Immunisation: Medical, Social and Legal Consequences

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His personal commitment to strengthening the ties between Medicine and the Law continues, particularly as his wife is a consultant at St Vincent's Hospital in Darlinghurst.

Introduction

Dominic and I decided a couple of days ago that we would break up the topics by deleting medical for me, and, bearing in mind lawyers' well known inability to socialise, we got rid of social issues for me as well. So I am talking about the legal consequences involved in immunisation.

While listening to Dominic, I thought that I should perhaps have considered the legal consequences of immunisation's adverse side-effects as well, but I am not going to cover that at all. Malfeasance has been covered elsewhere at other times and has probably been done to death in other places. I am just going to talk about immunisation and, specifically, the legal consequences involved in getting people to immunise their children.

Non-mandatory

Immunisation is not mandated in Australia; it is encouraged. I had cause to look at the website on this area for this talk and realized – and I have to let my wife know – that we get a maternity immunisation allowance. There are a whole lot of eligibility requirements and everything like that. The difficulty with it is – here are just a few of the criteria that you need to tick before you start getting this allowance – and it is probably only $100 or something.

- Maternity Immunisation Allowance is a non-income tested payment to encourage parents to immunise their children.
- If you received Baby Bonus for your child, the Family Assistance Office will automatically check your eligibility for Maternity Immunisation Allowance.
- If you were not paid Baby Bonus, you will need to claim Maternity Immunisation Allowance through the Family Assistance Office on or before the child's second birthday to receive the first amount and on or before the child's fifth birthday to receive the second amount.
- You can claim Maternity Immunisation Allowance for children who are adopted from outside Australia and who enter Australia before they are 16 years of age.
- If your child was adopted from outside Australia, you will need to claim on or before your child's fifth birthday or within two years of their arrival in Australia (whichever is later).

I don't know, but this is just the first page of requirements before you can get it. So you can understand that while the government might encourage these things, they don't make it easy. For anyone thinking, "I wonder if I am up for another baby bonus"?, that, apparently, is the key. If you got the baby bonus the first time around, you don't need to register for this allowance. Otherwise, go onto the web site, have a look and battle your way through that.

So immunisation is encouraged, but not mandated in Australia, except at some schools. I don't know if it is just because of the education we have chosen for our children, but we have to turn up with certificates of their immunisation status and we get reminders from the school for a recast of their immunisation sheets. This is probably good for the herd mentality at that school, but not of course in the broad community.

Who decides whether or not the child is to be immunised?

So who is making the decisions in relation to immunisation? Of course, a child can't make decisions for themselves. Obviously a young child in hospital can't make a decision, but when does a child become capable of consenting? There are not a lot of children out there – even 18-year-olds, I would assume – wouldn't say, "Gee whiz, I can't wait to have another immunisation." We have encouraged it in our children at least because they get some sort of chocolate festival afterwards and they are constantly asking to go to the doctor for another injection.

