney donation.[29] This has led some professional bodies to consider that liver resections should not be carried out on child donors.[30] Despite this, the removal of liver tissue would be treated at law in the same way as other regenerative tissues.

Removal of regenerative tissue from children for the purpose of transplantation into another person is usually restricted to transplants to family members.[31] The legislation in all Australian jurisdictions makes it an offence to remove tissue except in accordance with a consent or authority under the relevant Act;[32] all Acts provide a defence to this offence where the act is authorised by another law.[33] In Western Australia, South Australia and Victoria there is also an express prohibition in the statute against removal of regenerative tissue from a

29 Perioperative mortality for living kidney donation is reported at 0.03 per cent: Arthur J Matas et al, 'Morbidity and Mortality after Living Kidney Donation, 1999–2001: Survey of US Transplant Centers' (2003) 3 *American Journal of Transplantation* 830, 833. Cf the risk of death for live liver donors, which is quoted by transplant centres around the world as being between 0.2–2 per cent: Nadalin et al, above n 28, 323.

30 See American Medical Association, Council of Ethical and Judicial Affairs, *CEJA Report 3 – I-93 The Use of Minors as Organ and Tissue Donors* (1993) 4, 10 <http://www.amaassn.org/ama1/pub/upload/mm/369/ceja_3i93.pdf>; Council of Europe, Committee of Ministers, *Recommendation No R (97) 16 on Liver Transplantation from Living Donors* (30 September 1997). See also Nadalin et al, above n 28, 313.

31 *Transplantation and Anatomy Act 1978* (ACT) s 13(1) (family member or relative of the child); *Human Tissue Act 1983* (NSW) ss 10 (parent, brother or sister of the child), 11A (brother or sister of the child); *Transplantation and Anatomy Act 1979* (Qld) ss 12B, 12D (parent, brother or sister of the child); *Human Tissue Act 1985* (Tas) s 12 (family member or relative of the child); *Human Tissue Act 1982* (Vic) ss 15(1) (parent, brother or sister of the child), (2)(d) (brother or sister of the child); *Human Tissue and Transplant Act 1982* (WA) s 13(1) (family member or relative of the child). Note, in South Australia, regenerative tissue may be transplanted into 'another living person', but this is subject to approval by a Minister appointed committee: *Transplantation and Anatomy Act 1983* (SA) s 13. Children are generally defined in the legislation as persons who have not yet reached 18 years and are not married: see *Human Tissue Act 1983* (NSW) s 4(1); *Transplantation and Anatomy Act 1983* (SA) s 5(1); *Human Tissue Act 1985* (Tas) s 3(1); *Human Tissue Act 1982* (Vic) s 3(1). In the ACT, the person must be under the age of 18 years and not in a domestic relationship: *Transplantation and Anatomy Act 1978* (ACT) s 2. In Western Australia, there is no requirement for the person not to be married: *Human Tissue and Transplant Act 1982* (WA) s 3(1). The *Transplantation and Anatomy Act 1979* (Qld) contains no definition of a 'child', but the *Acts Interpretation Act 1954* (Qld) s 36 defines a child in as an individual under the age of 18 years.

32 *Transplantation and Anatomy Act 1978* (ACT) s 48(1); *Human Tissue Act 1983* (NSW) s 36(1); *Human Tissue Transplant Act 1979* (NT) s 27(1); *Transplantation and Anatomy Act 1979* (Qld) s 48(1) (note this provision creates a prohibition to remove tissue for any of the purposes referred to in ss 10–11; whilst these do not specifically relate to children, it seems the purposes are applicable to children and this would have the same effect as equivalent provisions in other jurisdictions); *Transplantation and Anatomy Act 1983* (SA) ss 12(b), 38(1)(a); *Human Tissue Act 1985* (Tas) s 30(1); *Human Tissue Act 1982* (Vic) ss 14(2), 44(1); *Human Tissue and Transplant Act 1982* (WA) ss 12(1), 33(1)(a).

33 *Transplantation and Anatomy Act 1978* (ACT) s 48(5)(b); *Human Tissue Act 1983* (NSW) s 36(4)(c); *Human Tissue Transplant Act 1979* (NT) s 27(3)(b); *Transplantation and Anatomy Act 1979* (Qld) s 48(3)(b); *Transplantation and Anatomy Act 1983* (SA) s 38(3)(c); *Human Tissue Act 1985* (Tas) s 30(4)(b); *Human Tissue Act 1982* (Vic) s 44(5)(b); *Human Tissue and Transplant Act 1982* (WA) s 33(3)(c).

child for the purposes of transplantation other than as provided for in the legislation.[34]

The majority of jurisdictions provide a process for removal of regenerative tissue from children where a parent has consented, the child has capacity to understand the nature and effect of the removal of the tissue and the nature of the transplantation, and the medical practitioner is satisfied both the parent and the child understand and agree.[35] However, few jurisdictions address the situation where the child (such as Tina) lacks the capacity to understand the nature and effect of the removal of the regenerative tissue and the nature of the transplantation.[36]

Currently in Australia, despite the possibility to do so, there are no documented live liver donations from young children.[37] Therefore, it is readily acknowledged that Tina's scenario is unlikely to occur in practice. However, an examination of Tina's case demonstrates that it is possible that such a risky and invasive procedure *could* legally be performed without the supervision of a court. Given that liver transplantation has only developed as a treatment in the last couple of decades (following the commencement of the relevant legislation), and the relatively high risks to the donor,[38] the current law is considered outdated,[39] and inadequate in its protection of young children.[40]

The relevant state and territory legislation explored below sets out two general positions – that in Western Australia, Tasmania, Australian Capital Territory and the Northern Territory, and that in NSW, Victoria and Queensland. South Australian law largely falls into the former category, but is considered separately below due to some idiosyncrasies.

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34 *Transplantation and Anatomy Act 1983* (SA) s 12(b); *Human Tissue Act 1982* (Vic) s 14(2); *Human Tissue and Transplant Act 1982* (WA) s 12(1).

35 *Transplantation and Anatomy Act 1978* (ACT) s 13; *Human Tissue Act 1983* (NSW) ss 10, 11; *Transplantation and Anatomy Act 1979* (Qld) ss 12B, 12C; *Human Tissue Act 1982* (Vic) s 15; *Human Tissue and Transplant Act 1982* (WA) s 13. Note that Tasmania provides that the parent and child must jointly consent: *Human Tissue Act 1985* (Tas) ss 12, 13. Note, in South Australia, in addition to this requirement, a committee appointed by the Minister must also approve the consent: *Transplantation and Anatomy Act 1983* (SA) s 13.

36 See Part II(B)(1)(c), below.

37 Australia and New Zealand Liver Transplant Registry, *20th Report* (2009) 31. The previous report does not specify the age of the live liver donors. See also views expressed in the professional literature: Nadalin et al, above n 28, 313; and the legal literature in the UK: J K Mason and G T Laurie, *Mason and McCall Smith's Law and Medical Ethics* (Oxford University Press, 7th ed, 2006) 488. Compare this with the position in the US where the National Data Report from 1 January 1988 – 26 July 2010 show that six children between the ages of 11–17 years acted as living liver donors. This information was obtained by selecting data for living liver donors by age via the Organ Procurement and Transplantation Network website: Organ Procurement and Transplantation Network, *Living Donors Recovered in the U.S. by Donor Age* (2010) <http://optn.transplant.hrsa.gov/latestData/step2.asp>.

38 See Matas et al, above n 29.

39 For comments regarding the Victorian legislation: see *Re Inaya* (2007) 213 FLR 278, 282 (Cronin J).

40 Cf the position in England, Wales and Northern Ireland, where the legislation provides different procedures for the removal of bone marrow and peripheral blood stem cells from young children compared with the removal of an organ or part of an organ: *Human Tissue Act 2004* (UK) c 30, ss 33(3), (7); *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) regs 10(1), (3)(b), 11, 12(1)–(2).

(a) Western Australia, Tasmania, Australian Capital Territory and Northern Territory

In Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory, there is no provision for allowing the removal of regenerative tissue from a child who does not understand the procedure. Given the offence provisions contained in those statutes, if independent parental authority to consent to such a procedure ever did exist at common law (and this appears unlikely), it has been wholly removed.[41] In order to proceed in these jurisdictions, Sandra and Frank would need to explore other avenues such as seeking an order under the common law *parens patriae* jurisdiction or under the *FL Act*. These options are discussed further below in Parts II(B)(2), II(C) and II(D).

(b) South Australia

Similarly, South Australia has no provision allowing removal of regenerative tissue from a young child. However, also potentially relevant in South Australia is legislation dealing with medical decision making for children in a broader context. The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) relevantly allows a medical practitioner to 'administer medical treatment to a child if … the parent or guardian consents'.[42] Given that the definition of medical treatment under that *Act* is technically wide enough to encompass a procedure such as removal of tissue for transplantation,[43] it is arguable that this section grants parents the right to consent to such a procedure. As a matter of statutory interpretation however it appears the more specific regime in the *Transplantation and Anatomy Act 1983* (SA) is likely to operate as an exception to the general scheme.[44]

41 See, eg, *Transplantation and Anatomy Act 1978* (ACT) s 48(1); *Human Tissue Act 1983* (NSW) s 36(1); *Human Tissue Transplant Act 1979* (NT) s 27(1); *Transplantation and Anatomy Act 1979* (Qld) s 48(1) *Transplantation and Anatomy Act 1983* (SA) ss 12(b), 38(1)(a); *Human Tissue Act 1985* (Tas) s 30(1); *Human Tissue Act 1982* (Vic) ss 14(2), 44(1); *Human Tissue and Transplant Act 1982* (WA) ss 12(1), 33(1)(a).

42 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12(a).

43 This is despite the fact that such a procedure would not normally come within the meaning of 'treatment' as it is commonly understood. Medical treatment is defined as meaning 'treatment or procedures administered or carried out by a medical practitioner in the course of medical or surgical practice or by a dentist in the course of dental practice and includes the prescription or supply of drugs': *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4.

44 See comments by the Privy Council in *Associated Minerals Consolidated Ltd v Wyong Shire Council* [1974] 2 NSWLR 681, 686. See also the discussion in Rebecca Bailey-Harris, 'Sterilisation, Children and the Constitution' (1995) 1 *Flinders Journal of Law Reform* 2, 16 n 63.

