FACULTY OF LAW

LAWS5152
MEDICAL LAW

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(1) Introduction to Health & Medical Law

(1.1) TERMS & CONCEPTS

  - Health law may be understood as encompassing five interrelated areas of academic and professional activity...
    - ...health care law...
    - ...mental health law...
    - ...public health law...(i.e. keeping populations healthy)
    - ...international health law and ‘global health governance’...(i.e. international administrative arrangements for dealing with issues)
    - ...law & health development (in low-and middle-income countries)...(the role of law in social development).
  - Courts have come to recognise both the vicarious liability of institutions for the acts of employees and others engaged in the business of that institution, as well as the direct and non-delegable duty owed by a health care institution to those patients who knock on its doors (p. 6):
    - Hillier v Governors of St Batholomew’s Hospital [1909] 2 KB 820: Although a hospital is responsible for exercising due care when selecting its professional staff...it is not responsible if any of them (surgeons, physicians, nurses etc.) act negligently in matters of professional care of skill.
    - Airedale NHS Trust v Bland [1993] AC 789: Where, in accordance with a responsible body of medical opinion, a doctor concludes that further medical treatment will be of no benefit to a permanently unconscious patient...there is no duty to provide such treatment, and that life-preserving treatment may be withdrawn.
  - The globalisation on health (i.e. international health law)...e.g...!
    - ...the World Health Regulations (IHR), revised following the SARS epidemic, which provides an international regime for the control of transmissible diseases (7).
    - ...the Framework Convention on Tobacco Control (FCTC). Signatory states to the FCTC are required to implement evidence-based tobacco control measures into their domestic laws (7).
  - ‘Global health governance’...looks beyond law to the way that health is governed and managed at the international level (7).
- What brought health law into being...
  - ...the rise of bioethics - technology has transformed medicine and created alot of medical possibilities that were not possible before.
  - ...the expansion of medical technology has contributed engagement between society and medicine.
  - ...law has engaged in legal oversight of clinical medicine.

(1.2) THE CURRENT & FUTURE CONCERNS OF MEDICAL LAW

  - Traditional approach to medical dilemmas...
    - ...the story of medicine is of an ineluctable process of development towards the conquest of disease...medicine re-defines its concern as disease rather than health (i.e. the great killers such as poverty, tobacco, alcohol, motor cars and pollution, remain largely untouched by medicine) (98).
  - Alternative approach...
    - ...is to set the terms of reference, the mode of discourse for our responses to the dilemmas at the frontiers of medicine, and determine our prediction (100).
    - ...predictions must not be seen as the unravelling of some inevitable process of discovery and development in which medicine is value-free...they must be seen to involve the making of choices, of considering now what the future may be.
    - ...the appropriate and valid mode is to recognise that what we face in the future depends on value choices made now...we determine our own dilemmas (101).
  - Problem areas for the future (104-105)...
    1. An aging population will pose questions about the proper care of the elderly, expensive health care costs, the treatment of the incompetent, the role and status of Living Wills, and the care of the dying.
    2. Claims of a right to bear children as reproductive technology develops. Maternal-fetal conflicts will become more obvious and urgent as monitoring during pregnancy allows us to know more, and causes some to press the claims of the fetus to the point of requiring the mother to undergo treatment on its behalf.
    3. The choices that may arise from gene therapy and genetic screening.
    4. The challenge of devising strategies for distributing scarce recourses.
    5. Access to, and control of, information about patients and their medical care.
    6. Recourse to litigation in the aftermath of medical mishaps - a need for alternative methods of establishing accountability and securing compensation; a need to control land regulate the conduct of medical research.
    7. Care of the vulnerable, mentally ill, mentally handicapped, elderly and poor, and of those with stigmatised diseases...
The discourse of bioethics should be rights-based...
* ...a right to equality...

### (1.3) Rising Health Care Costs; the Ageing Population

  - The principal source of funding for healthcare throughout Australia, is the Medicare levy...the impression one has is that through the taxation system the people of Australia fund a public health system to which they all have access, as of right, free of charge...
    * ...the reality is...that...
      - ...the rate of increase in health spending is the highest of any government sector...
      - ...health expenditure is increasing as a result of other factors including population growth and the aging profile, new health technologies, and rising community expectations...
    * ...part of the problem with public expectation and the clash with the reality of limited resources is that the public is not generally aware of the nature of the problem and...the cost of the provision of health services...public patients have little or no interest in the cost of their service or of its overall efficiency, but rather have a much narrower focus, namely how their particular episode of care affected them.
  - Three simple solutions (limited by a legal context - laws which affect the way in which one might go about this process)...
    1. ...increase the Medicare levy.
    2. ...modify the principles of free universal health care by raising a charge for each patient which relates to some or all of the health service which they have received.
    3. ...recognise the reality, preserve the principle of universal health care but to recognise that it occurs within appropriate budgetary constraints...devise a system both for the allocation of resources generally and for the allocation of particular care for individual patients which reflects a fair and just distribution of those limited resources.
  - Need for enablers (steps which must precede rational reform and which enable it to happen)
    * Knowledge - accessible health information which is timely and accurate.
    * Articulated process by which rules are created and decisions are made about the sharing of limited resources.
    * Cultural change for the health sector, and clinicians.

### (1.4) Professional Regulation & Professional Ethics

- Regulation by the health professions of the ethical and practice standards of the members of those health professions.
  - ...self regulation of its members within a statutory context (different to medical negligence).