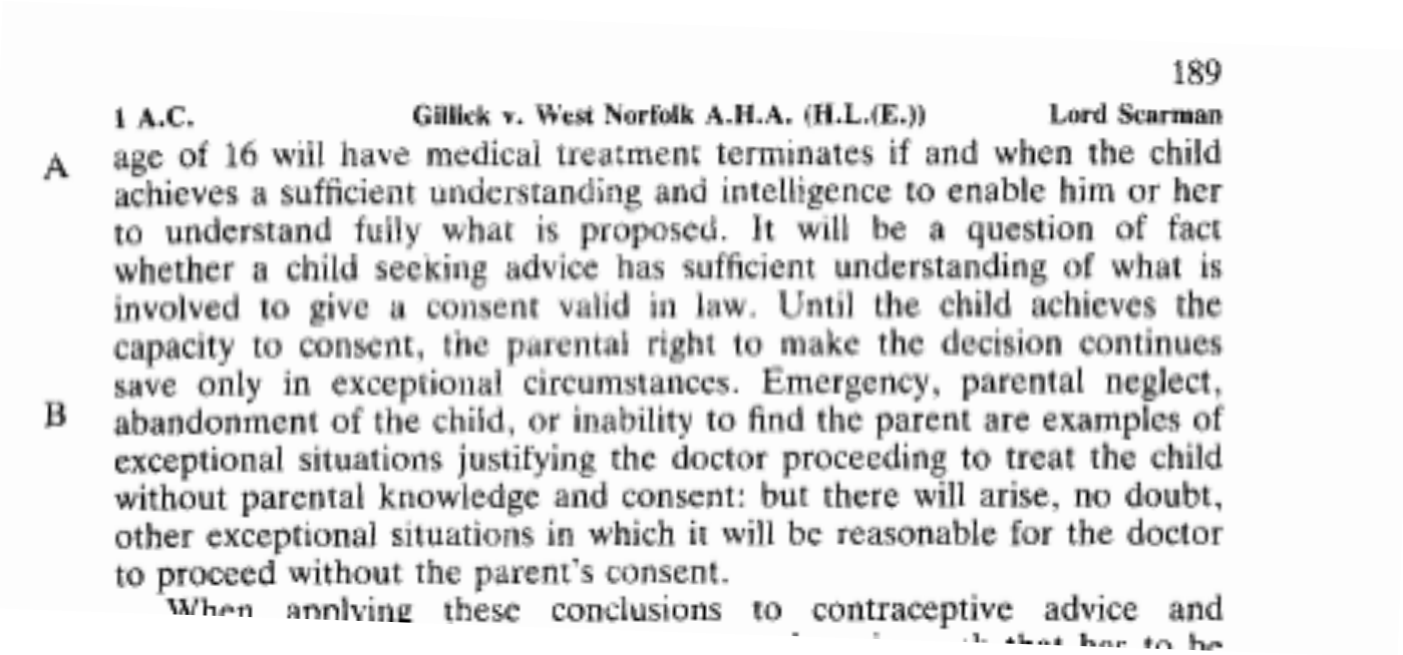
My second point is, I suppose, the most important one. Where a child is incapable of consenting, the question becomes, "Is the proposed treatment within the scope of the parent's ability to lawfully consent to the procedure?" In Australia, 95-97% of parents tend to say, "Of course I am going to take them off to the doctor to get them immunized." But I thought that we should just have a quick look at when does a child become competent to make medical decisions, because this has an effect on the medical decisions being made on that child's behalf by their parent.

The competent child

The competent child is not an age-based concept. It comes from what is known as the Gillick competency, an English case from the 1980s and it appears well into the judgment. Isn't it amazing that it took 77 pages for a bunch of lawyers to describe when a child becomes competent – but that is the nature of the beast. This is the sentence they came up with in Gillick:

> "A child becomes competent when the child achieves sufficient understanding and intelligence to enable him or her to understand what is proposed."

It shouldn't have taken 77 pages to get there.



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1 A.C. Gillick v. West Norfolk A.H.A. (H.L.(E.)) Lord Scarman

A age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect,

B abandonment of the child, or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent: but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parent's consent.

When applying these conclusions to contraceptive advice and

There would be people in this audience who would have those doubts about some of their adult patients as well. The elderly, the infirm, I suppose, generation-wide generally, you would have to worry about some people ever gaining competence at all.

We get down to this then: "Can parents consent to the proposed treatment?" (Never again worry about a lawyer's ability to complicate matters if they possibly can.) It is now in the Family Law Act – that would be the obvious place to look – which says that parents have parental responsibility for their children. It gets more complicated because section 61B of the Family Law Act defines parental responsibility as being "all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children". Again, statements of the bleeding obvious you might think, but that is what the Family Law Act says.

Can parents consent?

Can parents consent to proposed treatments? I thought that, before we got onto vaccinations, we should look at cases in relation to people's treatment of their children, or at least the proposed medical treatment of their children.

Marion's case was probably the seminal case in Australia dealing with this exact issue. Marion was pseudonym for a teenager who was 14-years-old at the time. She suffered from what they called then 'mental retardation'. The court did a good paragraph discussing whether 'mental retardation' was a good term to use, although, as they said, it was used in the Family Court, so therefore they would use it, but reluctantly. Their preferred use was 'intellectual disability'. This child was intellectually disabled – she had severe deafness, epilepsy, gait disorders and behavioural problems. They weren't specified in the judgment. Her parents, who were from the Northern Territory, at least they were living in the Northern Territory, applied to the Family Court for an order authorising the performance of a sterilisation procedure for her, or alternatively a declaration that it was lawful for it to be done.

They were doing this because the law treats as unlawful, both criminally and civilly, conduct which constitutes an assault or trespass to the person. Of course, you can imagine that, looking at the sterilisation of a child, it is a major trespass of the person. The court considered the matter and said that it was possible for a court to consent to authorise a form of sterilisation procedure.