(c) Victoria, New South Wales[45] *and Queensland*

In contrast with the jurisdictions above, the legislation in Victoria, NSW and Queensland specifically provides that parental consent is sufficient for the removal of regenerative tissue from a child who is incapable of understanding by reason of age,[46] as long as certification is provided by medical practitioner(s) and the relevant statutory criteria are satisfied.

The legislation requires that the tissue to be removed and transplanted is regenerative and that the tissue recipient (the donor child's brother or sister, or additionally in the case of Queensland, the child's parent)[47] is 'likely to die'[48] or, in NSW, to 'suffer serious and irreversible damage to his or her health'.[49]

The regimes differ across the jurisdictions. NSW requires:

- a medical practitioner to certify that a parent gave consent with an understanding the nature and effect of the removal of the tissue and the transplant; and
- two medical practitioners – one being a specialist in paediatric medicine or paediatric transplants and not involved in the care of the sibling – to certify that:
  - the child is not capable of understanding the nature and effect of the removal of tissue and the transplant;
  - that any risk to the child's health (including psychological and emotional health) caused by the removal of the tissue is minimal; and
  - and that the sibling is likely to die or suffer serious and irreversible damage to his or her health.[50]

Where these requirements are satisfied, another medical practitioner can carry out the procedure.[51]

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45 Note that in NSW, a provision similar to section 12 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (discussed above) is contained in *Minors (Property and Contracts) Act 1970* (NSW) s 49. Section 49(1) provides that a parent to give valid consent for medical treatment of their child below 16 years of age, but it is limited in scope in that it only applies to 'a claim by the minor for assault or battery'. Section 49(2) provides protection against a claim of assault or battery by a child where the child is 14 years or over and has consented. However, this section does not confer general capacity on a child to consent to medical treatment: *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311, 321 (Helsham CJ in Eq); NSW Law Reform Commission ('NSWLRC'), *Young People and Consent to Health Care*, Report No 119 (2008) 89–91 [4.27]–[4.32]; NSWLRC, *Minors' Consent to Medical Treatment,* Issues Paper No 24 (2004) [2.17].

46 *Human Tissue Act 1983* (NSW) ss 10, 11A(1); *Transplantation and Anatomy Act 1979* (Qld) ss 12B, 12D(1); *Human Tissue Act 1982* (Vic) ss 15(1), (2)(d)(ii).

47 NSW and Victoria provide for removal of tissue for siblings only: *Human Tissue Act 1983* (NSW) s 11A(1)(d)(ii); *Human Tissue Act 1982* (Vic) s 15(2)(d)(i). Queensland provides for removal of tissue for siblings and parents: *Transplantation and Anatomy Act 1979* (Qld) s 12D(1)(b).

48 *Transplantation and Anatomy Act 1979* (Qld) s 12D(1)(b); *Human Tissue Act 1983* (NSW) s 11A(i)(d)(ii); *Human Tissue Act 1982* (Vic) s 15(2)(d)(i).

49 *Human Tissue Act 1983* (NSW) s 11A(1)(d)(ii).

50 *Human Tissue Act 1983* (NSW) s 11A.

51 *Human Tissue Act 1983* (NSW) s 14(2).

Similar requirements exist in Queensland except that three medical practitioners are required to certify that the preconditions have been satisfied in the presence of a designated officer.[52] On the other hand, Victoria does not have the majority of these procedural safeguards; the legislation only requires certification from one medical practitioner, with no other criteria such as consideration of risk to the child.[53] No court authorisation is legally necessary in these jurisdictions as long as the legislative requirements are satisfied and the medical practitioner performing the tissue removal is satisfied the consent is effective.[54]

Notable in each of these jurisdictions' legislation is the absence of the best interests test.[55] In NSW [56] and Queensland[57] this has been replaced by a 'minimal' risk test. In Victoria there is no requirement for direct consideration of the donor child's welfare. Given the risk involved,[58] it seems likely that most medical practitioners would not consider that the risk to Tina's health would be 'minimal' were she used as a donor. This would then prevent the lawful removal of tissue from Tina in accordance with the legislation in Queensland and NSW, but would be no impediment in Victoria.

In addition, the position of a young child who objects is unclear[59] – particularly in Queensland and Victoria. There is no specific provision for taking into account a child's objection during the decision making process.[60] However, it appears that a child's objection may operate to make the consent ineffective.

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52 *Transplantation and Anatomy Act 1979* (Qld) ss 12B, 12D, 12E, 14A.

53 *Human Tissue Act 1982* (Vic) ss 15–16.

54 For circumstances where consent will not be sufficient authority: see *Human Tissue Act 1983* (NSW) s 15; *Transplantation and Anatomy Act 1979* (Qld) s 15; *Human Tissue Act 1982* (Vic) s 17.

55 Cf the position under the exercise of the *parens patriae* jurisdiction or federal jurisdiction exercised under the *FL Act* discussed in Part (II)(C)(1), below.

56 *Human Tissue Act 1983* (NSW) s 11A(1)(d)(iii). Section 11A(2)(b)(i) also specifies that an opinion must be provided for by a medical practitioner 'whose primary role in providing an opinion in the case is to ensure the health of the child from whom the tissue is to be removed.'

57 *Transplantation and Anatomy Act 1979* (Qld) s 12D(1)(c).

58 See Nadalin et al, above n 28; Matas et al, above n 29.

59 This is particularly so as the legislation does not create any legal obligation to seek the child's views during the decision-making process.

60 Cf the position in Scotland, where there must be no evidence of a child's 'unwillingness to be a donor' prior to the procedure being authorised: *Human Tissue (Scotland) Act 2006* (Scot) ss 17(1)(a), (4); *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) reg 5(9)(i). See also Price, above n 4, 359–60. The importance of taking into account the child's objection has been highlighted by the World Health Organisation: World Health Organization Executive Board, above n 19, 9; *Additional Protocol to the Convention on Human Rights and Biomedicine, on Transplantation of Organs and Tissues of Human Origin*, opened for signature 24 January 2002, ETS No 186 (entered into force 1 May 2006) art 14 ('*Additional Protocol to the CHRB*'). Another vulnerable cohort where the 'best interests' test is applied at common law is that of adults without capacity: see *Northern Sydney and Central Coast Area Health Service v CT (by his tutor ET)* [2005] NSWSC 551 (10 June 2005) [26] (Nicholas J); *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1997] 2 FCR 172, 175. In Victoria and Queensland, there is a statutory requirement to take into account the views or objections of such adults with incapacity where they are being considered as tissue donors: *Guardianship and Administration Act 2000* (Qld) s 69(2); *Guardianship and Administration Act 1986* (Vic) s 38(1)(a).

The position in NSW is clearest; where a young child 'has at least some understanding of the procedures involved' and has 'repeatedly and consistently expressed an unwillingness to undergo any such procedures', this will make any prior consent insufficient.[61] The position in Queensland and Victoria is ambiguous; the legislation states that a consent will not be sufficient authority where a child is no longer (or in Queensland, 'not') in 'agreement' with the procedure.[62] It is not clear if these provisions are meant to apply to young children, as – unlike children with capacity to understand – their agreement was at no time required during the decision making process.[63] There is also no guidance provided to the medical practitioner as to how the lack of agreement must be demonstrated.

This failure to take into account a young child's views during the decision making process and the ambiguity regarding the effect of any objection by a child in Queensland and Victoria is undesirable. Just because a child does not yet have capacity does not mean that a child's views or objections should not be heard and considered. Article 12 of the *CRC* requires nations to ensure children who are capable of forming their own view the right to express those views freely in all matters affecting them and for their views to be given due weight according to their age and maturity. In addition children must be given the opportunity to be heard in judicial or administrative proceedings affecting them, either directly or through a representative.[64]

If an application for authorisation of a similar procedure came before a court and the child expressed an objection, that court would need to take that objection into consideration in making a decision.[65] Such matters, as is shown below, will likely be taken into account in the *parens patriae* jurisdiction of the Supreme Court and also under the jurisdiction conferred by the *FL Act*.

These regimes result in a young child in Queensland and Victoria being in a different and arguably less protected position compared with similar children in other Australian jurisdictions.

2 *The Common Law*

So far, the position in Australia appears relatively clear; legislation in each jurisdiction either regulates or prohibits the removal of tissue from young children for the benefit of others. However, the general common law regarding

61 *Human Tissue Act 1983* (NSW) s 15(d).

62 *Transplantation and Anatomy Act 1979* (Qld) s 15(c); *Human Tissue Act 1982* (Vic) s 17(c). See also *Transplantation and Anatomy Act 1979* (Qld) s 21; *Human Tissue Act 1982* (Vic) s 19. Cf *Human Tissue Act 1983* (NSW) s 17, which only applies to children who have capacity to understand and agree.

63 However, contrast this with the position of children who are able to understand the nature and effect of the procedure: *Transplantation and Anatomy Act 1979* (Qld) s 12C; *Human Tissue Act 1982* (Vic) s 15(2)(c).

64 *CRC* art 12. See also art 24.

65 See, eg, *Family Law Act 1975* (Cth) ss 60CC(3)(a), 60CD; *Minister for Health v AS* (2004) 29 WAR 517, 228 [23] (Pullen J); *Royal Alexandra Hospital for Children v J* (2005) 33 Fam LR 448, 456–7 (Einstein J). See also *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 88 (Balcombe LJ), 93 (Nolan LJ) for similar statements from the UK.

medical procedures, through which state and territory Supreme Courts can exercise *parens patriae* jurisdiction to authorise procedures in the best interests of a child, exists (at least in some jurisdictions) in parallel to the legislation.[66]

(a) Parens Patriae *Jurisdiction*

The *parens patriae* jurisdiction comes from the jurisdiction of the English Court of Chancery in the 18th century to make orders protecting the welfare of children. This devolved from the sovereign responsibility to protect vulnerable members of the community.[67] The *parens patriae* jurisdiction was incorporated as part of the jurisdiction of the Supreme Courts of the states and territories as a consequence of the Acts creating those Courts.[68] The *parens patriae* jurisdiction is not limited to those activities that are within parental consent.