**Health Practitioner Regulation National Law (NSW) No 86a**

- ...applies within NSW the health practitioner national law (Australia wide set of standards): s7.
- ...facilitates rigorous assessment of overseas health trained professionals: s3(2).
- ...national scheme allows ethical and professional standards to be enforced across state lines.
- The purpose of professional disciplinary proceedings, is to protect the health of the public, not to compensate a person who has been injured (cf medical negligence).
- The Health Practitioner Regulation National Law establishes the Australian Health Practitioner Regulation Agency (s23) and a number of National Boards: s31(1).
- s35: functions of national boards...
  * ...registering suitably qualified people:35(1)(a).
  * ...deciding requirements for registration: s35(1)(b).
  * ...developing codes of practice: s35(1)(c)
- s38: registration standards
- s39: Codes & Guidelines...medical board of Australia can approve codes and guidelines
- s41: a code or a guideline developed by a national board is admissible to show what constitutes appropriate professional conduct for the health profession.
- Distinguishing national boards from state-based councils: 41B
  * NSW Medical Council of NSW - health care complaints are regulated under a co-regulatory system that consists of the Health Care complaints commission and the NSW Medical Council of NSW.
  * The HCCC (Health Care Complaints Commission) has broader rule: s145C and 145B sets out the actions that the HCCC and Medical Council of NSW may take.
  * Serious matters that are grounds for de-registration will be referred to the tribunal (quasi judicial body) and appeals from the tribunal make their way into the court system.
  * NSW Medical Council...
    * ...regulation of cosmetic surgery on minors...
(2) Consent to Medical Treatment

(2.1) General principles at Common law: Consent & Capacity

- Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 ("Marion's case")
  - As a general principle, medical or surgical treatment involving body contact will constitute battery if carried out without the consent of the patient...
    - underlying value...the law protects bodily integrity (232, majority); human dignity (265-269 per Brennan J); autonomy and dignity (309-310, McHugh J)
      - 'the law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled (266, Brennan J).
    - Exceptions to the general principle that surgical intervention requires consent...‘what, besides consent, can render surgical intervention lawful?’ (234, majority)
      - temporary incapacity (e.g. emergency).
      - children (i.e. patients who are 'developing' capacity) (235) ...parental consent...is an exception to the need for personal consent to medical treatment...parents can consent not because they're parents, but because they are guardians.
      - permanently incompetent patients (mentally handicapped)
      - patients who were once competent but are no longer
      - [NB: medical treatment of adults with full mental capacity does not come within any of the exceptions.]

- Issue of capacity to consent to medical treatment upon children...
  1. ...the rights of parents as guardians are ‘dwindling’ rights which ‘exist only so long as they are needed for the protection of the person and property of the child’: Gillick v West Norfolk A.H.A (237, majority; 290-294, Deane J)
    - ...parental power to consent to medical treatment on behalf of a child diminishes gradually as the child’s capacities and maturity grow (237, Majority)
    - [NB: Age of consent in Australia is 18 years; Powers of parent as guardian to consent to medical treatment on behalf of the child cease at that age. Powers recognised at common law and in legislation (see Family Law Act 1975 (CTH) 618-61C.)]
    - [NB: The nature of these rights/powers/duties over children may be altered by legislation...In some States (including NSW), legislation regulates a minor's capacity to consent to medical treatment (and may displace the common law, subject to a possible right in a guardian to obtain an injunction restraining a minor from exercising statutory rights to consent - see below). However, where legislation doesn’t exist, or otherwise apply, the general principle applies.]
  2. ...the capacity of a minor to consent to medical or surgical treatment and the scope of parental power to consent to such treatment will depend on the particular circumstances of the case, such as the maturity and intellectual capacity of the minor and the nature of the proposed treatment: Gillick v West Norfolk A.H.A (237, Majority))
    - ...a minor is capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed (i.e. understands nature, purpose and effect of treatment) (237, Majority)...
    - ...the onus of proof of consent is on the defendant, that is, the person carrying out the medical or surgical treatment.

- Criteria for regulating medical decisions involving children...best interests...(or) therapeutic/non-therapeutic...
  1. Where their child is incapable of giving valid consent to medical treatment, parents, as guardians, may in a wide range of circumstances consent to medical treatment of their child who is a minor (239)...the overriding criterion of the child’s best interests is a limit on parental power to consent (240, majority)
    - Brennan J criticizes the 'best interests' test...‘it does no more than identify the person whose interests are in question, it does not assist in identifying the factors which are relevant to the best interests of the child... (270).
  2. Brennan J drew a distinction between therapeutic and non-therapeutic surgical procedures...
    - ...therapeutic treatment...treatment administered ‘for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition, or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered (269)...
    - ...non-therapeutic treatment...treatment which is...
(2) Consent to Medical Treatment

(2.1) CONSENT TO MEDICAL TREATMENT INVOLVING MINORS

(a) ...disproportionate to the cosmetic deformity, pathological condition or psychiatric disorder... or ...

(b) ...when administered chiefly for other purposes (269)

• Applying the test: (1) What is the purpose of the treatment? (2) Is the treatment proportionate?

○ Consent to medical treatment upon intellectually handicapped children...
  
  • ...the age at which intellectually disabled children can consent will be higher than for children within the normal range of abilities...there is no reason to assume that all disabled children are incapable of giving consent to treatment...The capacity of the child to give informed consent to medical treatment depends on the rate of development of each individual (239).
(2.1.2) Effect of statute: regulation of medical decision-making involving minors (aged 16 and below) in NSW

**Minors (Property and Contracts) Act 1970 (NSW)**

**Section 49 - Medical and dental treatment**

(1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent. [undermines dwindling rights principle that the majority in Re Marion embraced. Take’s away uncertainty by allowing the parent to consent regardless of the maturity of the child. It may be that this even overrides Re Marion - but vary ambiguous provision, as is s49(2).]

(2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards [i.e. sets the age at which a child can consent to medical treatment at 14 years.]

(3) This section does not affect:

(a) such operation as a consent may have otherwise than as provided by this section, or

(b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent.

