

Invasive & IRREVERSIBLE

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The sterilisation of intellectually disabled children.

The child's right to be heard in the medical powers jurisdiction of the Family Court should be about a broad advocacy of the child's interests rather than mere representation in court. This article concentrates on the sterilisation of children with intellectual disabilities.¹ These cases highlight socio-economic and emotional issues confronting families, as well as the lack of information, advice and support services available to assist them with the care of their child. Fundamental to success in this jurisdiction is the support and co-operation of a broader community of medical practitioners, advocates, human service providers, specialist consultants in disability, and others. Any weak link compromises effective outcomes for the child and family. The current processes employed by the Court particularly relating to the rules of evidence and quasi-adversarial procedures cannot address these fundamental issues.

The views I express in this article are based on direct case work in the Victorian adult guardianship jurisdiction and the Family Court medical powers jurisdiction in my former capacity as Senior Advocate of Victoria's Office of the Public Advocate, a rights-based statutory authority representing the interests of people with disabilities, and in my current work. In these capacities I have had the opportunity of meeting many families seeking the sterilisation of daughters with disabilities as an option for fertility and menstrual management. The opinions expressed are mine. They do not necessarily express the views of these agencies.

The Family Court's medical powers jurisdiction

The Family Court of Australia in 1992 ratified Order 23B to frame its extended jurisdiction relating to 'Special Medical Procedures for Children'. The Order followed a long line of sterilisation cases culminating in *Marion's* case where the High Court of Australia held that the right to authorise sterilisation of children is not within the ordinary scope of parental power.² It found that the Family Court has the necessary authority to grant authorisation if it is equivalent to a declaration that sterilisation is in the best interests of the child. The medical powers jurisdiction of the Family Court envisages 'special medical procedures' being a broad category of sensitive and/or disputatious treatments, ethically contentious and irreversible treatments, and potentially life threatening medical neglect matters. To date, most matters coming before the Court in Australia have addressed proposed sterilisations of girls with intellectual disabilities but one addressed gender reassignment of an hermaphrodite child, and another, parental refusal to consent to heart surgery.³ Equivalent overseas jurisdictions have addressed cases involving cessation of life support, donation of non-regenerative tissue and treatment for anorexia nervosa against a minor's wishes. What is becoming increasingly clear is that the future will see an increase in and a diversity of special medical cases coming before the Court.

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Observations about the jurisdiction

Lawyers faced with a sterilisation application will grapple with the matter by referring to case law and precedent and pouring over judgments to learn what is required and how to best represent the interests of the child. A cautionary note: matters which reach the court are failures. They are not and can never represent models of best practice. Best practice is to be found in the cases which do not proceed to court. Best practice is possible if guidelines are in place as there were in Victoria in 1993 and are now in Queensland.⁴ For example, in Victoria in 1993 nine out of eleven matters were diverted from court and in 1995 in Queensland seven out of eight matters have been diverted. They are the success stories because the families and children involved received services such as respite care, home help, and needs-based developmental programs and the child retained a functioning organ and her bodily integrity.

What is striking about these matters is that most families at the time of application will not have been given medical or developmental options of a less invasive nature. In my experience, what is equally evident and appalling is that the families may never have received assistance from local council (such as home help), from disability agencies (such as respite care) or special educators (such as educational programs in personal hygiene or protective behaviours). With the provision of needs-based services most families do not proceed with an application and, what's more, the parents do not come back to the Court despite knowing exactly how to. These cases are not to be found in judgments.

This is my advice to lawyers in this jurisdiction. When parents say that they wish to have their intellectually disabled daughter sterilised never, in the first instance, think this is the problem. Referral to a gynaecologist implies a view has been formed that the problem is the reproductive organ. It rarely is. The organ is not diseased. These applications are not about medical problems but socio-economic and emotional situations in which parents find themselves by virtue of having an intellectually disabled child. Medical science can offer no quick fix. If the child's interests are to be heard then the presenting problem needs to be seen in context. A pivotal issue involves giving families options and most do not want to subject their child to invasive surgery.

