SUBMISSION TO INQUIRY INTO MATTERS RELATING TO DONOR CONCEPTION INFORMATION

Stephen Page

April 2022

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Directors:
Stephen Page Acc. Spec. (Fam)
Bruce Provan Acc. Spec. (Fam)

Level 22
69 Ann Street
Brisbane Qld 4003

All Correspondence to:
PO Box 12135
George Street Qld 4003

Page Provan Pty Limited
ACN 634 100 566
ABN 94 634 100 566

Telephone: (07) 3221 9751
admin@pageprovan.com.au
www.pageprovan.com.au

22 April 2022

Committee Secretary
Legal Affairs and Safety Committee
Parliament House
George Street
Brisbane Qld 4000

By email: lasc@parliament.qld.gov.au

Dear Secretary

SUBMISSION TO INQUIRY INTO MATTERS RELATING TO DONOR CONCEPTION INFORMATION

I am making this submission on my own behalf. What is stated in this submission are my views, not those of others. I am a lawyer who specialises in this field. I have been described by the Queensland Law Society as being[1]: ***"leading Queensland and internationally renowned surrogacy solicitor."*** I have set out my details briefly at the end of this submission. It is a welcome move that this Inquiry is taking place, 42 years after the commencement of IVF in Australia, and longer than that in respect of sperm donation.

Anonymity

I want to start with the concept of anonymity.

Anonymity with genetic donation is dead. When anonymity once existed, it exists no longer. The current regulation of "anonymous" donation, in place since 2004, is probably better described as it is by my US colleagues as open identity donation, i.e, after the child turns 18 the donor conceived adult has the choice of finding out the identity of the donor.

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[1] https://www.qlsproctor.com.au/2020/11/surrogacy-law-leader-named-inaugural-pride-in-law-award-recipient/ .

However, the rise of technology in other spheres means that anonymity is dead. This has happened in four ways:

- Databases of DNA such as www.ancestry.com and www.23andme.com have vast troves of data, enabling individuals to track down their genetic history. Whether it is wise for them to do so is beside the point- the fact is that this data is there now, and is being used by the parents or donor conceived adults to track down the donors- sometimes before the children turn 18.

- IVF clinics often provide photos of their prospective donors. As clients of mine have told me, a Google image search will quickly turn up the identity of the donor. As an exercise to test this idea, I used my Linkedin profile[2] picture, and underwent a Google image search[3]. I am glad to say that I am not Rolf Martin Schmitz, a German company director, whom Google identified me as, nor Abhijeet Jhala, a manager at Luna Park, who was also on the first page. However, Google located an image of me on its first page from *Lawyers Weekly* when I was a judge of the Champions of Pride 2021 Award[4].

- Social media- as happened when Natalie Parker donated an embryo, to be told by the Sydney clinic that the recipient patient had lost her pregnancy. It seems that is what the clinic was told by the recipient. There is no criticism of the clinic concerned, which acted properly throughout. Natalie Parker realised something was awry when she saw pictures of the baby on Facebook and noted the uncanny resemblance to her child[5].[6]

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[2] https://www.linkedin.com/in/stephenpagelawyer/ .

[3] On 13 April 2022. https://www.google.com/search?tbs=sbi:AMhZZis7ieemn1b13ISelzmfeIyyx8qdZDdWVHoCvBGPc4hkHUG8WxAVFhCa4dAhKoZfnq5L7KeVK7xprthyvbKjiH8GGPicmoRUJC-DpTrw8SluRIL8HurNgq87cjaaOLdcWW0suDMrDTAgceZubHfiC4dgpa0K1VQhUxByUexqdp2oAbidCC_1DO0cUy7UX0gX_191uwzZTUFN0jy6iUg_1F8eobjS0EoMG6f5Dv1imR6nDfTxVwe_1w1ekzEe7Idx2jLM-5UQqtydQCfaZfRo3EUzwT_1A1TPi4q2mFy10ym6YqCmt42ly2SL9D4u9VNvcKiwY9mqWy0tFqD7t7KsGXjStT0jl5OnXqA&hl=en-AU

[4] https://www.lawyersweekly.com.au/champions-of-pride/resources/methodology-and-judging

[5] https://www.smh.com.au/national/embryo-donor-mum-upset-by-claims-of-lost-pregnancy-20160401-gnwl99.html

[6] The story prompted changes to the law in NSW, which in my view have done nothing to solve the problem which was identified- namely the honesty or otherwise of the recipient. The changes, by increasing complexity in donor laws in NSW, instead have brought confusion to IVF clinics, and cost by the need to obtain legal advice as well as ongoing, extra compliance issues.

- In regional areas, despite the cap on the number of families[7] that donors can donate to, I have heard reports of lookalike children- one being the child of a gay father, and the other belonging to a lesbian couple, where the gay father had also been a sperm donor at the local IVF clinic.

If retrospective laws are passed to remove the anonymity of donors (which I support), it should not be assumed that the early records (kept about 40 years ago) will exist or are accurate. Donor conceived adults may find that despite the best will in the world on the part of Parliament and clinics, and despite the availability of DNA databases that they do not ultimately find the person who was their donor.

I have every confidence that the records since 2011 are accurate[8] (and likely from 2004[9]),)- but they reveal ultimately the identity of the donor.