(4) In this section:

"dental treatment" means:

(a) treatment by a dentist in the course of the practice of dentistry, or

(b) treatment by any person pursuant to directions given in the course of the practice of dentistry by a dentist.

"medical treatment" means:

(i) treatment by a medical practitioner in the course of the practice of medicine or surgery, or

(ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.

**Urgent treatment - child 15 or younger**

**Children and Young Persons (Care and Protection) Act 1998 (NSW)**

**Section 174 - Emergency medical treatment**

(1) A medical practitioner may carry out medical treatment on a child or young person without the consent of:

(a) the child or young person, or

(b) a parent of the child or young person,

...if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health.

(2) A registered dentist may carry out dental treatment on a child or young person without the consent of:

(a) the child or young person, or

(b) a parent of the child or young person,

...if the dentist is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health.

(3) Medical or dental treatment carried out on a child or young person under this section is taken, for all purposes, to have been carried out with the consent of:

(a) in the case of a child-a parent of the child, or

(b) in the case of a young person-the young person.

(4) Nothing in this section relieves a medical practitioner or registered dentist from liability in respect of the carrying out of medical or dental treatment on a child or young person, being a liability to which the medical practitioner or dentist would have been subject had the treatment been carried out with the consent of:

(a) in the case of a child-a parent of the child, or

(b) in the case of a young person-the young person.

**Section 3 - Definitions**

"child", except in Chapter 13, means a person who is under the age of 16 years.
‘Special’ treatment - child 15 or younger

**Section 175 - Special medical treatment**

(1) A person must not carry out special medical treatment on a child otherwise than in accordance with this section.

(2) A medical practitioner may carry out special medical treatment on a child if:

   (a) the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child’s life or to prevent serious damage to the child’s health, or

   (b) the Civil and Administrative Tribunal, in the case of special medical treatment described in paragraph (a), (b) or (c) of the definition of “special medical treatment” in subsection (5), consents to the carrying out of the treatment, or

   (c) consent is granted to the carrying out of the treatment in accordance with the regulations, or

   (d) the Director-General, in the case of special medical treatment described in paragraph (c1) of the definition of “special medical treatment” in subsection (5), grants an exemption under subsection (4A).

(3) Consent to the carrying out of special medical treatment on a child must not be given by the Civil and Administrative Tribunal unless the Civil and Administrative Tribunal is satisfied that it is necessary to carry out the treatment on the child in order to save the child’s life or to prevent serious damage to the child’s psychological or physical health.  

   [cf Re Marion where the Court referred to the Family Court.]

(5) In this section...

   - “medical treatment” includes:
     - any medical procedure, operation or examination, and
     - any treatment, procedure, operation or examination that is declared by the regulations to be medical treatment for the purposes of this section.

   - “special medical treatment” means:
     - any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, not being medical treatment:
       - that is intended to remediate a life-threatening condition, and
       - from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence, or
     - any medical treatment for the purpose of contraception or menstrual regulation declared by the regulations to be a special medical treatment for the purposes of this section, or
     - any medical treatment in the nature of a vasectomy or tubal occlusion, or...

   - (c1) any medical treatment that involves the administration of a drug of addiction within the meaning of the Poisons and Therapeutic Goods Act 1966 over a period or periods totalling more than 10 days in any period of 30 days, or
   - (c2) any medical treatment that involves an experimental procedure that does not conform to the document entitled National Statement on Ethical Conduct in Human Research 2007 published by the National Health and Medical Research Council in 2007 and updated in 2013, or
   - any other medical treatment that is declared by the regulations to be special medical treatment for the purposes of this section.

**NB:** For Children aged 16 or 17 - see application of Part 5 of the Guardianship Act 1987 (NSW) below
### (2.1.3) Potential Commonwealth/State Conflicts re Sterilization

#### (i) State Laws
- **Children and Young Persons (Care and Protection) Act 1998 (NSW) s 175** authorises sterilisation of children 15 years and under in an emergency (s 175(2)(a)).
  - Apart from this, the Civil and Administrative Tribunal must consent, and consent must be refused unless the operation is necessary “in order to save the child’s life or to prevent serious damage to the child’s health”.
- Similarly, the **Guardianship Act 1987 (NSW)** ss 33-35, 45 envisages that the Civil and Administrative Tribunal must consent to sterilisations upon persons 16 years and over, and can consent to them only “to save the patient’s life; or to prevent serious damage to the patient’s health.”

#### (ii) Supreme Court Parens Patriae
- The Supreme Court has an inherent parens patriae jurisdiction...
  - ...which applies to the mentally disabled, the mentally ill, and children...

#### (iii) Commonwealth Laws
- The Family Court has a “welfare jurisdiction” in the **Family Law Act 1975 (Cth)** 67ZC to authorize sterilization...
  - In *Re Marion*, Court envisaged applications to the Family Court, which would authorise sterilisation (of children 18 years and younger) (of children 18 years and younger) without referring to the Supreme Court. The majority judgment noted that the Family Court’s jurisdiction depends upon the scope of the Constitutional powers supporting the **Family Law Act**.