Unlawful activity

We are in fact faced with significant human rights and social problems in this jurisdiction. Despite the clear legal framework established by the High Court in *Marion's* case, the law does little to prevent unauthorised sterilisations occurring throughout Australia. In the five years preceding *Marion* (1987-1992), the national total of sterilisation procedures for girls under 18 years was 2313.⁵ Post *Marion*, in 1992-93, there were 384 sterilisation procedures performed on girls. In 1993-94 the number increased to 417 and in 1994-95 it increased to 464 for the same age group.⁶ Since *Marion* (although we do not have accurate figures), the number of cases which proceeded to the Family Court is in the order of 20. That means about 20 out of 1200 sterilisation procedures came to the attention of relevant authorities. It is probable that few of these hundreds of sterilisation procedures will be a by-product of surgery appropriately carried out to treat some malfunction or disease⁷ and, therefore, these figures suggest that there is significant unlawful activity and abuse of the rights of these children.

Why are we seeing an increase in the number of unlawful sterilisations?

It seems in large part a consequence of parents' fears for the sexual vulnerability of their daughters, a lack of information and advice about both the short and long-term risks of procedures like hysterectomy, and a paucity of support services and educational programs available to assist with the child's care.⁸ Another issue seems to be the fact that the adversarial system and judicial processes create an environment where parties become locked in and wedded to winning. Most people wish to avoid this situation and the significant financial and emotional costs associated with litigated matters. The other and most obvious reason is that doctors and families are ignorant of the requirement to gain court authorisation for these procedures. How are we to address these issues?

What is required is a practical, less intrusive framework which addresses the presenting problems of parents in a timely manner through the identification of and access to appropriate services. The framework ought to create the mechanism for 'informed decision making' by parents through the exploration of alternative options to sterilisation.⁹

A case study

Annie's case will put my comments in context and illustrate why it is so important *not* to see an application for sterilisation as a 'legal problem' or a 'medical problem'.

Annie had severe intellectual and physical disabilities as a result of a near drowning when she was two years old. She was admitted to a Children's Home for care. She spent school holidays with her family. She lived at the Children's Home for nine years until it closed its residential facility. At age 11 Annie returned to the care of her parents. This was difficult for both her parents and her siblings since Annie required full nursing care.

Over the years she had undergone numerous surgical procedures and after each one 'she had regressed' taking a long time to relate again to her family and carers. This was a matter of great despair for all, particularly when the outcomes of surgery did not live up to the expected improvements in her quality of life. Her father described an incident three years earlier when he and his wife had been asked to attend a case conference with a number of physicians who were considering an orthopaedic procedure to cut Annie's tendons to release her legs from their contracted and stiff position. The intended result would be increased flexibility which would make transporting and caring for her easier. He said the surgeons asked him to show them the range of flexibility in her legs. He initially declined saying he was really not familiar with Annie's condition as he was not her primary carer. The surgeons encouraged him to do so on the basis that 'Annie would feel more comfortable with her father than strangers'. He complied with their wishes and broke both her legs as a consequence. He said Annie was subsequently terrified of him and that it took almost a year before she would make eye contact with him. The operation proceeded and after much pain and suffering, months in plaster casts, traction and skin ulcers, the increase in her limb flexibility was minimal.

The next recommended surgery was a hysterectomy. Her parents now viewed surgical intervention cautiously. Nevertheless, they had to maintain faith with the medical profession and felt that if doctors were proposing the hysterectomy then it ought to be in her interests. Some two months after her

return home Annie's parents contacted a solicitor to assist with an application to the Family Court. The application suggested that the procedure would assist with her care and nursing management. She was not menstruating but it was thought that she would do so within the next couple of years. Her parents wished for a hysterectomy on the grounds that she would require nursing care with her menstruation. They were also worried that she was vulnerable to sexual abuse and its potential consequence, pregnancy. It was accepted that Annie would always require full nursing care and supervision and that she would be unable to care for a child.

The application was made to the Family Court which referred the matter to a State department with expertise in disability under Guidelines referred to above. A case conference followed. Annie's father expressed extreme anger about what he perceived to be legal intervention in matters which in his view rightly belonged to parents. He expressed his feelings about 'the lack of humanity', 'the high moral ground of professionals' and 'the high and mighty society' which offered rhetoric but little else in protection of his daughter's interests. He said he was terrified by Annie's vulnerability and the pain and suffering she had experienced since her acquired brain damage from a near drowning. He described his family as having had little if any assistance in coming to terms with the accident and the pervasive guilt which overwhelms them about what has happened since.

The question to be answered — is sterilisation a blessing or burden for Annie?