A number of cases indicate that the continued operation of the *parens patriae* jurisdiction in conjunction with the state and territory legislation is likely.[69] In *Minister of State for the Interior of the Commonwealth v Neyens*, Barwick CJ stated that the *parens patriae* jurisdiction would only be ousted if done so 'expressly or by necessary, indeed inescapable, implication'.[70] This was confirmed in *Carseldine v Director of Department of Children's Services*, where Mason J indicated the desirability of maintaining the *parens patriae* jurisdiction.[71] The qualification in each statute's offence provisions that transplant procedures may take place where otherwise 'authorised by law',[72] would seem enough to maintain the *parens patriae* jurisdiction of the Supreme Court in the majority of jurisdictions (although perhaps not in South Australia,

66 The continued existence of the *parens patriae* jurisdiction in parallel to the federal jurisdiction under the *FL Act* has been doubted because of the inclusion in the latter legislation of section 69B. This is considered further in Part II(D)(2), below, in the analysis of the High Court's decision in *P v P* (1994) 181 CLR 583.

67 John Seymour, 'Parens Patriae and Wardship Powers: Their Nature and Origins' (1994) 14 *Oxford Journal of Legal Studies* 159. See also *AMS v AIF* (1999) 199 CLR 160, 189 (Gaudron J) citing *Re X (a minor)* [1975] Fam 47, 50–1 (Latey J).

68 The general *parens patriae* jurisdiction was inherited by the Supreme Courts from the UK Courts of Equity. See, eg, *Supreme Court Act 1970* (NSW) s 70; *Constitution Act 1975* (Vic) s 85; *Supreme Court Act 1935* (SA) s 17(2)(a)(i); *Supreme Court Act 1935* (WA) s 16(1)(d). The *Supreme Court Act 1867* (Qld) and *Equity Act 1867* (Qld) are cited in *Carseldine v Director of the Department of Children's Services* (1974) 133 CLR 345, 363 (Mason J) as establishing the *parens patriae* jurisdiction in Queensland.

69 This can be contrasted with legislation which expressly states that it does not limit the jurisdiction of the Supreme Court. See, eg, *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 247.

70 (1964) 113 CLR 411, 419 (Barwick CJ).

71 (1974) 133 CLR 345, 366 (Mason J); see also *Johnson v Director-General of Social Welfare (Vic)* (1976) 135 CLR 92, 97 (Barwick CJ), 100 (Murphy J); *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311, 323 (Helsham CJ in Eq).

72 *Transplantation and Anatomy Act 1978* (ACT) s 48(5)(b); *Human Tissue Act 1983* (NSW) s 36(4)(c); *Human Tissue Transplant Act 1979* (NT) s 27(3)(b); *Transplantation and Anatomy Act 1979* (Qld) s 48(3)(b); *Transplantation and Anatomy Act 1983* (SA) s 38(3)(c); *Human Tissue Act 1985* (Tas) s 30(4)(b); *Human Tissue Act 1982* (Vic) s 44(5)(b); *Human Tissue and Transplant Act 1982* (WA) s 33(3)(c).

Victoria or Western Australia).[73] Therefore, legislative prohibitions or regulation of tissue transplantations from young children may be circumvented if an appropriate order is given by the Supreme Court.[74]

(b) Exercise of the Parens Patriae *Jurisdiction*

In exercising *parens patriae* jurisdiction, the court *must* take the general welfare of the child as the paramount consideration. This requires the court to deliberate on a broader range of factors than those identified in the statutory regimes.[75] The court will only exercise this jurisdiction with caution, and as well as expert evidence placed before the court, it will take into account the views and wishes of the parents and the child the subject of the proceedings.[76] It is clear that the court, in exercising its *parens patriae* jurisdiction, will consider the wishes of the child as an important factor, although not a determinative one, in making a decision.[77]

This approach is given further weight when article 12 of the *CRC* is considered.[78] The Supreme Court of NSW in *Re Thomas* has indicated that the *Convention*, while not incorporated into domestic law, 'has relevance to decisions made in respect of children by administrative and judicial decision-makers'.[79]

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73 There is an argument that in South Australia, Victoria and Western Australia, the existence of an express prohibition which makes the removal of tissue from children unlawful: see, eg, *Transplantation and Anatomy Act 1983* (SA) s 12(b); *Human Tissue Act 1982* (Vic) s 14(2); *Human Tissue and Transplant Act 1982* (WA) s 12(1) which may affect the Supreme Court's power to make an order in the *parens patriae* jurisdiction. Some cases have limited the exercise of the jurisdiction to circumstances that are 'lawful': see, eg, statements in *Queensland v B* [2008] 2 Qd R 562, 565 (Wilson J); *Y v Austin Health* (2005) 13 VR 363, 368, 372 (Habersberger J); *Queensland v Nolan* [2002] 1 Qd R 454, 456, 460 (Chesterman J); or where no statutory prohibition exists that is contrary to the order requested: *Re Denman* [2004] 2 Qd R 595, 598 (Atkinson J). If this alternative argument succeeded, then in South Australia, Victoria and Western Australia, Sandra and Frank would have to apply to the Family Court to circumvent the State statutory provisions.

74 See, eg, the comments of Hargrave J in *AB v Attorney-General (Vic)* (2005) 12 VR 485, 505 (although in a slightly different context). It was also recognised that a Supreme Court, although possessing jurisdiction, may choose not to provide such authorisation in light of the statutory regime: at 504.

75 A court in considering the best interests of a potential vulnerable donor is likely to consider the current and future relationships of the donor and the recipient (which may be particularly relevant in Tina's situation given that Tina and her brother have not lived together for some time), the effect on the donor if the procedure does not go ahead, compared with if it goes ahead, the risks involved and the views of the donor. See, eg, *Northern Sydney and Central Coast Area Health Service v CT (by his tutor ET)* [2005] NSWSC 551 (10 June 2005) [26]–[29] (Nicholas J); *Re Inaya* (2007) 213 FLR 278, 552–3 [36]–[43], 284–5 (Cronin J); *Re W* (1997) 136 FLR 421, 428–9 (Hannon J). Note that in the last two cases, the Family Court was exercising federal jurisdiction under the *FL Act*, however, as discussed in Part II(C)(1), this jurisdiction is similar to the *parens patriae* jurisdiction. Cf Part II(B)(1)(c), below.

76 See, eg, *Director-General, Department of Community Services; Re Thomas* (2009) 41 Fam LR 220, 229–30, 232 (Brereton J) ('*Re Thomas*'); *Minister for Health v AS* (2004) 29 WAR 517, 226–7 [8]–[15], 228 [23] (Pullin J); *Royal Alexandra Hospital for Children v J* (2005) 33 Fam LR 448, 451–6 (Einstein J).

77 See, eg, above n 65 and the cases cited.

78 See above Part II(B)(1)(c); see also *CRC* art 12.

79 (2009) 41 Fam LR 220, 232–3 (Brereton J). See also *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273.

Related to the question of whether a child's views will be considered by a court is whether a potential child donor will be separately represented during proceedings.[80] This depends on individual jurisdictions' court rules, how the matter is brought before the court and the discretion of the judge hearing the application.[81] For example, where the child is included as a party (whether applicant or respondent), it may be necessary to have a litigation guardian or tutor appointed pursuant to court rules.[82] Normally, a parent can act in this position; however, arguably in the situation of tissue transplantation, if the recipient of the tissue is also close to the parent, there may be a conflict of interest that may result in their unsuitability for this position.[83] Geoff Monahan suggests that the common law recognises that a litigation guardian or tutor should act in the best interests of the child.[84] Alternatively, in some circumstances, a court may ask counsel to appear amicus curiae. This appears especially likely in cases where there is no contradictor to an application.[85] However, the role of an amicus is quite different from that of a litigation guardian (or an independent children's lawyer under the *FL Act*) as their duty will be to the court and not to the individual child.[86]

Arguably then, given there is no physical benefit received by the child who has tissue removed (and the psychological benefit remains open to debate), if a child strongly objects to the procedure, a Supreme Court exercising its *parens patriae* jurisdiction would be unlikely to find that authorising such a procedure would be in the best interests of the child. When this is coupled with the fact that an application to the court, in itself, offers a procedural safeguard and third party oversight, it is clear that this process offers substantially more protection for

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80 See also *CRC* art 12(2), which provides: 'For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.'

81 Cf the position under the *FL Act*, discussed in more depth below in Part(II)(C)(1).

82 See, eg, *Uniform Civil Procedure Rules 1999* (Qld) rr 93–8 (a person under a legal capacity is defined in sch 2 of the *Supreme Court of Queensland Act 1991* (Qld) as including a person under 18 years of age); *Uniform Civil Procedure Rules 2005* (NSW) rr 7.13–18. In relation to NSW, see comments in *Royal Alexandra Hospital for Children v J* (2005) 33 Fam LR 448, 450 (Einstein J) referring to provisions which are now contained in the *Uniform Civil Procedure Rules 2005* (NSW) rr 7.13–18.

83 See *Uniform Civil Procedure Rules 1999* (Qld) r 94(1)(b); *Uniform Civil Procedure Rules 2005* (NSW) r 7.15(2)(c). Cf *Queensland v B* [2008] 2 Qd R 562, where a public hospital sought authorisation for termination of the pregnancy of a 12 year old girl. In this case, the Supreme Court accepted the girl's father as her litigation guardian despite the Court recognising that her parents may act in accordance with conflicting interests that favour the family as a whole rather than just B: at 565. Justice Wilson in that case appointed counsel as amicus curiae to act as contradictor: at 566–7.

84 Geoff Monahan, 'Autonomy vs Beneficence: Ethics and the Representation of Children and Young People in Legal Proceedings' (2008) 8 *Queensland University of Technology Law and Justice Journal* 392, 396.

85 *Queensland v B* [2008] 2 Qd R 562, 566–7 (Wilson J).

86 *Bropho v Tickner* (1993) 40 FCR 165, 172 (Wilcox J): 'the amicus' role [is] normally ... 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'.

young children. This is particularly true when compared with the position under some statutory regimes.