### Section 67ZC - Orders relating to welfare of children

1. In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.
2. In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

#### (iv) Reconciling State & Commonwealth Laws
- **P v P (1994) 120 ALR 545**
  - HC considered conflict between Guardianship Act 1987 (NSW) and the Family Court’s jurisdiction recognised in *Re Marion*...
    * ...the jurisdiction to authorise a sterilisation came within the powers of the Family Court. Pursuant to s 109 of the Constitution, the Guardianship Act was invalid so far as it purports to prohibit a medical procedure to be carried out on a child of a marriage intended to render that child permanently infertile.
  - The Child welfare jurisdiction of the Family Court corresponds with the traditional parens patriae jurisdiction of the State Supreme Courts...
    * ...the Family Court welfare jurisdiction does not extinguish that of the State Courts, but encompasses the substance of it, freed from the pareliminary requirement of a wardship order.
  - The intent of Parliament was that both jurisdictions should exist concurrently...
    * ...the Guardianship Act 1987 (NSW) prohibits sterilisation unless it is necessary to save life or prevent serious harm to health.
    * ...the **Family Law Act 1975 (Cth)** and approach of the Family Court are much wider in their scope...in the case of a conflict between orders made by the Family Court and those of a State Supreme Court, the Family Court orders would necessarily prevail, as per s109 of the Constitution.
  - [The case involved a child who had a mental disability. Her parents believed that it was in her interests to be sterilized. They wanted court authorisation to do this, and decided that, as the NSW Guardianship Board required that such a procedure would have to be either life-saving or for the prevention of serious damage to health (and this case did not fit those criteria) they would apply to the Family Court for authorisation of the procedure.]
  - [CRITICAL COMMENT: The end result is that parents have a choice: they can go the federal “Family Ct” route, or the State “Supreme Court or Civil and Administrative Tribunal” route.]
2.1.4 Categories of case

(i) Sterilization - a special case

- **Secretary, Department of Health and Community Services v fWB and SMB (1992) 175 CLR 218 ("Marion’s case")**
  - Sterilization...a special case...
    * ...except where sterilization is an incidental result of surgery performed to cure a disease or correct some malfunction, the decision to sterilize an intellectually disabled minor should be excluded from the ordinary scope of parental power to consent to medical treatment...[249; 253]
      - ...court authority is necessary as a procedural safeguard (249, 253, majority).
      - [NB: State legislation affects this (see above): Children and Young Persons (Care and Protection) Act 1998 (NSW) s175; Guardianship Act 1987 (NSW), s33-5, 45, as regards children aged 16 or 17.]
    * ...parents, guardians and the court have no power under the general law to authorize the non-therapeutic sterilization of intellectually disabled children...[but have power to authorize therapeutic sterilization] (277) (Brennan J).
    * Reasons why court approval required (250, see also 246)...
      - Sterilization requires invasive, irreversible and major surgery.
      - Significant risk that the wrong decision will be made about the child’s present or future capacity to consent.
      - Significant risk that the wrong decision will be made about what are the best interests of the child.
      - The consequences of a wrong decision are particularly grave.
    - **Role of the Court...**
      * The function of a court when asked to authorize sterilization is to decide whether, in the circumstances of the case, that is in the best interests of the child...sterilization can only be authorized in the case of a child so disabled that other procedures or treatments are or have proved inadequate...[259, majority]"
      - The HC concluded that the Family Court has jurisdiction to authorize sterilisation...this arose from s64(1)(c) of the Family Law Act, which gave the Court power to make such orders as it considered proper in proceedings with respect to the custody, guardianship or welfare of or access to, a child [NB: The Family Court has the power to consent to a non-therapeutic sterilization when it is in the best interests of the child. Although s64 has been repealed, the Family Court now has a specific ‘welfare jurisdiction’ which would extend to sterilization: s67ZC...this is similar to the parens patriae jurisdiction (258-259).]
    - [Marion was the pseudonym of a person aged 14 years at the time of this appeal. She suffered from a severe intellectual disability and was unable to care for herself. Her parents applied to the Family Court for an order authorising the performance of sterilisation procedures for the purpose of preventing pregnancy and menstruation, or alternatively, for a declaration that it would be lawful for them to consent to such a procedure. The appeal concerned two questions: (1) Could Marion's parents lawfully authorize the carrying out of a (non-therapeutic) sterilisation procedure without an order of the court - Nic (2)(a) Does the Family Court have jurisdiction to authorize the carrying out of such a procedure? Yes; (2)(b) Does the Family Court have jurisdiction to enlarge the powers, rights or duties of the Applicants as guardians of the said child to enable them to lawfully authorize the carrying out of such a procedure? No; (2)(c) Does the Family Court have jurisdiction to approve the consent of the guardians to the proposed procedure to make the procedure lawful? No]
  - **Re Angela (Special Medical Procedure) [2010] FamCA 98 (Justice Cronin)**
    - The Family Court’s welfare jurisdiction extends to authorizing sterilization...
    - **In the present case...**
      * ...the decision that Angela should have a hypersesctomy falls outside of the parental responsibility of the mother and father because of the invasive nature & irreversible effect of the procedure [48].
      * ...from a medical point of view...the procedure was ‘urgent and necessary’ [49].
      * ...from the law’s perspective, the surgery was in her best interests and necessary for her welfare [58]...
        - ...Angela’s pain and suffering seriously affects her quality of life [54]...her physical condition will improve [55]
        - ...her susceptibility to epilepsy seizures puts her at risk in an environment where control of her menstrual cycle has been unsuccessful [54].
        - ...the nature of the risks are minimal [56]
    - [Angela, an 11 year old girl, had Rett Syndrome (a progressive neurological disorder). A hysterectomy was proposed that Angela should have a hysterectomy to improve her quality of life, which would help control epileptic seizures and significant bleeding (that caused her to be anaemic) that occur when Angela has a heavy menstrual period. Queensland health required court approval due to the irreversible nature of the surgery. Angela’s mother gave evidence that Angela cannot talk nor has she the...]
coordination or mental faculties to use sign language, and that she acts as a three month old baby would. Dr T gave evidence that sterilisation, although a consequence of the procedure, was not its purpose (cf Marion’s case). Dr C also supported the hysterectomy. Dr M was also of the view that the hysterectomy was the only way to proceed.

[CRITICAL COMMENT: This case differs principally from Marion’s case because in that case, the sterilisation procedure was the purpose (i.e. non-therapeutic), whereas here the procedure was ‘therapeutic’.