The family were given medical advice about the proposed hysterectomy and it was the same advice which appears in almost all applications.¹⁰ The advice came from generic specialists who offered no options other than the removal of her uterus. Her parents were not referred to experts in disability. The procedure was marketed as a panacea for all potential problems. Was it a social judgment masquerading as a medical need? The Family Court referred her parents to the appropriate government department for information and advice on alternative and less invasive options to sterilisation. The department offered services like respite care, home help and other supports to the family to assist with Annie's care. The family decided not to proceed with the application for sterilisation.

Are alternatives heard?

Interestingly, alternative opinions are not often heard in the majority of cases which get to court. What is clear is that the court needs to hear about clinical research which critically questions a range of long held assumptions about the nature and purpose of invasive procedures like the removal of the uterus. As well as this, there are some common sense questions worth asking. For example, if a functioning organ is removed will it have long-term consequences? Here are some views to consider. Removal of the uterus may cause the onset of early menopause, compromise skeletal structure, lower bone density and increase the risks of osteoporosis.¹¹ It may increase the risks of heart disease.¹² It is true that hysterectomy will solve the problem of menstrual management for care givers.¹³ The child will no longer bleed for five days a month. However, she will continue to urinate and defecate each day for the rest of her life. This is a greater nursing management problem. Why is there an inconsistency of approach to menstruation as opposed to other bodily functions? A hysterectomy will never solve vulnerability to sexual abuse but it will avoid pregnancy. How likely is it that she

will be raped?¹⁴ What should be done about this? Do you think she is entitled to educational programs about how to indicate to others she does or does not like sexual involvement?¹⁵ There is no data to suggest that pregnancy is a significant risk in this population. There are approximately 18 million people in Australia: 50.2% of them are females. The number of females under the age of 18 years is approximately 2,300,000. Of these approximately 2% have some form of intellectual impairment.¹⁶ Crudely this means approximately 40,000 intellectually impaired girls may be potential candidates for sterilisation because they are potentially at risk of pregnancy. If pregnancy is a significant risk in this population where are all the babies? Thinking about these figures it becomes clear that the numbers of unwanted pregnancies (or pregnancies) in this population seem statistically insignificant.¹⁷ This ought to raise a cautionary note when thinking about authorising sterilisation on the basis of risk of pregnancy. This response is a matter of fear not fact. It may be camouflaged eugenics.¹⁸ What is apparent is that a respectable body of medical evidence and critical investigation of options has been excluded from the majority of cases before the court.

In a search for information

We should be seeking information not acting as arbiter of opposing views in these matters. Those familiar with this jurisdiction will know that since *Marion* this area of law has been the subject of heated debate.

Human rights advocates, the disability sector and some counsel have raised concerns about cases before the courts. They variously described their concerns about the speculative nature of evidence, particularly relating to children who have not commenced menstruation, the lack of investigation to establish the real problem, the lack of separate representation for the child, and, if a separate representative is appointed, the illustrated lack of expertise and knowledge. They also query the processes employed by the Court particularly relating to adherence to the rules of evidence and quasi-adversarial procedures, the use of the 'expeditious' hearing rule and decisions being made on first return dates when there is no identifiable need for a 'quick fix' response, and of course the financial costs associated with court action.

Added to this the courtroom setting elicits comments like: '... an attack on the parents as care givers', '... cross-examination and the strong undercurrent of criticism and subtle demotion of their worthiness as care givers'. It 'elicits strong emotional reactions', 'palpable distress', and so on and so forth.¹⁹ If this is a true reflection of these cases then there is cause for serious concern. If costs are added to the concern, will the option of a declaration of lawfulness by the courts simply be rejected by parents and doctors as intrusive and unnecessary? The answer may be diversion into unlawful activity. The current system is clearly not serving to encourage applications and may well be discouraging them.

In a search for the solution

The Family Court, to its everlasting credit, has embraced the need for guidelines and protocols for the conduct of these matters. Attempts have been made proactively to develop co-operative arrangements between key stakeholders as in Queensland and Victoria, to ensure that 'special medical procedures' are responded to appropriately, consistently and in a manner which protects the rights and best interests of the child. The debate continues, however, and becomes increas-

ingly focused on whether legislation is required to prescribe the circumstances in which the Court can authorise the sterilisation of the child.²⁰ Even with legislation and guidelines there remain concerns about the standards of critical investigation and calibre of the evidence presented to the Court. Whatever the preferred option, the outcome must centre on placing the Court in the best possible position to make decisions in the best interests of the child. In practical terms this means ensuring 'quality of evidence' before the Court, complimented by procedures conducive to hearing such evidence. What is also clear is that these cases should never be a matter of contest but should involve the critical investigation of all pertinent issues. The problem is how to ensure the rigorous exploration of the problem. If investigation is limited, all things being equal, a pitched battle may be required to ensure that the interests of the child are protected.