C Introducing the Federal Regime

The federated structure of the Australian legal system, consisting of a complicated series of overlapping and at times inconsistent state, territory and federal law means the legal position regarding tissue transplantation procedures is even more complex. An order authorising such a procedure under the federal jurisdiction of the *FL Act* can circumvent state and territory legislation regulating or prohibiting these procedures, as well as the *parens patriae* jurisdiction of the Supreme Court.

The Family Court did not inherit the general *parens patriae* jurisdiction and is therefore limited to the statutory jurisdiction conferred by the *FL Act* (and other legislation).[87] Jurisdiction over the welfare of children – which would cover the regulation of medical procedures – is not an area that is directly within the legislative power of the Commonwealth Parliament.[88] However, jurisdiction has been conferred on the Family Court regarding the welfare of children using some other heads of Commonwealth power in Part VII of the *FL Act*.[89] A brief outline of this jurisdiction in relation to the welfare of the child is required: its structure demonstrates the restrictions caused by the constitutional basis on which the *Act* is founded.

87 *Marion's Case* (1992) 175 CLR 218, 254–5 (Mason CJ, Dawson, Toohey and Gaudron JJ). A wider jurisdiction that had been conferred on the Family Court pursuant to the original cross-vesting scheme was held invalid in *Re Wakim; Ex parte McNally* (1999) 198 CLR 511. The cross-vesting scheme had vested the *parens patriae* jurisdiction of the Supreme Court in the Family Court. However, in *Wakim*, the High Court held that this was invalid as it purported to vest State judicial power in a federal court. Chapter III of the Constitution permitted only the conferral of federal judicial power on federal courts.

88 Pursuant to *Constitution* ss 51–2.

89 The Commonwealth Parliament has also been able to confer more general jurisdiction on the Family Court (not limited to children of a marriage) through State referral of powers pursuant to s 51(xxxvii) of the *Constitution*, in the areas of maintenance, custody, guardianship, access and parentage: see *Commonwealth Powers (Family Law – Children) Act 1986* (NSW); *Commonwealth Powers (Family Law) Act 1986* (SA); *Commonwealth Powers (Family Law) Act 1987* (Tas); *Commonwealth Powers (Family Law) Act 1986* (Vic); *Commonwealth Powers (Family Law – Children) Act 1990* (Qld) s 3(1). Notably absent from these referrals is any reference to the welfare of the child. The High Court has confirmed that these references are narrower than a general welfare jurisdiction, which means that the welfare jurisdiction over children of a marriage is not expanded by these State referrals: see *Marion's Case* (1992) 175 CLR 218, 255 (Mason CJ, Dawson, Toohey and Gaudron JJ); *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365, 387 (Gleeson CJ and McHugh J), 405 (Gummow, Hayne and Heydon JJ), 435, 439 (Callinan J) ('*MIMIA v B*'). The jurisdiction of the Family Court under the *FL Act* is also vested in the State Supreme Courts: *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth) s 5. This has been relied upon, for example, in *Director-General, Department of Community Services; Re Jules* (2008) 40 Fam LR 122, 125–6 (Brereton J), where the Court was uncertain as to whether the Supreme Court *parens patriae* jurisdiction existed concurrently with the *FL Act* jurisdiction.

1 *Section 67ZC: A Limited Welfare Jurisdiction*

Section 67ZC of the *FL Act* is the most important provision for the purposes of this article. It creates jurisdiction to 'make orders relating to the welfare of children'.[90] In making any such order, the court must regard the best interests of the child as the paramount consideration.[91] The principle of 'best interests of the child' is further explained in the Act,[92] and the factors that are relevant to its determination are very similar to the considerations taken into account by the Supreme Courts under the *parens patriae* jurisdiction. In fact, the majority in *Marion's Case* said the jurisdiction is 'similar to the *parens patriae* jurisdiction'.[93] The court must consider, inter alia, 'any views expressed by the child and any factors (such as the child's maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child's views',[94] and 'any other fact or circumstance that the court thinks is relevant'.[95]

The *FL Act* also makes provision for the appointment of Independent Children's Lawyers at the discretion of the court.[96] The role of such lawyers is to form an independent view of what is in the best interests of the child and, although they are not obliged to act on the child's instructions, they must 'ensure that any views expressed by the child in relation to the matters to which the

90 *Family Law Act 1975* (Cth) s 67ZC(1).

91 *Family Law Act 1975* (Cth) s 67ZC(2). See, eg, *Re Inaya* (2007) 213 FLR 278, 290–1 (Cronin J); *Re W* (1997) 136 FLR 421, 428–9 (Hannon J).

92 See *Family Law Act 1975* (Cth) pt VII div 1 sub-div BA, particularly ss 60B, 60CC. Although, since the amendments incorporated by the *Family Law Amendment (Shared Parental Responsibility) Act 2006* (Cth), the focus has been on taking into account the need for both parents to be involved in a child's life, the factors identified are also relevant to welfare orders regarding medical treatment made by the Family Court: see *Family Law Act 1975* (Cth) s 67ZC(2).

93 *Marion's Case* (1992) 175 CLR 218, 258 (Mason CJ, Dawson, Toohey and Gaudron JJ); see also *P v P* (1994) 181 CLR 583, 598–9 (Mason CJ, Deane, Toohey and Gaudron JJ).

94 *Family Law Act 1975* (Cth) s 60CC(3)(a).

95 *Family Law Act 1975* (Cth) s 60 CC(3)(m). In the context of authorising sterilisation of a child without capacity, Nicholson CJ set out a number of other factors that will be relevant to determining the best interests of the child: *Re Marion (No 2)* (1992) 17 Fam LR 336, 351. The factors were the particular condition of the child which requires the procedure or treatment; the nature of the procedure or treatment proposed; the reasons for which it is proposed that the procedure or treatment be carried out; the alternative courses of treatment that are available in relation to that condition; the desirability of and effect of authorising the procedure or treatment proposed rather than the available alternatives; the physical effects on the child and the psychological and social implications for the child of (a) authorising the proposed procedure or treatment and (b) not authorising the proposed procedure or treatment; the nature and degree of any risk to the child of: (a) authorising the proposed procedure or treatment and (b) not authorising the proposed procedure or treatment; the views (if any) expressed by (a) the guardian(s) of the child; a person who is entitled to the custody of the child; a person who is responsible for the daily care and control of the child; and the child to the proposed procedure or treatment and to any alternative procedure or treatment. These factors have also been applied by the courts in the context of tissue transplantation procedures: *Re W* (1997) 136 FLR 421, 428–9 (Hannon J). See also *Re Inaya* (2007) 213 FLR 278, 291 (Cronin J). Although note that in *Re W* the Court thought that the only relevant factors from Chief Justice Nicholson's list were the nature of the procedure or treatment proposed and the physical effects on the child and the psychological and social implications for the child were relevant to the situation of a bone marrow transplant: at 428–9 (Hannon J).

96 *Family Law Act 1975* (Cth) s 68L. See, eg, *Re Inaya* (2007) 213 FLR 278, 281 (Cronin J).

proceedings relate are fully put before the court'.[97] If such a lawyer is appointed, there is a far greater chance that the child's views will be made known and therefore taken into account.[98]

2 *Constitutionality of section 67ZC and Chapter III of the* Constitution

Marion's Case considered the constitutionality of the welfare jurisdiction under the *FL Act*.[99] The jurisdiction of the Court was challenged on the basis that the conferral of the power on the Family Court to authorise a sterilisation procedure for a child of a marriage was not 'federal judicial power' and therefore could not be conferred on a federal court.[100] It was argued the power was not federal judicial power because it did not involve a 'matter' – that is, there was no controversy over an 'immediate right, duty or liability to be established by the determination of the Court'.[101] The High Court determined that the welfare jurisdiction in circumstances where the parents applied for an order authorising a sterilisation procedure involved a 'matter' and therefore was federal judicial power.[102] The 'matter' in *Marion's Case* stemmed from the controversy over parental obligations to care for the child created by the Act.[103] This was subsequently considered and further explained by the High Court in *MIMIA v B*.[104] Chief Justice Gleeson and McHugh J explained that the 'welfare of children' itself was not a 'matter';[105] rather the matter arose from the controversy

97 *Family Law Act 1975* (Cth) ss 68LA(2)(a), (4)(b), 5(b). See also, National Legal Aid, *Guidelines for Independent Children's Lawyers* (6 December 2007) <http://www.nla.aust.net.au/res/File/PDFs/ICL%20guidelines-6-12-07.pdf>.

98 See Monahan, above n 84, 398–400.

99 *Marion's Case* (1992) 175 CLR 218 considered *Family Law Act 1975* (Cth) ss 63, 64. These sections were inserted by the *Family Law Amendment Act 1983* (Cth) and were replaced as s 67ZC in substantially the same form by the *Family Law Reform Act 1995* (Cth).

100 As such, it would be inconsistent with Chapter III of the *Constitution*, and more specifically the second limb of the *Boilermaker's* doctrine: *R v Kirby; Ex Parte Boilermakers' Society of Australia* (1956) 94 CLR 254 ('*Boilermakers' Case*'), which prohibits the conferral of anything other than federal judicial power on federal Chapter III Courts, such as the Family Court.

101 *Re Judiciary and Navigation Acts* (1921) 29 CLR 257, 265 (Knox CJ, Gavan Duffy, Powers, Rich and Starke JJ).

102 *Marion's Case* (1992) 175 CLR 218, 257 (Mason CJ, Dawson, Toohey and Gaudron JJ).

103 See, eg *Family Law Act 1975* (Cth) s 63E as it then was: *MIMIA v B* (2004) 219 CLR 365, 381 (Gleeson CJ and McHugh J). In *MIMIA v B,* an order was sought against a third party, but the Court held that no 'matter' existed; there was no conflicting right or obligation, because the Act did not create rights or obligations on third parties: at 390–1 (Gleeson CJ and McHugh J). The joint judgment of Gummow, Hayne and Heydon JJ found that the power of the Family Court under s 69ZH was similarly limited to parental responsibilities under the legislation and did not extend to matters involving third parties: at 396, 405 (Gummow, Hayne and Heydon JJ). See also 434–9 (Callinan J).

104 (2004) 219 CLR 365.