(ii) Bone marrow donation

- GWW and CMW (1997) FLC 92-748 (non-therapeutic donation by a minor)
  - The Family Court did have jurisdiction to hear the application pursuant to its welfare jurisdiction...
    * ...the parents’ application properly invoked the welfare jurisdiction of the Court.
    * ...this was a special case outside the scope of parental power to consent.
  - The approach taken in Marion’s case did not only apply to sterilisation, but extended to other ‘non-therapeutic’ procedures...including...the donation of healthy organs such as a kidney from one sibling to another...
    * As the proposed medical procedure was of no benefit to the boy, it was a non-therapeutic procedure which justified the intervention of the Court pursuant to its welfare power.
    * ...while the procedure here was not irreversible (in that the stem cells can regenerate an blood can be re-infused into the donor) it was nevertheless an invasive procedure requiring general anaesthetic that was not for the benefit of the child.
  - The paramount consideration was the welfare of the child, and whether the procedure would be in his interests...
    * ...as the boy firmly wished to be a donor of tissue for his aunt, as he had a close relationship with members of his extended family, and as the risks involved in the procedure were very small, his best interests justified him being permitted to undergo the procedure...
      * these factors outweighed the risk or discomfort of the procedure.
    * The plight of the aunt was not a relevant consideration.
    - [The collection of bone marrow or peripheral blood stem cells for donation to his aunt, who suffered from leukaemia. The aunt was expecting to die within 12 months without the transplant, and B had expressed a strong wish to donate the tissue. If the nephew donated his bone marrow, the Aunt’s chance of survival increased by 30-40%. It was accepted that whilst B had an understanding of the nature of the procedure, his understanding was not adequate for him to provide informed consent. Could the parents lawfully authorise the procedures, and if not, Was in B’s best interests for the Court to intervene and exercise its welfare jurisdiction to authorize the procedures? No, and Yes.]

- (cf) Re Inaya (Special Medical Procedure [2007] Fam CA 658 (27 June 2007)
  - Consenting to the transplant procedure (bone marrow donation) was within the scope of ‘parental responsibility’ under the Family Law Act...(i.e. the Court did not follow GWW and GMW)
    * ...the Family Court therefore had power to make an order regarding that exercise of parental responsibility.
  - To the extent that the Human Tissue Act purports to prevent an order allowing the procedure, it is inconsistent with the Family Law Act...
    * Section109 of the Australian Constitution provides that if a State law is inconsistent with a Commonwealth law, the Commonwealth law prevails.
    * ...the Family Law Act is exclusive and exhaustive in relation to parental responsibility... accordingly, the Family Law Act, rather than the Human Tissue Act, must apply in Inaya’s case.
    * ...The Family Court decided that the Victorian Human Tissue Act insofar as it prohibited the donation of bone marrow to a non sibling or non parent in circumstances where it would nevertheless be for the psychological welfare of the infant for the donation to occur...was inconsistent with the Family Law Act which allows he Family Court to consider the welfare of the child in matters of parental responsibility.
      * ...because donations to siblings was within parental responsibility...donations per se must fall within parental responsibility...
  - In the present case...
    * ...the relationship between Inaya and Mansour was of particular importance and should be preserved if possible ... Inaya may suffer psychological harm derived from guilt, self-blame and exposure to a traumatised and grief-stricken family and community, as well as the loss of important relationships if the procedure was not performed. ...in all of the circumstances it was in the best interests of Inaya to enable her parents to lawfully consent to the transplant.
○ The child (Inaya) was 13 months old. The question was whether you could harvest the bone marrow from a 13 month old in order to give it to her year old cousin (Mansour), who was suffering from infantile osteoporosis. The major problem with the proposed transplant was that in Victoria, the Human Tissue Act prohibits the removal of tissue from children for transplantation. It is an offence to do so. There is an exception where a parent consents in writing to the transplantation of the tissue to the body of a brother, a sister or a parent of the child who is likely to otherwise die. However, the judge noted that while this exception would apply to Inaya if she had been Mansour’s sister, it could not apply to Inaya as she was in fact Mansour’s cousin. The judge had to consider whether to permit a bone marrow transplant from a donor child (aged thirteen months at the hearing) to her first cousin (aged approximately eight months at the hearing) in circumstances where State law rendered such a transplant a criminal offence.

○ [NB: Unlike in GWW and CMW, the Court saw bone marrow donation as falling within parental responsibility.]

### (iii) Gender reassignment

- **Re Jamie (No 2) [2013] FamCAFC 110 (31 July 2013)**
  ○ Stage 1 treatment for gender dysphoria was reversible, was treatment provided in response to a disorder (whether psychological or psychiatric), was clearly administered for therapeutic purposes, was not attended by a grave risk if a wrong decision was made, and therefore fell within the scope of parental capacity to consent
    * ...it did not fall within the class of cases considered by the HC to be outside parental consent and requiring court authorisation [97, 98, 108].
  ○ In relation to stage two treatment however, court authorisation for parental consent remains appropriate unless the child is capable of autonomous decision-making (i.e. is Gillick competent), in which case the child can consent to treatment (absent any controversy).
    * ...Stage 2 treatment is qualitatively different from Stage 1 because of its irreversibility, nature and effects.
    * ...while Stage 2 treatment was irreversible major treatment, a Gillick-competent child could consent to Stage 2 treatment
    * ...a decision about whether the child was so competent would have to be made by the Court, because of the nature of the treatment, the risk of a wrong decision being made as to the child’s capacity, and the gravity of the consequences
      * ...if the Court found the child was not competent to consent to Stage 2 treatment, then because of the significant nature of the treatment, its irreversible effects, and the grave consequences of a wrong decision, the decision was outside parental capacity to consent and it would be for the Court to determine if it was in the child’s best interests to order the Stage 2 treatment [129]-[139].