Potential hearing impairments in the legal process

Even though the rules of evidence do not strictly apply in matters involving the welfare of children, by and large the Family Court adheres to them. This has serious implications for the role of the separate representative because it means that the outcome, in each application, depends on the evidence put before the Court. In my discussions with counsel about sterilisation applications, expressions of frustration abound. For example, one said: '... we continue to have to work up elaborate legal argument to get non medical evidence into court in the hope that the presiding judge will give appropriate weight to it ...' Another considered that '... options and alternatives must be investigated and tested prior to hearing ...' Yet another considered that '... the Court is responsible for its decisions and should make more use of its discretionary powers to seek alternative expertise ...' while another expressed frustration about established practices and that '... the Court has not taken on board an inquisitorial role; its only lip service in practice ...'

Lawyers make other troublesome comments such as: '... if the situation continues then agencies should withdraw from court involvement and use valuable resources to secure direct service provision because the court will likely give consent to sterilisation, and agencies would only be viewed as spoilers and frustrators'.²¹

It appears that a major task lies ahead for the child's separate representative. Unless the separate representative critically investigates, the presiding judge will not be afforded the opportunity to consider pertinent issues. Mushins J in *Re A (a child)* (1993) FLC 92:402, a gender reassignment case, noted that problems arise when materials indicating available options or contrary views are not filed for the Court's consideration. The current process of hearing evidence does not necessarily inform the Court about whether investigation of options has occurred or not. The right questions are not always asked. Until such time as they are, it may be necessary for the separate representative to act as a 'contradictor' seeking out contrary opinion, testing assumptions and the calibre of evidence. That is not to suggest that the role ought be obstructionist. It would be preferable that 'testing' is undertaken prior to the hearing, and outcomes filed for the Court's consideration. Primary dispute resolution options may be appropriate forums for a co-operative and open exchange of information, drawing on expertise in the disability area as well as traditional medical opinion.²²

Let all the facts be heard and let justice be seen to be done

If the Court is to deal with the facts then let all the relevant facts be heard. It is generally accepted that the separate representative is deputised by the Court to act as an investigator but in all fairness the separate representative cannot deliver on this expectation in a vacuum. It is not unreasonable to suggest that definition and structure is necessary to operationalise critical investigation. Principles of critical investigation ought to be drafted and rigorously applied. Concepts such as best interests should be defined, if not by legislation, at least by guidelines. Another pervasive need seems to be education about disability for the Court, the separate representative and interested parties. Dialogue and co-operative arrangements are an integral part of an appropriate response and look to the development of a multidisciplinary approach. Nicholson CJ some five years ago saw the value of co-operative arrangements. As already mentioned the Family Court and the Office of the Public Advocate in Victoria developed guidelines for conduct in these matters. The aim was to identify needed services and supports for the child and her family so that the application could be deferred until such time as all issues could be explored, to provide reports which would assist the Court in determination, to avoid a pitched battle, and to keep trauma and costs at a minimum. Guidelines which promote a greater emphasis on prelitigation resolution are operational in Queensland.

Are guidelines and protocols a sufficient condition?

In my view the Court and key stakeholders must give parents every opportunity to participate in an investigation of alternative options and information. If this does not happen then they are unlikely to make an informed decision. This situation has serious ramifications for the legal process particularly given the significant weight the court gives to the wishes of the parents.²³ In these circumstances it seems to me to be incumbent on the court to determine whether or not the wishes of the parents are in fact 'informed' wishes rather than misguided expressions premised on fears or lack of options. Most parents are distressed about the prospects of surgical intervention and if given practical options will opt for less drastic alternatives.

A cautionary conclusion

The appointment of a separate representative will not and can never be all things to all people in these matters. It is churlish to suggest that responsibility for the child's right to be heard lies solely with separate representation. The separate representative plays a major role in applications to do with the welfare of children but in reality it is a bit part entirely dependent on the support and co-operation of a broader community of expertise.