But never again believe that a lawyer would not try to create a second case where there was a good one to be had. The High Court remitted the case back down to the Family Court to decide whether or not the order should be made in this particular case, giving rise to Marion's Case No. 2. In that case, a whole lot of conditions came up – very sensible ones about very much the sort of things that Dominic was talking about – that ordinary people think about when they are going to engage in medical treatment, and the parents could make that decision on behalf of the child.

a. the particular condition of the child which requires the treatment
b. the nature of the proposed treatment.
c. the reasons for the proposed treatment.
d. the available, alternative treatments.
e. the desirability and effect of authorising the proposed treatment rather than the available alternatives.
f. the physical effects of the child and the psychological and social implications for the child of (i) authorising the proposed treatment (ii) not authorising the treatment.
g. the nature and degree of any risk to the child arising from authorising or not authorising the proposed treatment.
h. any views expressed by the parents, other carers or the child about the proposed treatment and the alternative treatments.

There is another case of In Re Jane. These are all pseudonyms, of course. There are a whole lot of cases out there, there is Thomas's, there is James, and the names at this stage are getting, as you would imagine, quite spectacular as we move through into the 21st Century with the names that have been chosen. It seems to me that although they are pseudonyms, people are trying to outdo themselves with their pseudonyms. There was a case recently that was boringly called Thomas and it was an important case, but perhaps no-one reads it because of the name.

Immunisation is different

Immunisation is in a different category from these sorts of cases. Jane was again a sterilisation case. Before we go there, and bear in mind that these people are wanting to invade the sanctity of their child's body to perform the sterilisation, I pose the question: "What is the role of the medical practitioner in all of this?" Section 175 of the Children and Young Persons (Care and Protection) Act 1998 provides that a person "must not carry out special medical treatment on a child otherwise than in accordance with this section".

Special medical treatment includes:

> "Any medical treatment that involves an experimental procedure that does not conform to" a document which is put out by the NHMRC.

It seems to me that all the vaccinations currently wandering around would not be 'special medical treatment'. However, regarding those heading into view (Dominic mentioned about 15 coming on stream soon), if people are reacting badly – in a social sense – to vaccinations at the moment, how are they going to react to more vaccinations in the future? Is that going to be seen to be 'special medical treatment'?

The doctor's responsibility

Of course there is something which helps concentrate the mind for medical practitioners at this point: if they get it wrong, they are liable for seven years' imprisonment. The whole idea then is that a doctor, when confronted with parents coming to them – and this is obviously not a situation with most vaccinations – and say, "I would like this done to my child", they need to consider their position very carefully.

What happens if the doctor wants to do something and the parents won't let the doctor do so? That gives rise to cases which rarely have to do with vaccination. The parent has a liability in criminal law for doing things to their child in a positive sense, but they also have other liabilities in tort law. I am not going to talk about that in any great detail because it has been talked to death, but there are also now 'care and protection proceedings' and offences which can be brought. 'Care and protection' is an expanding area of law. There are whole fleets of barristers heading off to court in care and protection matters. The Department of Community Services takes children, tries to take children, tries to have children treated in certain ways and tries to protect itself from criticism in the popular media in relation to children at risk. That potentially includes children whose parents are refusing to permit treatment.

Criminal remedies?

Are there remedies before it is too late? Before I go there, I should talk in terms of the criminal law. You will all remember the 2009 manslaughter case in the Supreme Court where a homeopath and his wife refused to treat their daughter who had eczema. She developed eczema at about the age of three months and ended up dying at the age of nine months. They chose to treat her with homeopathic treatments which did not work and she died.

They were charged with manslaughter. They were convicted effectively on the basis of such a gross falling short of the standards that one could expect of a parent that it was worthy of criminal sanction. That case was reviewed in the Court of Criminal Appeal in March this year, and the convictions and sentences were confirmed. The mother got a lesser sentence. She is doing six years, with a minimum of four, and the father is doing a minimum of six years out of eight and a half years. So there is a jurisdiction to supervise the delinquent parent.

Civil remedies?

There is also the civil jurisdiction to supervise the delinquent parent. Re Paul this is one of the named cases. The child in this particular case had a neuroblastoma. The parents, Jehovah's Witnesses, were reluctant to allow a transfusion. The doctor was unwilling to continue treatment, which was chemotherapy, in circumstances where, if the child's blood crashed, he would not be able to immediately transfuse the child and save his life. So, right at the beginning of the treatment he, separate from the parents, approached the Supreme Court through DoCS to get an order authorising him to do what the parents would not authorise. He got the order. This particular jurisdiction is called *parens patriae* jurisdiction.