  ○ [Jamie was a child diagnosed with childhood gender identity disorder, being a recognised psychological condition. Jamie’s parents, on Jamie’s behalf and with the agreement of the treating doctors, sought the Court’s authorisation for the administration of puberty-suppressant hormones (stage one treatment) and oestrogen (stage two treatment) pursuant to s 67ZC of the Family Law Act 1975 (Cth) in order to allow Jamie, born a male, to live in her affirmed sex as a female. The trial judge provided such authorisation in relation to stage one, which was totally reversible, but not in relation to stage two, which normally commenced at about age 16 and was only reversible with surgical intervention. The parents then argued on appeal that Court approval was not in fact required for either stage of treatment when all relevant parties agree to the course of action to be taken. Held: Parents could consent to stage 1, but court authorisation was required for stage 2 treatment.]

- **Re Shane [2013] FamCA 864**
  ○ The Court followed Re Jamie...it was confirmed that a Gillick-competent child can consent to Stage 2 treatment, but that if the child is not competent, Stage 2 treatment is a special type of medical procedure requiring court authorisation.
(iv) Abortion

- State of Queensland v B [2008] 2 Qd R 562
  - Where a 12 year old girl was pregnant, had an intellectual disability and was not Gillick-competent, court authority was required to authorize the termination of pregnancy...
  - It is unlawful in Qld to administer a drug or to perform a surgical or other medical procedure intending to terminate a pregnancy unless that conduct is authorised, excused or justified by law (i.e. unless it is necessary to preserve the life, health or welfare of the pregnant person)...
  - The abortion could only be lawfully performed if it was a therapeutic procedure...
    * The Court cannot authorise what would otherwise be criminal conduct. Moreover, it would not be in B’s best interests to subject her to an unlawful act, especially a criminal act.
    * In the circumstances of this case, the administration of the drug *misoprostol* in order to terminate B’s pregnancy would be reasonable to avoid danger to her mental health, and so it would not be unlawful. It would be in B’s best interests for termination of her pregnancy by that means to proceed.
  - In the present case...
    * For similar reasons to those in *Marion’s Case*, B’s parents should not be able to consent to the termination of her pregnancy...
      - Her Honour relied on the authority of *Marion’s case* and in particular the reasoning regarding the risk that parents could make the wrong decision, the grave consequences of doing so, the possibility that the parents’ own interests may influence their decision, the role of the doctors in the decision, and the result that the decision meant the negation of the possibility of the girl giving birth to this baby...
    * The Court in its parens patriae role must act in the best interests of the child, B, whereas her parents may ultimately make a decision which favours other and possibly conflicting interests of the family as a whole.
  - [Concerned an order made for the pharmaceutical termination of a pregnancy at 18 weeks’ gestation of a 12 year old girl with mild intellectual impairment. The applicant sought declarations that the termination of the girl's pregnancy by therapeutic administration of the drug misoprostol would be reasonable in the circumstances to avoid danger to her mental health, and that she be permitted to undergo (and the hospital be permitted to perform) termination by use of the drug. The medical evidence was that continuation of the pregnancy would pose serious dangers to her mental health and well-being, beyond the normal dangers of pregnancy and childbirth.]

(v) Children who refuse to consent to life preserving medical treatment

- The Sydney Children’s Hospital Network v X [2013] NSWSC 368.
  - The case concerned the exercise of the parens patriae jurisdiction...the court can exercise the same jurisdiction that the family court enjoys under s67ZC since the Supreme Court enjoys that very same jurisdiction under the cross-vesting legislation [7]...
  - In exercising the parens patriae jurisdiction...the court must ultimately consider the welfare and best interests of the child...[10]...this involves...a focus on the individual circumstances of each case [12]...including [13]...
    * The particular condition of the child...
    * The nature of the procedure or the treatment proposed...
    * The reasons for which it is proposed that the procedure/treatment be carried out...
    * The alternative courses of treatment that are available...
    * The desirability and effect of authorising the procedure over alternatives...
    * The physical effect on the child and the psychological and social implications...
    * The nature and degree of any risk...
    * The views regarding the proposed procedure and any alternative procedure...
  - Whist the fact of a ‘mature minor’ refusing to consent to treatment is a relevant and important factor, it does not prevent the Court from authorising medical treatment where the best interests of the child/yong person require it [15]...the parens patriae jurisdiction of the Supreme Courts can supplant the choice of Gillick-competent mature minor...
    * It may be appropriate to suborn an informed decision (i.e. where they understand the nature purpose and effect of the treatment) of a minor, and invoke the parens patriae jurisdiction of the court, if the circumstances demand such a course [40]...
    * The sanctity of life is a more powerful reason to make orders than is respect for the dignity of the individual [49]...the court had a right to impose ‘best interests’ medical treatment on the child...
In the present case...

- ...there is no doubting X’s devotion to his faith, but his life has been cocooned in that faith [41]...
- ...there was evidence that, apart from ripping out the intravenous drip if he could, the child would obey a court order that he be transfused and he would co-operate. It was agreed that if he had blood transfusions against his will there would be no ramification within his church [45].
- ...the decision of X should be overruled and he should be given blood transfusions ’as a last resort’...

- [This case raises the issue of children who refuse life-preserving medical treatment. Patient X was a 17 year old Jehovah’s Witness with cancer; refusing a blood transfusion necessary to prevent him from dying from anaemia and allowing him to undergo higher strength chemotherapy. Should the court exercise its parens patriae jurisdiction to override the wishes of the child? Yes. The order of Gzell J was upheld on appeal.]