As suggested earlier, any weak link compromises effective outcomes for the child. It is incumbent on all parties to form a view as to the child's welfare based on full and informed evidence obtained through critical investigation of the problem. Critical investigation is dependent on the development and implementation of a set of guiding principles and processes. Principles and processes should not be limited to legal niceties but incorporate the social, economic and political realities of being a vulnerable child whether disabled, abused or enmeshed in family dispute. Principles must be strictly adhered to. In my view, materials before the Court,

and certainly in sterilisation matters, must include documented evidence of the trial of less invasive medical treatments and developmental options. There is, however, a danger in becoming complacent with the introduction of guidelines, and indeed, rules. They should never be viewed as 'hurdles' or 'lip service' to social justice principles like the protection of the interests of children and their rights to be heard in proceedings.

The child's right to be heard is about adequate resourcing and this is not only in the area of training and accreditation of separate representatives. It is fundamental to the resolution of matters relating to vulnerable children that resources also be targeted to the development of multidisciplinary team approaches.

Resource allocation does not rest solely with State departments and service provision but also with the Commonwealth through the adequate funding of representation for children. As suggested above, it takes little intellectual rigour to accommodate a justification for the sterilisation of children if you are predisposed to placing an overriding emphasis on parental burden which is, in reality, a consequence of scarce public resources and concomitant lack of service options.²⁴ This reality reflects a socio-economic problem, not a medical problem and not a legal problem. Invasive surgical interventions need to be called for what they are and what they are not. If the Court's responsiveness to scarce public resources is authorisation of invasive and irreversible surgical intervention then it should be called that rather than 'best interests' and 'last resort' findings for the child at issue.

References

1. This paper concentrates on the sterilisation of girls with intellectual disabilities because most sterilisations are performed on girls and all the litigated cases in the Family Court of Australia involve applications to authorise the sterilisation of girls. This is not to say that boys are not subject to unlawful sterilisation procedures. The unabbreviated and footnoted version of this article is available in the Proceedings of the 29th Australian Legal Convention, Brisbane, September 1995 titled 'The Rights of the Child to be Heard. The Extended Jurisdiction — Potential Hearing Impairments in the Legal Process', pp.101-16.
2. *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.
3. See *Acting Public Advocate for the State of Victoria v GP and KP and Human Rights and Equal Opportunity Commission*, unreported, 17 May 1994, file no. ML 8841/93; and *Re A (a child)* (1993) FLC 92:402.
4. Practice Notice 3/95, 'Draft Guidelines for Special Medical Procedures Involving the Sterilisation of and Other Medical Procedures in Respect of an Intellectually Disabled Child pursuant to Order 23B of the Family Law Rules' between the Family Court of Australia Northern Region, the Queensland Department of Family and Community Services and the Queensland Legal Aid Commission.
5. Family Law Council, *Sterilisation and Other Medical Procedures on Children*, Discussion Paper, Canberra, 1993, pp.13-15.
6. Health Insurance Commission, Government Programs Statistics, July 1995, provided data to the writer for 1993-94 on sterilisation procedures for girls under 18 years. Sterilisation categories include, hysterectomy, ovariectomy, endometrial ablation, laparoscopic sterilisation and tubal ligation.
7. See Kessler, Kreutner, A.K. and Hollingworth (eds) *Adolescent Obstetrics and Gynaecology*, Year Book Medical Publishers Inc., Chicago. This book contains 18 articles indicating the percentage rates of reproductive tract malignancies in female children under 15 years. They are statistically rare.
8. For a discussion of these issues see Brady, S.M., 'The Rights of the Child to be Heard. The Extended Jurisdiction — Potential Hearing Impairments in the Legal Process', Proceedings of the 29th Australian Legal Convention, Brisbane, September 1995, pp.101-16.
9. See Brady, S.M., 'Medical Procedure Cases in the Family Court — The Role of Protocols', forthcoming Proceedings of the Family Court of Australia, 2nd National Conference, 20-23 September 1995; Brady, S.M., 'Law Reform in Ethically Contentious Medical Treatments for