> 1 His Honour: This is an application in effect to substitute the consent of the Court for the consent of the parents of a child to the administration of medical treatment by way of blood transfusion. The child is a boy aged just over one who has been diagnosed with an unresectable abdominal neuroblastoma. The parents' refusal or reluctance to consent to treatment by blood transfusion arises from their faith as Jehovah's Witnesses. I should make it clear at once that it is

plain on the evidence that they are caring parents. Part of the evidence of this is the fact that they have been willing, indeed anxious, to cooperate with the child's medical advisers concerning all aspects of his potential treatment apart from their reluctance in relation to transfusions.

7 I do not need to go into details. Dr Stevens has given evidence that if the chemotherapy treatment which is proposed depresses various elements in the child's blood to dangerous degrees, the situation will need to be remedied by a transfusion, in the absence of which the condition would be life threatening. It is true that Dr Stevens has indicated that in the case of juvenile chemotherapy patients it is not in all cases that transfusion becomes necessary. However, there is a better than even chance in his opinion that treatment by transfusion will be necessary. Upon that evidence, if the parents will not give consent, then the Court should and will.

11 In this case, as I have already said, the parents have cooperated with the hospital authorities in relation to treatment except in this one regard. Furthermore, the mother gave oral evidence before me in which, moved to tears, she said that, if a Court order giving consent were made and the parents were required to bring the child to hospital for a transfusion to be administered, they would bring the child for that purpose, because they must obey the law. In the face of that very different attitude of these parents, I believe that an order for wardship is unnecessary. I further believe that the making of an order for wardship at this stage would be an unnecessary affront to parents whose attitude as shown in evidence I have set out above.

There have been quite a few judgments in the last few years in this particular area. The parents in this particular case were co-operative in that they allowed the proceedings to proceed without objection. They said to the judge, "You decide; if you think it is good for our child, authorise it and we will make sure the child gets to hospital and do all things necessary. We have our beliefs but we are not prepared to act unlawfully in relation to our children", which was a very noble thing for them to do.

Unco-operative parents

There are other cases, unfortunately, where the parents have not acted so well. In the case of Re Jules, I will show you this chronology.

Date	Event
19 August 2008	Date of birth (mother Hep B carrier)
21 August 2008	DOCS approached Barrett J (duty judge) seeking orders to administer Hep B vaccine, Vitamin K injection, monitor blood glucose levels – parents ordered to present child to hospital for treatment by 11.59pm on 21 August (failing which DOCS could take custody of the child)
22 August 2008	DOCS approached Brereton J as duty judge seeking orders in relation to authorising police assistance in taking custody of "Jules" for Hep B vaccine – orders made
25 August 2008	Parents did not appear. Child had not been found. Adjourned to the next date.
26 August 2008	DOCS sought dissolution of recovery order and order authorising Hep B vaccination on grounds that medical evidence did not support any continued benefit after 7 days of age. DOCS also sought to have interim wardship and parenting orders removed – not granted.
15 September 2008	Matter returned to court – Jules's parents appeared. Child had been medically examined; parents agreed to Hep B screening at 1yo. Wardship orders vacated ("not without reservation"). Not prosecuted for contempt – apologised to court, didn't understand the gravity, difficulties in proving notice of proceedings

It shows you how quickly the law can respond. A child was born on 19 August 2008. Two days later, the Department of Community Services approached the duty judge in the Supreme Court, seeking orders to administer the Hepatitis-B vaccine via an injection, and to monitor the blood glucose levels, because the mother was Hepatitis-B positive.

The medical view is that the vaccination has to be administered within seven days of birth in order to be effective. The parents were ordered to present the child for treatment by midnight that night – of course, we are up to day 2 at this stage – failing which, DoCS could take custody of the child. The next day DoCS went back to the Supreme Court, reported that the child had not been presented. His Honour Justice Brereton, whom I recall as a barrister once giving a talk in this forum a long time ago, as duty judge, made orders authorising the police to look for Jules and his parents, take them all into custody, then to hospital and to make sure that Jules was treated.