- [The Sydney Children’s Hospital went to court seeking an order authorising it to administer blood and blood products to a 17 year old boy 'X', despite his objections. A little over a year previously, X was diagnosed with hodgkin’s disease and was treated with a 7 month regime of chemotherapy and went it to remission for a time but it didn’t last, and in November 2012 there was evidence of disease in his lungs, spleen and lymph nodes. It was at this point, that X and his parents wrote to Professor Marshall the treating physician asking that X be treated with non blood treatment, seeking assurances that he wouldn’t be given a blood transfusion. In Dec 2012 X began a further round of chemotherapy which was no different to the previous round. Professor Marshall testified that where a relapse occurs, his approach involves switching to different cytotoxic chemotherapy drugs that are administered at a higher dose in order to overcome the resistance that is part of the relapse process. As a side effect, those higher doses kill off the production of blood cells and bone marrow and require a transfusion to compensate. With the best therapy available, Professor Marshall assessed X’s chance of a cure at 40%-50%. As X’s and his parents were Jehovah’s witnesses, they wanted to make that X’s therapy wouldn’t include a blood transfusion. In order to accommodate X’s desire to avoid blood transfusions, X was put on two cycles of chemotherapy at a lower dose from Dec 2012 to Feb 2013, and although the tumors reduced in size, it was a disappointing result because if higher doses had been given the tumors should have disappeared completely. The mix of drugs was then altered in March 2013 but mid-way through that month X was back in hospital severely anaemic and chemotherapy was suspended. The anaemia wasn’t immediately life threatening, but as soon as chemotherapy was restarted, it would likely render him severely anaemic again. Professor Marshall began discussing with the parents the need to use blood so that they could give him the higher doses of chemotherapy which would kill off his bone marrow and blood cells but which would be replenished by a transfusion. X’s response was that if the hospital administered blood during an emergency, he would rip the IV line out, and if he was sedated first, in his view it would be akin to being sedated and raped.
- [CRITICAL COMMENT: The case involved someone who might be said to be 'Gillick-competent' - ten months out from their 18th birthday. There was no question of intellectual disability, he’s just a normal person with strong religious views that impact on the treatment that he’s prepared to accept. Professor Marshall described him as the ‘leader of the team’, and the Court said he is clearly a mature minor, and yet they still overrode his decision not to have a blood transfusion. Does it make any difference if the stakes are higher? This is a separate thing from the Gillick-competency test - from understanding the purpose, nature and effect of the medical treatment.]

X v Sydney Children’s Hospitals Network [2013] NSWCA 320 [Basten JA]

- The court has parens patriae jurisdiction to authorise medical treatment for a person below 18 years of age [45-47] ...
  - ...even if that person was capable of understanding and consenting to or withholding consent for a particular form of treatment...
  - ...such capacity in a mature minor was relevant to the exercise of that jurisdiction, but it did not diminish its scope.

- In the present case...
  - ...the order made (at trial) should be amended to impose a temporal limit on the authority of the Hospital...
  - ...the interest of the state is in keeping him alive until his 18th birthday, after which he will be free to make his own decisions as to medical treatment [72-72].
  - ...the state interest is not satisfied merely by keeping the applicant alive until his 18th birthday if the appropriate treatment to allow the continuation of his life thereafter should be given now...

- [NB: The Court loses its jurisdiction after the child turns 18 - parens patriae applies to mentally disabled, children, and mentally ill. Once he reaches 18 the Court doesn’t have any jurisdictional base for second-guessing the decision.]

cf In Re Heather [2003] NSWSC 532

- The court using its parens patriae jurisdiction to uphold the child’s best interests, over the objections of both the parents and the child.
- [The court authorised chemotherapy to a 12-year old child for a malignant ovarian tumour. The child’s parents objected to the chemotherapy, subjecting her to ozone or oxygen therapy instead.]
(vi) Withdrawal of treatment in the best interests

- In Re Marion, the High Court carved out a category of special medical procedures that explicitly required a court authorisation (i.e. those procedures which limited the parent as guardian to consent on behalf of the child) [173]...
  
  * The procedure in this case is not a “special case” as identified in Marions Case, as although the extubation procedure is invasive, it is a routine medical procedure to be undertaken for the treatment of a bodily malfunction or disease [227].
  
  * The proposed procedure is therefore within the ambit of parental responsibility as relating to major long-term issues in respect of the health of the child and her care, welfare and development within s 64B(2)(i) of the Family Law Act 1975 (Cth) [227-9].
    
    * ...this was not a case where you would need to go to court to get specific court authorization, in the sense that that parents lacked legal authority to consent on the child’s behalf...the parents did have authority... (nevertheless, where there’s disagreement between parents and treating physicians you may still need to go to court because of the doubt about whether the parents are acting in the best interests)
  
  * The removal of the tube was considered to be in the best interests of Baby D in order to see whether she could live without the tube... because leaving it in was aggravating and causing her airway to deteriorate [229]...
    
    * ...if she was to have a long-term chance of survival, they needed to get the tube out.

- [The Family Court considered an application that the parents of Baby D and the hospital supported to remove an endotracheal tube from her throat on the basis that it was in her best interests. The applicants also sought authorization to sedate her if the removal of the tube resulted in air hunger in the knowledge that the level of sedation required would also depress her respiratory drive and cause her to die. Baby D had the endotracheal tube inserted at birth because her lungs weren’t working properly (i.e. rescue treatment) But, her larynx became inflamed and had narrowed due to the prolonged insertion of the tube. For longer term prospects, they had to get rid of the tube. The hospital had tried to once before because it was damaging her long term prospects of being able to breathe independently. But, when it did remove the tube, she stopped breathing and required resuscitation, cardio pulmonary massage and adrenalin and it took 35 minutes to re-insert the tube - by that stage, Baby D who was one of a set of twins suffered a major hypoxic brain injury and from that point on would be severely disabled for live. Continued incubation was likely to lead to lung decline, because it leads to closure of air sacs in her lungs. So the hospital wanted to ween her from the tube if it could. Was it legally and ethically acceptable to remove the tube with the expectation and probably could not be replaced in the event that a life threatening airway obstruction developed? Yes.]