105 Ibid 379 (Gleeson CJ and McHugh J).

over the statutory obligations in the Act. Thus, the welfare jurisdiction in section 67ZC is only as broad as the obligations that arise under the *FL Act*.[106]

3 *Section 67ZC: Legislative Power and Breadth*

At first glance, section 67ZC appears to provide a broad jurisdiction to make welfare orders for the best interests of a child. The confusion that exists around the breadth of section 67ZC arises because of the difficult drafting of the *FL Act* and its reliance upon a patchwork of federal legislative powers – the marriage power, the referral power and the territories power.[107] Section 67ZC must be read against sections 69ZH, 69ZE,[108] 69ZG and 69ZJ. The effect of these provisions is that with two exceptions, each reference to a child in the welfare jurisdiction is confined to a child of a marriage.[109] The exceptions are where the child is situated in a Territory,[110] or where the child's parents reside in different states.[111]

D The State and Federal Regimes and Section 109

At the federal level then, the *FL Act* provides jurisdiction to make orders for the welfare of a child of a marriage, a child in a territory, or where the child has parents residing in different states. State legislation and the common law provide the legal framework for issues regarding the tissue transplantation for children who do not fall within the jurisdiction under the *FL Act*. However, the state legislation is drafted in a more general form than this, as it applies to all children within that jurisdiction, as does the *parens patriae* jurisdiction of the Supreme Court. Therefore, more than one of the different regimes may purport to apply to

106 Cf *T v F* (1999) 151 FLR 312, 335 (Nicholson CJ, Lindenmayer and Kay JJ), which seems to imply a broader 'welfare jurisdiction' may be found in s 68B, which gives the power to the Court to order injunctions as it considers appropriate for the welfare of the child. It is doubtful after *MIMIA v B* that this jurisdiction would be as broad as the earlier decision finds, but it would also be limited to where there are rights and obligations in issue under the remaining provisions of the *FL Act*.

107 When trying to determine the breadth of s 67ZC, Gleeson CJ and McHugh J have commented in *MIMIA v B* (2004) 219 CLR 365, 375, that '[t]he principal difficulty in the appeal arises out of the complexity of the legislative scheme contained in Pt VII … dealing with children, a complexity that is not reduced by a form of drafting that is sometimes used in federal legislation. This form of drafting commences with the enactment of a provision that, standing alone, suggests an absence of constitutional constraints on the Federal Parliament. Other sections of the legislation, however, then operate to confine the primary provision and bring its content within one or more heads of federal constitutional power'.

108 This section extends the jurisdiction over children in Part VII insofar as there is a reference to the Commonwealth from the States. These references do not extend to the welfare of children, and therefore are not relevant for the purposes of this article. See above n 89.

109 *Family Law Act 1975* (Cth) s 69ZH(2)(a). Section 60F defines a 'child of a marriage' to include adopted children, children born prior to the marriage, children born as a result of artificial conception procedures and surrogacy arrangements. It also includes a child of a marriage that has ended (by divorce, annulment or death). Finally, s 60E provides that the Part applies to void marriages *as if the marriage were valid*.

110 *Family Law Act 1975* (Cth) s 69ZG; the Commonwealth Parliament has plenary power over Territories pursuant to s 122 of the *Constitution*.

111 See *Family Law Act 1975* (Cth) s 69ZJ, and its application in *Re Brodie (Special Medical Procedures: Jurisdiction)* [2007] FamCA 776 (24 July 2007) [42]–[43] (Carter J). The federal power over this area comes from the jurisdiction granted in s 75(iv) of the *Constitution*.

a single situation. This raises the question as to whether the regimes are inconsistent.

Inconsistency appears to arise in a number of circumstances, including where:

a) a state regime for regenerative tissue prohibits the taking of tissue from a young child but there is a court decision made under the *FL Act* authorising the procedure;[112]

b) a state regime for regenerative tissue allows the taking of tissue from a young child when certain conditions are met, those conditions are not met but there is a court decision made under the *FL Act* authorising the procedure;

c) the state regime for regenerative tissue allows the taking of tissue from a young child when certain conditions are met, those conditions are met but there is a court decision made under the *FL Act* refusing to authorise the procedure;

d) there has been an unsuccessful application in the state Supreme Court's *parens patriae* jurisdiction for authorisation to undertake the procedure but there is a court decision made under the *FL Act* authorising the procedure; or

e) there has been a successful application in the state Supreme Court's *parens patriae* jurisdiction for authorisation to undertake the procedure but there is a court decision made under the *FL Act* refusing to authorise the procedure.[113]

Section 109 of the *Constitution* provides that where there is any inconsistency between federal and state law, the federal law prevails. The High Court has developed a number of tests to determine whether constitutional inconsistency exists.

1 *Inconsistency Tests*

The initial test for inconsistency developed by the High Court was whether a person can obey both 'laws' simultaneously.[114] In a situation where there may be conflicting court orders, or a conflict between a court order and a statutory scheme, it may seem prima facie that such obedience is not possible. However, orders under the *FL Act* will generally *authorise* but not *require* medical

112 Whilst not 'laws', decisions such as orders and awards made pursuant to legislation have been regularly considered by the High Court as actively engaging s 109: *Commonwealth v New South Wales* (1923) 33 CLR 1, 27 (Knox CJ and Starke J), 54–5 (Isaacs J), on the basis that the inconsistency arises with the legislation *authorising* the action: *Metal Trades Industry Association of Australia v Amalgamated Metal Workers' and Shipwrights' Union* (1983) 152 CLR 632, 648 (Mason, Brennan and Deane JJ).

113 Options (d) and (e) are unlikely to occur due to the operation of *Family Law Act 1975* (Cth) s 69B (previously s 63A), discussed at more length below at Part II(D)(2).

114 See, eg, *R v Brisbane Licensing Court; Ex parte Daniell* (1920) 28 CLR 23; *Australian Boot Trade Employees Federation v Whybrow* (1910) 10 CLR 266.

procedures to be carried out,[115] or refuse to authorise such procedures, rather than prohibit them outright.[116] Therefore, simultaneous obedience is possible.

Where a Commonwealth law *permits* an act without *requiring* it and the state law prevents or regulates it,[117] there may still be inconsistency. The court will consider whether the federal law, correctly construed, intended the action to be able to be performed without concurrent or supplementary regulation by the states, or whether it intended the action to be able to be performed subject to any applicable state law.[118] In the context of the *FL Act*, this question was considered by the High Court in *P v P*.[119]

2 P v P

P v P concerned a question of inconsistency between a Family Court order authorising a sterilisation procedure and the *Guardianship Act 1987* (NSW), which regulated the grounds on which such a procedure could be conducted, including requiring the consent of the Guardianship Board. The child in question was the child of married parents who had subsequently divorced. Both parents supported the application for a sterilisation procedure in the Family Court;[120]

115 Generally, the Supreme Court in the exercise of its *parens patriae* jurisdiction will make an order authorising a procedure, which can, for example, be used by a medical practitioner in lieu of the consent of the parents. In rare cases the Supreme Court has made orders *requiring* a procedure to be carried out: See, eg, *DoSC v Y* [1999] NSWSC 644 (7 July 1999) [3], [121] (Austin J).

116 Generally, the Supreme Court in the exercise of its *parens patriae* jurisdiction will refuse to make an order as requested. However, in limited cases the Court has issued an injunction, for example, to stop a HIV positive mother from breastfeeding her child: *Re Baby A* [1999] NSWSC 787 (26 July 1999) (Young J).

117 Although it is also likely that such an inconsistency will arise if a state permission is modified or regulated by a federal law: see Geoffrey Lindell, 'Grappling with Inconsistency between Commonwealth and State Legislation and the Link with Statutory Interpretation' (2005) 8 *Constitutional Law and Policy Review* 25, 28.

118 *Australian Mutual Provident Society v Goulden* (1986) 160 CLR 330, 339. An inconsistency may arise on the basis that a law has modified rights, privileges or liabilities conferred by the federal law: See, eg, *Colvin v Bradley Brothers Pty Ltd* (1943) 68 CLR 151; *O'Sullivan v Noarlunga Meat Ltd (No 1)* (1954) 92 CLR 565, 591, 593 (Fullagar J); *R v Public Vehicles Licensing Appeal Tribunal (Tas); Ex parte Australian National Airways Pty Ltd* (1964) 113 CLR 207, 222–3; cf the decisions in *Commercial Radio Coffs Harbour v Fuller* (1986) 161 CLR 47; *Ansett Transport Industries (Operations) v Wardley* (1980) 142 CLR 237; or the state law is impermissibly encroaching onto a legislative area that was intended to be regulated exhaustively by the Commonwealth (the 'covering the field' inconsistency test: first established in *Clyde Engineering Co Ltd v Cowburn* (1926) 37 CLR 466, 489 (Isaacs J); *Ex parte McLean* (1930) 43 CLR 472, 483 (Dixon J)). There is some academic debate as to the correct classification of the inconsistency tests: see, eg, Allan Murray-Jones, 'The Tests for Inconsistency under Section 109 of the *Constitution*' (1979) 10 *Federal Law Review* 25; Gary A Rumble, 'The Nature of Inconsistency under Section 109 of the *Constitution*' (1980) 11 *Federal Law Review* 40; Peter Hanks, '"Inconsistent" Commonwealth and State Laws: Centralizing Government Power in the Australian Federation' (1986) 16 *Federal Law Review* 107; Lindell, above n 117. There is some overlap in the application of these two tests. As said above, the crucial question in determining whether either test has been met lies in whether the Commonwealth intended the court exercising federal jurisdiction to make orders exclusive of any other jurisdiction, or whether the power was intended to operate cumulatively upon the State legislation and common law in the area.

119 *P v P* (1994) 181 CLR 583.