- Children with Intellectual Disabilities', Proceedings, Queensland Intellectual Disability Services Conference 'Building Professional Diversity', 28-30 June 1995, Brisbane.
10. See Brady, S.M. 'The Rights of the Child to be Heard, above, ref. 8.
11. Nishiyama, S., Kuwahara, T. and Matsuda, L., 'Decreased Bone Density in Severely Handicapped Children and Adults with Reference to the Influence of Limited Mobility and Anti Convulsant Medication', (1986) 44 *European Journal of Paediatrics* 457- 63.
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13. See for further discussion Snowden, R. and Christian, B., (1993) 'Patterns and Perceptions of Menstruation', World Health Organisation, Croom Helm, Manuka, Australia; and Melita, B., Bartak, L., Nyberg, E. and Armstrong, J., 'Report to the Minister for Community Services Victoria on Menstrual Suppressants', Intellectual Disability Review Panel, Victoria, 1992.
14. Brookhouser, P., 'Medical Issues', in Garbarino, J., Brookhouser, P.E. and Authier, K. (eds) *Special Children. Special Risks*, De Gruyer, New York 1987; Chamberlain, A., Rauh, K., McGrath, M. and Burkett, R., 'Issues in Fertility Control for Mentally Retarded Female Adolescents: Sexual Activity, Sexual Abuse and Contraception', (1984) 73(4) *Paediatrics* 445-450; Corin, L.S., 'Sexual Assault of the Disabled: A Survey of Human Service Providers' (1984) 7(3-4) *Sexuality and Disability* 110-16; Sobsey, D., Gray, S., Wells, D. Pyper, D. and Reimer-Heck, B., *Disability, Sexuality and Abuse: An Annotated Bibliography*, Paul Brookes, Baltimore, 1991.
15. Hamre-Nietupski, S. and Williams, W., 'Implementation of Selected Sex Education and Social Skills to Severely Handicapped Students' in (1977) 12(4) *Education and Training of the Mentally Retarded* 364-72.
16. Australian Bureau of Statistics (ABS) Population Data No.3201.0 released January 1995 and ABS Welfare Section Unpublished Data sourced 30 June 1995. It is essential that the figures are recognised as only those people within households and does not represent those in institutional or hospital settings. The population as of 30 June 1994 was 17,843,300. The proportion of males at 49.8%. The proportion of females in Australia under 18 years is approximately 25% of the total being 2,238,200. A survey was conducted listing 17 criteria to distinguish disability and a single criteria 'Slow Learning' which can constitute developmental delay was screened. It was conceded that this criteria would identify about 50% of the intellectually disabled population. The national total of people categorised as slow learners is 139,900 of which 61,500 are female. Crudely this constitutes approximately 19,800 females under the age of 18 years.
17. Figures from the Victorian Office of the Public Advocate since 1987 note 132 sterilisation applications, 20 termination applications and 40 cases involving protective services and foster care/adoption issues. Note that these figures include not just women with intellectual disabilities but other statutory disabilities like mental illness. Many of the sterilisations will also represent women who are beyond child bearing age and the primary issue is gynaecological health because of disease or malfunction. In Queensland, data is not available but anecdotal information from the Office of the Legal Friend notes that there have been in the past seven years approximately 30 sterilisations requests, two being male and two termination requests.
18. For a discussion of involuntary sterilisation and eugenics see Cepko, Roberta, 'Involuntary Sterilisation of Mentally Disabled Women' in (1993) 8 *Berkeley Women's Law Journal* 122-65.
19. See *Re a Teenager* (1988) 94 FLR 181 particularly Cook J's judgment.
20. Family Law Council, above.
21. See Brady, S.M., above, ref. 8, pp.108-9.
22. See for an example Practice Notice 3/95, 'Draft Guidelines for Special Medical Procedures Involving the Sterilisation of and Other Medical Procedures in Respect of an Intellectually Disabled Child pursuant to Order 23B of the Family Law Rules' between the Family Court of Australia Northern Region, the Queensland Department of Family and Community Services and the Queensland Legal Aid Commission.
23. The High Court in *Marion's case* 1992, said that the best interests of the child will ordinarily coincide with the wishes of the parents.
24. See for a discussion of sterilisation *Re Eve* (1986) 2 RCS 31 DLR (4th) 1, Supreme Court of Canada where the Court held that as it can never safely be determined that non-therapeutic sterilisation is for the benefit of the intellectually disabled person, the Court should never authorise a non-therapeutic sterilisation of such a person under its *parens patriae* jurisdiction.