(vii) Cosmetic procedures on children

Public Health Act 2005 (Qld)

Section 213A - Definition for ch 5A

(1) In this chapter—cosmetic procedure means any of the following—

- a procedure involving the removal of excess skin or fat from, or the reshaping of, a part of the human body, including the following—
  
  * abdominoplasty, also known as a tummy tuck;
  * blepharoplasty, also known as eyelid surgery;
  * brachioplasty, also known as an arm lift;
  * foreheadplasty, also known as a brow lift;
  * liposuction or liposculpture;
  * rhytidectomy, also known as a face lift;
  * thighplasty, also known as a thigh lift;
  * torosoplasty, also known as a body lift;

- a procedure involving resurfacing of the skin by removing the epidermis and penetrating the papillary dermis;

- a surgical procedure involving the insertion of facial contour implants;

- a surgical procedure involving the alteration of the breast to improve its shape, size or position, known as mammoplasty;

- a surgical procedure involving the alteration of the chin to improve its shape or size, known as genioplasty;

- a procedure involving the injection of a non-biodegradable substance under the skin to improve its volume, known as permanent injectable fillers;
Section 213B - Offence to perform, or offer to perform, cosmetic procedure on a child

(1) A person must not perform, or offer to perform, a cosmetic procedure on a child [Maximum penalty—2000 penalty units or 2 years imprisonment.]

(2) A person does not commit an offence against subsection (1) if the person believes, on grounds that are reasonable in the circumstances, that performance of the procedure is in the best interests of the child.

(3) Proof that the person did not have sufficient regard to any of the following matters is sufficient proof that the person did not have the belief mentioned in subsection (2)—
   (a) if the child is able to form and express views—the views of the child, including the reasons why the child wants the procedure to be performed, taking into account the child’s maturity and understanding of the procedure, including the risks, limitations and possible consequences of the procedure;
   (b) to the extent it is practicable for the person to consult a parent of the child—the views of the parent, including whether the parent supports the procedure being performed on the child;
   (c) the child’s physical health, including whether performance of the procedure would correct a growth or congenital abnormality or the physical effect of a medical condition, illness or trauma;
   (d) the child’s psychological health, including whether the effect of performing the procedure on the child is likely to be positive;
   (e) the timing of the procedure, including whether waiting until the child is an adult would be better than performing the procedure now.

Section 213C - Offence to procure, or offer to procure, performance of cosmetic procedure on a child

A person must not, for a fee or other reward, procure, or offer to procure, the performance by someone else of a cosmetic procedure on a child [Maximum penalty—2000 penalty units or 2 years imprisonment.]

Section 213D - Chief executive may report contravention

(1) If the chief executive considers a person has contravened section 213B or 213C, the chief executive may report the alleged contravention to a relevant entity.

(2) In this section— relevant entity means—
   (a) the health ombudsman; or
   (b) a board established under the Health Practitioner Regulation National Law; or
   (c) another entity that has the power under an Act of the State, the Commonwealth or another State to deal with the matter.

Section 12F - Procedures that are not cosmetic procedures for Act, ch 5A—Act s 213A(2)

(1) For section 213A(2) of the Act, the following procedures are prescribed—
   (a) a procedure involving the removal of a skin tag;
   (b) a procedure involving the reshaping of the external structure of the ear, also known as otoplasty;
   (c) a procedure involving the reshaping of a hand or foot that is polydactyl or syndactyl;
   (d) a procedure involving the circumcision of the penis;
   (e) a procedure involving the correction of disfiguring scarring resulting from a medical condition, illness or trauma;
   (f) a procedure involving the removal of a naevus that is disfiguring, melanotic or interferes with the function of a part of the human body;
   (g) a procedure involving the removal of a tattoo;
   (h) a procedure—
      (i) that is part of a plan to treat a child; and
      (ii) involving cranio-facial surgery, orthognathic surgery, or otolaryngological surgery, to correct a deformity, congenital abnormality or the physical effect of a medical condition, illness or trauma;
   (i) mammaplasty to correct a deformity, congenital abnormality or the physical effect of a medical condition, illness or trauma;
   (j) genioplasty to correct a deformity, congenital abnormality or the physical effect of a medical condition, illness or trauma;
   (k) rhinoplasty to correct a deformity, congenital abnormality or the physical effect of a medical condition, illness or trauma.

(2) In this section—skin tag means a polypoid outgrowth of both epidermis and dermal fibrovascular tissue.
### (2.1.5) Suspicion of child abuse

**Children and young Persons (Care and Protection) Act 1998 (NSW)**

Section 27 - Mandatory reporting

(1) This section applies to:

   (a) a person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children’s services, residential services, or law enforcement, wholly or partly, to children, and
   
   (b) a person who holds a management position in an organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children’s services, residential services, or law enforcement, wholly or partly, to children.

(2) If:

   (a) a person to whom this section applies has reasonable grounds to suspect that a child is at risk of significant harm, and
   
   (b) those grounds arise during the course of or from the person’s work,

   it is the duty of the person to report, as soon as practicable, to the Director-General the name, or a description, of the child and the grounds for suspecting that the child is at risk of significant harm.

(3) A person to whom this section applies satisfies his or her obligations under subsection (2) in relation to two or more children that constitute a particular class of children if the person reports that class of children to the Director-General together with:

   (a) a description that is sufficient to identify all the children who constitute the class, and
   
   (b) the grounds for suspecting that the children of that class are at risk of significant harm.