120 Ibid 591 (Mason CJ, Deane, Toohey and Gaudron JJ).

neither parent intended to apply to the Guardianship Board under the *Guardianship Act*.[121]

The joint majority of the Court found the Family Court's jurisdiction was not subject to the *Guardianship Act*, because of an inconsistency between the two schemes.[122] The Court found 'operational inconsistency' only.[123] This meant that the conferral of jurisdiction by the *FL Act* did not permanently invalidate the entire *Guardianship Act* (or remove the *parens patriae* jurisdiction of the NSW Supreme Court).[124] However, where there was a valid order of the Family Court authorising the procedure, the *Guardianship Act* was invalid insofar as it operated to prevent or regulate such an authorisation.[125]

This outcome was not without controversy. The majority decision is contrary to Mason J's earlier view that the Supreme Court lost any jurisdiction that had been vested in the Family Court.[126] This earlier judgment was not referred to in the majority's reasoning. Other cases and commentary have drawn upon the existence of section 69B (previously section 63A) of the *FL Act* to support the conclusion that the Supreme Court's jurisdiction has been more generally ousted.[127] This provision states that proceedings that may be instituted under Part VII of the *Act* may not be instituted otherwise. Perplexingly, the majority in *P v P* also did not refer to section 63A in its reasoning.[128] Queen's Counsel David Jackson in his argument for the applicant indicated that section 63A operated to preclude instituting state proceedings (even in the Guardianship Tribunal), but only where proceedings had been 'properly brought under Part VII'.[129] Although not expressed in the judgment, this interpretation of section 63A is most consistent with the majority's decision.

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121 Ibid 592 (Mason CJ, Deane, Toohey and Gaudron JJ).

122 Ibid 606 (Mason CJ, Deane, Toohey and Gaudron JJ). See also McHugh J at 635–6; cf the decision in *Dunne v P* (2004) 29 WAR 232, 437 [96], 439 [107], [109] (Malcolm CJ), 450 [173] (McLure J), in which the Court found that the *FL Act* jurisdiction was intended to be subjected to State laws such as the Bail Act.

123 For a further explanation of 'operational inconsistency', see: *Victoria v Commonwealth* (1937) 58 CLR 618, 631 (Dixon J) and *Commonwealth v Western Australia* (1999) 196 CLR 392, 416 (Gleeson CJ and Gaudron J).

124 *P v P* (1994) 181 CLR 583, 604, 606 (Mason CJ, Deane, Toohey and Gaudron JJ).

125 Ibid 603 (Mason CJ, Deane, Toohey and Gaudron JJ).

126 *Fountain v Alexander* (1982) 150 CLR 615, 636 (Mason J). This is consistent with the second reading speech for the relevant legislation: 'Although the *relevant amendments in the Bill will prevent the State Supreme Courts from exercising ward of court powers in proceedings concerning a child of a marriage and involving a party to the marriage*, I would stress that the Commonwealth does not propose to intrude into the area that is commonly termed State child welfare law': Commonwealth, *Parliamentary Debates*, Senate, 1 June 1983, 1097 (Gareth Evans) (emphasis added).

127 John Seymour, 'The Role of the Family Court of Australia in Child Welfare Matters' (1992) 21 *Federal Law Review* 1, 23. See also *Mulhall v Hartnell* (1988) 91 FLR 240, 240 (Young J); *Young v Lalic* (2006) 197 FLR 27, 36–9 (Brereton J); *Re Jules* (2008) 40 Fam LR 122, 125–6 (Brereton J).

128 McHugh J did consider s 63A, finding that it rendered invalid any part of the State legislation that purported to confer jurisdiction over welfare of a child of a marriage on a Court but not a tribunal. This turned on the use of the word 'proceedings': *P v P* (1994) 181 CLR 583, 632–3 (McHugh J).

129 Ibid 589 (Mason CJ, Deane, Toohey and Gaudron JJ).

3 *Subsequent Consideration*

The majority position in *P v P* has subsequently been applied in a number of Family Court decisions.[130] Most recently, Cronin J considered *P v P* in *Re Inaya*, in the context of a potential inconsistency between a prohibition on a bone marrow transplantation from a young child under the *Human Tissue Act 1982* (Vic) and Part VII of the *FL Act*. He commenced with broad statements about the inconsistency between the *Human Tissue Act* and the *Family Court Act*, which seemed to support a conclusion that there was a general inconsistency. However, his final conclusion was not so sweeping, noting that the inconsistency only eventuated where there was an inconsistent Family Court order – that is, an operational inconsistency.[131]

The result in *P v P* and its subsequent application has caused some confusion.[132] Ian Freckelton has asserted that 'any State legislation which narrows the circumstances in which sterilisation procedures may be authorised by prescribing more restrictive criteria than those established by *Re Marion* will be invalid.'[133] Ian Kerridge, Michael Lowe and Cameron Stewart have said '*Re Inaya* has effectively rendered the State based legislative restrictions on parental consent to donation of regenerative tissue void.'[134] Others have asserted that state legislation is invalid where it authorises procedures that fall within the *FL Act*, that is, the state creates an alternative method of authorisation.[135]

These conclusions sit in contradiction with the statements in *P v P* that, for example: 'the intent of Parliament … was that both jurisdictions should exist concurrently',[136] and that '[a]s a practical matter, ... invalidity will only be significant in a case where the Family Court exercises its jurisdiction to authorise particular medical treatment and then only in respect of that treatment.'[137] Essentially, this allows state regimes and the *parens patriae* jurisdiction to be *circumvented* if an order authorising the prohibited procedure is obtained under the *FL Act*. However, it does not invalidate the alternative procedure in the absence of such authorisation.[138] Figures 1 and 2 in Appendix A illustrate the position.

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130 See, eg, *JLS v JES* (1996) 20 Fam LR 485, 488–9 (Bryson J); *Docs v Y* [1999] NSWSC 644 (7 July 1999) [90]–[97] (Austin J).

131 *Re Inaya* (2007) 213 FLR 278, 290 (Cronin J).

132 See, eg, Freckelton, above n 3, 303–4; Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professionals* (Federation Press, 3rd ed, 2009) 492; Tait, Carney and Deane, above n 3, 141–2, *contra* at 164–5; William J Keough, 'Authority to Treat: A Comparative Look at the Jurisdiction, Practice and Procedure of the Supreme Court of Victoria, Children's Court of Victoria and Family Court of Australia in Medical Matters' (2003) 10 *Journal of Law and Medicine* 442, 454; Bailey-Harris, above n 44, 15–6.

133 Freckelton, above n 3, 303.

134 Kerridge, Lowe and Stewart, above n 132, 610.

135 Bailey-Harris, above n 44, 15–6. See also Tait, Carney and Deane, above n 3, 141–2, *contra* at 164–5.

136 *P v P* (1994) 181 CLR 583, 604 (Mason CJ, Deane, Toohey and Gaudron JJ).

137 Ibid 606 (Mason CJ, Deane, Toohey and Gaudron JJ).

138 See, eg, discussion of the case in Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report No 51 (1996) vol 1, 97–9.

E Analysis: Tina's Position

Returning to Tina's case, uncertainties exist regarding the correct forum for seeking authorisation of these types of procedures.[139] If living in NSW and Queensland, Frank or Sandra could, with the certification of multiple medical practitioners, consent to regenerative tissue (including liver tissue) being removed for transplantation into Nathan, where there is 'minimal risk' to Tina, subject to that consent remaining effective. However, if resident in Victoria, Frank or Sandra could consent to such removal of regenerative tissue from Tina if only one medical practitioner has provided certification, subject to that consent remaining effective. In most, if not all, Australian jurisdictions,[140] Frank and Sandra may be able to seek an order of the Supreme Court to authorise the procedure under the common law *parens patriae* jurisdiction, in which the court must consider the best interests of the child as paramount. In all jurisdictions apart from Western Australia,[141] if Frank and Sandra did not wish to comply with the above outlined regimes, or they sought to circumvent such regimes, they could apply under the *FL Act* (generally to the Family Court) for an order authorising the procedure.[142] Under the *FL Act*, a Children's Independent Lawyer is likely to be appointed to expressly consider Tina's best interests and advocate for the child. The court would apply the statutory 'best interests' test in determining whether to authorise the procedure or not. However, if Frank and Sandra were not and had never been married, the Family Court would not have jurisdiction to give orders under the *FL Act* unless they were resident in a territory, or they were resident in different states.

As a consequence of this maze of regimes, Tina's position is uncertain: different outcomes depend on her place of residence, the forum in which her parents seek authorisation, and even her parents' marital status. Not only is this unsatisfactory for the child involved, but it leaves the medical practitioners who tread a fine line between acting within and outside the law, and the parents in a difficult position. All are required to navigate legal complexities while under significant time pressure and other stresses. Doubt about the constitutional validity of state regimes authorising procedures – that are also within the jurisdiction of the *FL Act* – also leaves Tina, her parents and medical practitioners in the centre of a constitutional maelstrom.[143]

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139 See, NSWLRC, *Minor's Consent*, above n 45, [4.27]; Belinda Bennett, 'Symbiotic Relationships: Saviour Siblings, Family Rights and Biomedicine' (2005) 19 *Australian Journal of Family Law* 195, 209–10.

140 See discussion at above n 73.

141 In Western Australia, the position is similar to (d), but the application would be made to the Family Court of Western Australia, not the Family Court. See *Family Court Act 1997* (WA) s 162(1), which confers jurisdiction on the Family Court of Western Australia over welfare.

142 This will turn on whether such a procedure is found to be within parental authority. See the discussion of the relevant authorities and considerations in Part II(A) above.

143 *Australian Constitution* s 109; see also discussion of the differing views in Part II(D) above.

F Ethical Guidelines

So far we have attempted to elucidate the legal position of a young child who is being viewed as a potential tissue donor. We are unable to comment as to whether the legal position reflects the reality of medical practice in Australia.[144]

Many international policies and guidelines emphasise that tissue removal from those without capacity should only occur in exceptional circumstances.[145] Preconditions to removal of tissue are specified in these documents that are often not reflected in domestic laws.[146] Given that young children are most often used as donors because they are compatible with a relative, ethically it is recognised that an unavoidable conflict of interests arises. This is particularly true for parents who may view one child as a donor and one as a sick child in need of tissue.[147] Therefore, some guidelines have advocated conducting a variety of medical, psychological, ethical and legal assessments, the use of a donor advocate, consideration by an independent committee separate from the transplant team, and ongoing donor support post-transplant.[148]

It is not unreasonable to assume that such policies and guidelines will influence those health care professionals who carry out such procedures on children like Tina. In Australia we have the *Organ and Tissue Donation by Living Donors – Guidelines for Ethical Practice for Health Professionals* compiled by the National Health and Medical Research Council.[149] Those guidelines recommend compliance with far more stringent procedural requirements prior to transplantation from children than those statutory regimes discussed above.[150] Unfortunately, no empirical study has been undertaken from which to draw conclusions as to whether medical practitioners may be complying with these guidelines rather than utilising the law to its fullest extent.[151]

144 Previous studies in the US have shown that despite the legal position allowing organ transplantation from children, many practitioners and medical centres have a policy that does not allow such procedures to take place: see Aaron Spital, 'Should Children Ever Donate Kidneys?: Views of US Transplant Centers' (1997) 64 *Transplantation* 232; See also Mason and Laurie, above n 37, for the position in the UK.