The parents apparently went to ground. By 25 August, six days after the birth, as the parents had not appeared, the case was back on again in court, the child hadn't been found and court was adjourned to the next day to keep trying. On 26 August, DoCS effectively surrendered and sought and received dissolution of all the orders, because there was no longer any point having this vaccination done.

The next month, the matter returned to court. Jules' parents appeared this time. The child had been medically examined. The parents had agreed to Hepatitis B screening at one-year-old. The child had been made a ward of the court, because his Honour had been so concerned that the parents were so delinquent in his opinion that he made the child a ward of the court. He considered prosecuting or whether a prosecution should be laid against the parents for contempt. They had apparently apologised profusely to the court on 15 September, “We didn't understand the gravity of it all”, and there was an underlying element of not being able to prove that the parents had ever received the orders in the first place.

You have got a very busy month for the government lawyers in this case, running over four weeks but in particular in those first seven days. It shows that a court is, in the right circumstances, willing to order the vaccination of a child. It is recent law and, as I said, it is a developing area of jurisdiction in the Supreme Court, but the court will do it.

Are doctors obliged to report?

What can be drawn from it? Is there an obligation by doctors to report? Arguably, yes. There is a provision in the Care and Protection Act which says doctors observing something wrong have a duty to report it. I don't know that it goes to the extent of reporting a failure to vaccinate ordinarily. However, if there were a failure to vaccinate in relation to Hepatitis-B, where you knew the mother was Hepatitis-B positive, I suggest that there would be a duty on the doctor. The Supreme Court does have jurisdiction to intervene, but is the court likely to do so in the other vaccination cases, bearing in mind the size of the population and treatment terms?

The National Immunisation Program Schedule

This is the National Immunisation Program Schedule. These are just those vaccinations to be done before you turn 18. Some of them are specific to women, some are specific to the indigenous population, but most of them are applicable to all children.

You can imagine if you wanted the court to start supervising the immunisation of people for all these things where people were taking conscientious objection to being immunised. We would have a very successful Phillip Street, with barristers constantly running up to court, we need this M and R and we need it now, your Honour, right now, says DoCS.

Of course it is not going to happen. It is not obviously going to happen because of the lack of resources and it is probably not going to happen because there is not the public will for it to happen. I wonder if that will change if we start getting epidemics of the sort Dominic spoke about. I think that the important thing to remember is that for the extreme cases, yes, I would suggest that there is an obligation on a medical practitioner to report; and there is, in the right circumstances, a jurisdiction for the court to step

into the shoes of the parents, to consent and to make it happen, to send the police out to arrest the child to make it happen. It is amazing the range of work expected of a police officer.

National Immunisation Program Schedule

(VALID FROM 1 JULY 2007)

Age	Vaccine
Birth	• Hepatitis B (hepB) [a]
2 months	• Hepatitis B (hepB) [b] • Diphtheria, tetanus and acellular pertussis (DTPa) • *Haemophilus influenzae type b (Hib)* [c,d] • Inactivated poliomyelitis (IPV) • Pneumococcal conjugate (7vPCV) • Rotavirus
4 months	• Hepatitis B (hepB) [b] • Diphtheria, tetanus and acellular pertussis (DTPa) • *Haemophilus influenzae type b (Hib)* [c,d] • Inactivated poliomyelitis (IPV) • Pneumococcal conjugate (7vPCV) • Rotavirus
6 months	• Hepatitis B (hepB) [b] • Diphtheria, tetanus and acellular pertussis (DTPa) • *Haemophilus influenzae type b (Hib)* [c] • Inactivated poliomyelitis (IPV) • Pneumococcal conjugate (7vPCV) [e] • Rotavirus [i]
12 months	• Hepatitis B (hepB) [b] • *Haemophilus influenzae type b (Hib)* [d] • Measles, mumps and rubella (MMR) • Meningococcal C (MenCCV)
12-24 months	• Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas) [f]
18 months	• Varicella (VZV)
18-24 months	• Pneumococcal polysaccharide (23vPPV) (Aboriginal and Torres Strait Islander children in high risk areas) [g] • Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)
4 years	• Diphtheria, tetanus and acellular pertussis (DTPa) • Measles, mumps and rubella (MMR) • Inactivated poliomyelitis (IPV)
10-13 years [h]	• Hepatitis B (hepB) • Varicella (VZV)
12-13 years [i]	• Human Papillomavirus (HPV)
15-17 years [i]	• Diphtheria, tetanus and acellular pertussis (dTpa)