145 See, eg, *Additional Protocol to the CHRB*, above n 60 art 14; World Health Organization Executive Board, above n 19; World Medical Association, *Statement on Human Donation and Transplantation* (2006) art 23.

146 Ibid.

147 See, eg, Dwyer and Vig, above n 13, 9–10; Lynn A Jansen, 'Child Organ Donation, Family Autonomy, and Intimate Attachments' (2004) 13 *Cambridge Quarterly of Healthcare Ethics* 133, 135; Nuffield Council on Bioethics, *Human Tissue: Ethical and Legal Issues* (1995) 46 [6.25]; National Health and Medical Research Council, *Organ and Tissue Donation by Living Donors: Guidelines for Ethical Practice for Health Professionals* (2007) 26; World Health Organization Executive Board, above n 19.

148 See, eg, National Health and Medical Research Council, above n 147, 25–7, 33–44; World Medical Association, above n 145; *Additional Protocol to the CHRB*, above n 60, art 14.

149 National Health and Medical Research Council, above n 147.

150 Ibid.

151 For example, regardless of the ambiguity of the effect of a child's objection in some statutory regimes, some medical professionals may not proceed where a child objects if they see it to be incompatible with their professional medical ethics.

However, these ethical guidelines have no legal force.[152] There is, therefore, no legal compulsion on those involved in transplants to follow these requirements strictly or at all.

The newly established Australian Organ and Tissue Donation and Transplantation Authority ('AOTDTA') can also introduce policies in this area.[153] The CEO of the AOTDTA is able to formulate 'policies and protocols relating to organ or tissue donation and transplantation matters'.[154] This includes any policy or protocol developed in relation to transplantation of tissue from young children.[155] AOTDTA recognises that there are a number of issues with respect to inconsistency of legislation nationally and has said it will consider these issues as part of the process of establishing a nationally coordinated and consistent approach to tissue donation.[156] However, any policies produced by the AOTDTA will also rely upon voluntary compliance.[157]

III CONCLUSIONS: AUSTRALIA, TISSUE TRANSPLANTATION AND THE 'BEST INTERESTS OF THE CHILD'

A The Current Regimes: Inconsistencies and Overlap

The current unsatisfactory position is the result of a complex overlay of jurisdictions conferred by state and territory legislation, the *parens patriae* jurisdiction possessed by the Supreme Courts, and the federal jurisdiction.

The existence of different standards and forums regarding medical procedures such as tissue transplantation from a young child has a number of concerning consequences. Within Australia, young children may be subjected to different tests as to when such procedures may be undertaken, based on their (or their parents') residency, or the legal status of their parents' relationship. There is uncertainty regarding the constitutional validity of state forums (that is, the statutory regimes and/or the Supreme Court) to authorise such procedures, as the operation of the section 109 inconsistency test on such schemes is not beyond doubt. This leaves parents and medical practitioners potentially open to prosecution if acting pursuant to an invalid regime.[158] In some jurisdictions, considerations that are held to be important aspects of assessing the 'best interests of the child' under international and common law are not relevant, including consideration of the child's views. Further, an independent advocate

152 See comments in relation to other guidelines released by the National Health and Medical Research Council in *Re Gray* [2001] 2 Qd R 35, 37 (Chesterman J); *YZ v Infertility Treatment Authority* (2005) 25 VAR 1, [68] (Morris P).

153 See *Australian Organ and Tissue Donation and Transplantation Authority Act 2008* (Cth) ss 9, 11.

154 *Australian Organ and Tissue Donation and Transplantation Authority Act 2008* (Cth) s 11(1)(a).

155 *Australian Organ and Tissue Donation and Transplantation Authority Act 2008* (Cth) s 4 (definition of 'organ or tissue donation and transplantation matter').

156 Email from Australian Organ and Tissue Donation and Transplantation Authority to Shih-Ning Then, 29 September 2009.

157 *Australian Organ and Tissue Donation and Transplantation Authority Act 2008* (Cth) s 57.

158 See further discussion in Keough, above n 132, 442–4.

for the child's interests is not guaranteed in the different forums. As a consequence, decisions could be made without independent argument being put forward on behalf of the child. In some jurisdictions, the ability to obtain authorisation is relatively accessible, Victoria offers the most extreme example, where the consent of one medical practitioner together with the consent of a parent may be sufficient. Fundamental rule of law ideals of consistency and predictability are undermined in the situation where there are several fora that may authorise a procedure, many of which are not bound by precedent. The situation therefore of a child in an acutely vulnerable position is difficult to legally predict.

These factors demonstrate that the status quo appears to be failing to reach the goal of consistent and appropriate protection of young children.

In Australia, we are used to jurisdictional differences arising and, particularly in the context of health, to different legislative requirements causing operational issues.[159] However, it is questioned whether this is justifiable in relation to invasive medical procedures, particularly regarding vulnerable young children.

The concerns raised by overlapping and inconsistent jurisdictions in relation to medical procedures on children have been voiced elsewhere.[160] The NSW Law Reform Commission Report on Young People and Consent to Health Care criticised the 'uncertainty', 'confusion' and 'forum-shopping'[161] that can result from the current situation.[162] Chief among the protagonists for change has been Alastair Nicholson, former Chief Justice of the Family Court. Writing with others, he suggested:

> Uniform State and Territory legislation could overcome this problem or, a similar result could be achieved by the referral of powers by the States with respect to the jurisdiction. Another option would be for Commonwealth legislation based on the external affairs power pursuant to the *United Nations Convention on the Rights of the Child*.[163]

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159 For example, the position in relation to guardianship legislation around Australia has garnered criticism: House of Representatives Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *Older People and the Law* (2007) 121–2 [3.198]–[3.200].

160 See, eg, NSW Law Reform Commission, above n 44, 119 [8.64]; Alistair Nicholson, Margaret Harrison and Danny Sandor, 'The Role of the Family Court in Medical Procedure Cases'(1996) 2 *Australian Journal of Human Rights* 242; Shaun Keays-Byrne, 'Sterilisation of Children: The Need for Uniform Legislation' (April/May/June 1995) *On the Record* 8, 9; Danny Sandor, 'Sterilisation and Special Medical Procedures on Children and Young People. Blunt Instrument? Bad Medicine?' in Ian Freckelton and Kerry Peterson (eds), *Controversies in Health Law* (Federation Press, 1999) 2, 14; Keough, above n 132, 457.

161 The ability to 'forum-shop' in Australia is protected by the immunity given to inter-state residents by s 117 of the Constitution. The section provides that 'A subject of the Queen, resident in any State, shall not be subject in any other State to any disability or discrimination which would not be equally applicable to him if he were a subject of the Queen resident in such other State.' Justice Brennan said in *Street v Queensland Bar Association* (1989) 168 CLR 461, 521 that the provision 'opens … the doors of State universities, *hospitals* and other institutions for entry by subjects of the Queen resident in other States on the same terms as residents of the relevant State' (emphasis added).

162 While these views were expressed mainly in relation to authorisation for sterilisation of children, they are also relevant in this context, see: NSWLRC, *Minors' Consent*, above n 45, [4.27], [4.29]; NSWLRC, *Young People and Consent*, above n 45, 210 [8.64].

163 Nicholson, Harrison and Sandor, above n 160.

B Reform

1 *Avenues of Reform*

Nicholson identified three avenues for reform. First is the possibility that federal jurisdiction could be broadened pursuant to the external affairs power.[164] The Family Court in *B v MIMIA* held that the welfare jurisdiction in the *FL Act* was broadly applicable to all children, and supported by the external affairs power because it implemented the obligations under the *CRC*. The High Court overturned this broad interpretation of the welfare jurisdiction of the *FL Act*.[165] However it did not necessarily discount the possibility that such a broad jurisdiction *could be* vested in the Family Court pursuant to the external affairs power. Instead the High Court concluded that as it was presently drafted, it did not confer that jurisdiction.[166]

There exists therefore a means by which the Commonwealth can ensure that consistent protection in this complex area is implemented across Australia; the real question is whether there exists the necessary political will.

Second, Nicholson considered the possibility of developing uniform state and territory legislation. Uniform legislation is notoriously difficult to reach consensus upon and implement across each jurisdiction. Nonetheless, such a prospect seemed promising earlier this decade in relation to the creation of uniform legislation for the authorisation of sterilisation procedures on children without capacity. This was considered by the Standing Committee of Attorneys-General but was withdrawn from their agenda in early 2008 on the basis that the number of sterilisations in Australia was significantly less than reported, education had assisted doctors and hospitals in understanding their legal obligations, alternatives to sterilisation were now available, and the existing processes in each jurisdiction seemed to be working adequately in light of these improvements.[167] The Committee did not address, as a matter of legal principle, the confusion and overlap that still exists in this area (as it does in the area of tissue transplantation). How medical practitioners can be better educated about their legal obligations where the legal profession remains unsure how the regimes interact, is unclear.

Third, Nicholson considered referral of powers by the states to the Commonwealth. It seems such a referral would be unnecessary given the breadth of the external affairs power, but it may be more politically palatable than a unilateral usurpation of jurisdiction by the Commonwealth.

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164 *Australian Constitution* s 51(xxix).

165 *MIMIA v B* (2004) 219 CLR 365, 405, 406–7 (Gummow, Hayne and Heydon JJ), 434 (Callinan J). See also 390 (Gleeson CJ and McHugh J), in which their Honours stated it is not necessary for them to decide the issue as, unlike in *Marion's Case* (1992) 175 CLR 218, they found there was no 'matter' that arose here, not dealing with the relationship between the parents, or duties or obligations owed by the parents to the children.

166 Although contra the position of Callinan J in *MIMIA v B* (2004) 210 CLR 365, 441–2 [222], who believed that the *CRC* may contain aspirational obligations only.

167 Robert McClelland, 'Standing Committee of Attorneys General Communiqué' (Press Release, 28 March 2008) 6–7.

2 *A Reform Option from the UK: One Authority, Different Jurisdictions*

Given there exist avenues for achieving reform, it must be considered what form it may take. One option for a quasi federal regime could be modelled upon some aspects of the human tissue regulatory regime in the UK. Within the UK there is separate legislation regulating human tissue transplantation (including where a young child is donating specific tissue)[168] in England, Wales and Northern Ireland,[169] and Scotland.[170] Similar to the position here, the legislation within the UK jurisdictions makes it an offence to remove and use tissue from a living person for the purposes of transplantation,[171] but specific exceptions are provided.[172] As is the case in Australia, the legislation between the UK jurisdictions is similar, but not identical. Without delving fully into the complexities of another legislative tissue transplantation regime, there are some key features of the UK regime that are, for present purposes, useful to consider.[173]

The UK Human Tissue Authority ('HTA')[174] was established to, among other functions, licence and monitor those involved in the use of human tissue. Conditions of such licences include compliance with Codes of Practice regarding transplantation that the HTA issues and frequently updates.[175] Throughout the UK, each jurisdiction has delegated power to the HTA[176] to oversee and

168 The UK model as it applies to transplantation of bone marrow or peripheral blood stem cells from a child without capacity is focussed upon here.

169 *Human Tissue Act 2004* (UK) c 30; *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK).

170 *Human Tissue (Scotland) Act 2006* (Scot) asp 4; *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot).

171 *Human Tissue Act 2004* (UK) c 30, s 33(1)–(2); *Human Tissue (Scotland) Act 2006* (Scot) asp 4, s 17(1)(a).

172 *Human Tissue Act 2004* (UK) c 30, s 33(3)–(4) and *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) regs 10–12; *Human Tissue (Scotland) Act 2006* (Scot) asp 4, s 17(4); *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) reg 5.

173 For more information about the regulatory system in the UK refer to the Human Tissue Authority website: Human Tissue Authority, *HTA – The Human Tissue Authority* (2010) <http://www.hta.gov.uk>.

174 *Human Tissue Act 2004* (UK) c 30, s 13.

175 *Human Tissue Act 2004* (UK) c 30, s 28.

176 See *Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) regs 2 (definition of 'Authority'), 11. For Scotland, reg 5 of the *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) requires the Scottish Ministers to make a decision regarding tissue donation. However, this power has been delegated to the Human Tissue Authority: see Scottish Government, *Human Tissue (Scotland) Act 2006: A Guide to Its Implications for NHS Scotland* (2006), 6 [27] <http://www.hta.gov.uk/_db/_documents/Information_about_HT_%28Scotland%29_Act.pdf>.

authorise certain types of tissue transplantations where the donor is a young child.[177]

At a practical level, the regime requires the practitioner with responsibility for the donor to refer the matter to the HTA for authorisation if certain tissue is to be removed for transplantation from a child who lacks capacity.[178] The HTA will investigate the case before making a determination and must, among other things, take into account evidence of duress or coercion,[179] and be satisfied that no reward has been given and that the relevant consent has been obtained.[180] The HTA will apply the relevant tests under the legislation of the different jurisdictions. However, only in Scotland does the 'unwillingness' of a donor child need to be expressly considered.[181]

The HTA model therefore retains some of the weaknesses and inconsistencies evident in the current Australian position. However, it presents a model that, with modification, could be adopted in Australia to help standardise the approach to removal of tissue from young children without a complete takeover of the area by the Commonwealth. It would be an important part of any such model that the factors that the body must consider in the decision making process included the views of the child.

This model allows different jurisdictions to coexist. It would, therefore, allow those states that have legislation prohibiting regenerative tissue transplantation from young children and other jurisdictions that allow such procedures to maintain these general policies. However, in those regimes where it was permitted, it would give power to a centralised body to authorise removal of tissue from young children using a consistent standard of assessment. A centralised body that is not a tribunal or a court that operates in an inquisitorial style will allow consistent, certain and efficient resolution regarding the question of authorisation and would ensure a child's views were independently ascertained and assessed. Also, as in the UK, if there were any doubt or dispute about a situation or decision, recourse to the courts would still be available.[182]

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177 Note, in the UK the common law still applies alongside the human tissue legislation so court authorisation may, in some circumstances, also be necessary: Human Tissue Authority, *Code of Practice 2 – Donation of Solid Organs for Transplantation* (September 2009) app A <http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code2donationoforgans.cfm>; Human Tissue Authority, *Code of Practice 6 – Donation of Allogeneic Bone Marrow and Peripheral Blood Stem Cells for Transplantation*, (September 2009) app A <http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code6donationofbonemarrow.cfm>.

178 *Human Tissue Act 2004* (UK) c 30, s 33(3); *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) regs 10(3)(b), 11(2); *Human Tissue (Scotland) Act 2006* (Scot) asp 4, s 17(1)(a); *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) regs 5(1), (7).

179 *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) reg 11(8)(a); *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) reg 5(9)(j).

180 *Human Tissue Act 2004 (Persons Who Lack Capacity to Consent and Transplants) Regulations 2006* (UK) reg 11(3); *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) reg 5(9).

181 *Human Organ and Tissue Live Transplants (Scotland) Regulations 2006* (Scot) reg 5(9)(i).

182 See above n 177 and accompanying text.

Another important aspect of the HTA that should be incorporated in any new Australian regime is the flexibility that the Codes of Practice provide.[183] These Codes allow the centralised body in effect to issue guidance to practitioners to keep abreast with medical developments. This ensures regulation and standards do not become outdated, as has occurred under the older Australian tissue transplantation regimes.

This model could operate concurrently with the *parens patriae* jurisdiction and federal jurisdiction under the *FL Act*, although the interrelationship between them ought to be clearly stated to avoid the confusion of the current regimes. This model of authorisation would ensure that, even where the courts are not involved, similar standards that are being used by the courts would still be applied.[184] It would be hoped that a centralised body applying the best interests test would ensure a greater level of consistent protection for children that was easily accessible for practitioners and parents.

3 *Conclusion*

The government of Australia has an obligation to ensure children are protected and cared for. As a society, we also have a moral obligation to ensure this. The importance of protecting children through the adoption of the best interests principle has been recognised legally both domestically and internationally. The status of children as rights holders, and as being entitled to participate in any decision making process affecting them, is also recognised. This article has demonstrated that Australia, across its jurisdictions, is failing to meet its obligations in relation to prospective young child tissue donors. We have presented a number of avenues by which more consistent and certain protection of young children could be achieved and offered an example of how these obligations could be achieved modelled on the current the UK regime.

183 It is noted that in Western Australia the *Human Tissue and Transplant Act 1982* (WA) already makes provision for such Codes: ss 32A, 32B. However, it does not appear that any Codes have been produced.

184 Although it is conceded that there is likely to emerge differences in the application of similar legal tests: see, eg, Ford, above n 3.

APPENDIX A: FIGURES 1 & 2

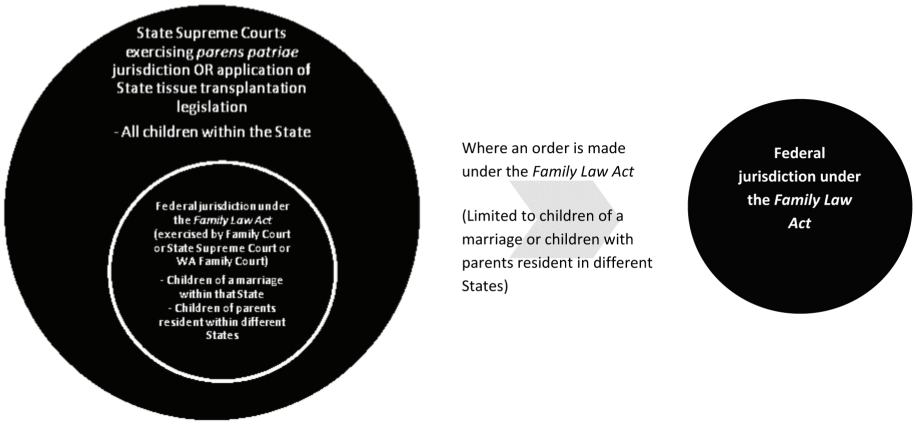

Figure 1 - Overlapping exercise of judicial power to make decisions regarding tissue donation on behalf of children without capacity within each Australian State. Shown is the extent of the States' jurisdiction under State legislation and/or the *parens patriae* jurisdiction, and the jurisdiction under the *Family Law Act 1975* (Cth).

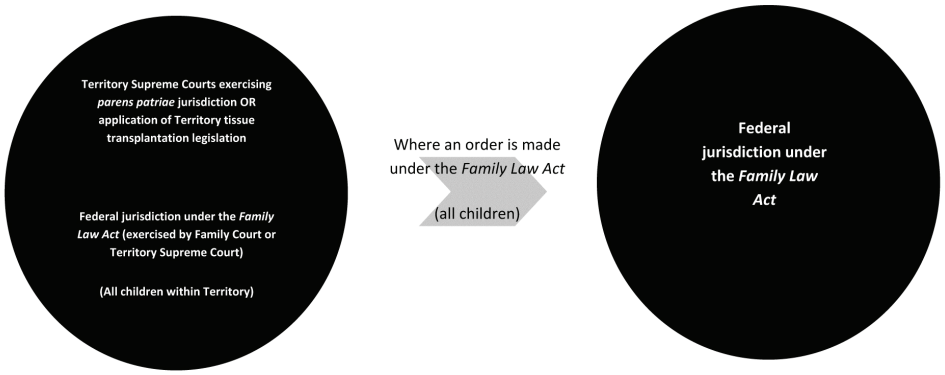

Figure 2 - Overlapping exercise of judicial power to make decisions regarding tissue donation on behalf of children without capacity within each Australian Territory. This figure demonstrates that the jurisdiction under the *Family Law Act 1975* (Cth) in relation to the Territories is not limited in the same manner as it is for the States.