All of us have a right to know where we have come from. On current figures, about 1 in 20 babies born in Australia are born through some form of assisted reproductive treatment[10] (or to put it another way, one child in every schoolroom). About 5% of the children born through ART will have been born from donor gametes or embryos[11]. One cannot begin to imagine the pain of those who wonder where they came from- and are told that they can never find out.

I ask that if the Committee's recommendations are to remove anonymity retrospectively, that the Government does this sensitively, by writing to the parents and donors *first*. I received a number of reports from IVF clinics that after Victoria removed anonymity that Victorian authorities wrote to the donor conceived children first. Many of their parents had not told them that they had been conceived from donors- and they were denied the ability to explain to their children before their children found out from the Government.

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[7] Under the NHMRC *Ethical Guidelines*, this is a reasonable number. The common practice of Queensland IVF clinics is 10 families, including that of the donor. A lesbian couple who each is seeking sperm to reproduce will be counted as one family.

[8] Following reaction to the Senate inquiry described below.

[9] When the current rules about open identity donation commenced, commencing with the NHMRC *Ethical Guidelines* 2004 version.

[10] Calculated from the number of births per year as reported by the Australian and New Zealand Assisted Reproductive Database (ANZARD) most recent annual report (2019), p.34 (16,639) divided by the number of births in Australia calculated by the Australian Bureau of Statistics for the same year (306,200) so that there is a true comparison, or 5.4% born through ART.

[11] ANZARD reports that the number of births nationwide arising from embryo or gamete donation in 2019 was 837, or 5% of births for children from assisted reproductive treatment in IVF clinics, or approximately 0.3% of all births. This figure does not include at home donor inseminations or at home traditional surrogacy.

Contrasting issues of retrospectivity

Some years ago, I spoke at a seminar to fellow lawyers about fertility law issues, including how Victoria had become the first place in the world to remove anonymity retrospectively. I said that it was likely only a question of time before this change came to Queensland- advocates for donor conceived individuals want transparency.

Afterwards, I was approached by two colleagues, both men.

The first colleague had been born almost 40 years ago, a year apart from his sister. They had learnt many years afterwards from their mum and dad that a sperm donor was their genetic father. They had approached the Queensland clinic involved, which had advised that the identity of the sperm donor was anonymous- and could not be released.

They then did their own searches- using the DNA databases- and discovered that they did not have the same sperm donor. It seems his DNA connection was with a family that had the same surname as the treating doctor- who had since died.

He was very hopeful that the laws would change in Queensland so that he could find out the truth of where he came from. I warned him that I had been told that the old records were often unreliable- or had been destroyed. While the law may change, he may not get closure.

The second colleague, who was approaching 50, spoke strongly about his concerns about how “these men” had signed contracts where they were anonymous: “contracts are contracts” and now there was a proposal to retrospectively change the law- which was a terrible idea- because “these men” had been promised anonymity, but now it was being removed from them.

The more he spoke, the more I had the impression that he was a sperm donor- and was fearful of being contacted by a child born from his sperm.

The Facebook contact

Some while ago a client saw me. He had been a sperm donor- when to donate was anonymous in Queensland, i.e., before 2004. One day he had been looking at his phone when he had received a third party message on Facebook from someone he did not know. Without opening it (and therefore revealing his Facebook identity to the sender) he was able to see the message and picture. The message was from a lesbian couple: “this is your son”. He didn’t know how they had found him- but was certain that the IVF clinic had leaked. He was especially concerned about how he would explain matters to his daughter- who was about the same age.

I said that there were three possible ways:

1. The clinic had leaked. My experience was that IVF clinics jealously guard privacy data, and are very concerned not to breach their licence requirements with the Fertility Society, nor to end up on the front page of *The Courier-Mail*- for all the wrong reasons. I doubted this was the cause.
2. Someone had done a search with ancestry.com or 23andme.com.
3. There had been some connection in person or via social media (as I have described above).

He was certain the clinic had leaked. I referred him to a fertility counsellor – who greatly assisted him in dealing with the implications of what had occurred[12].

As it turns out, the answer was option 2: his mother had done an ancestry.com test. The couple had done a subsequent test- and were able to positively identify him from that.

Current overview of regulation

There is a thicket of regulation in Queensland of IVF and egg, sperm and embryo donation. This is contained in both federal and state regulation.

IVF clinics in Queensland, in addition to being regulated as medical practitioners and medical clinics, including through Medicare, are regulated under a Commonwealth/State scheme by which in effect the regulation is left in the hands of two bodies:

- National Health and Medical Research Council

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[12] And I would encourage anyone affected to speak with an ANZICA (Australian and New Zealand Infertility Counsellors Association) counsellor. They are highly trained and empathic.

- Fertility Society of Australia and New Zealand Limited (“Fertility Society”)

This regulation is achieved by requiring all IVF clinics to be accredited by the Fertility Society, which in turn mandates that IVF clinics must comply with *Ethical Guidelines*[13] issued by the NHMRC and other requirements, such as quality control and being audited by the Fertility Society’s Reproductive Technology Accreditation Committee (“RTAC”). The *Ethical Guidelines* are not law, and are therefore subject to contrary Commonwealth, State or Territory laws. The *Ethical Guidelines* act in effect as licensing conditions- so that a breach of the *Ethical Guidelines* is a breach of the licence. They are therefore a powerful tool in the hands of regulators.

One might think on reading the term that if they are called *Ethical Guidelines* that they are somehow brief and not proscriptive, and that compliance is optional. Reading their 134 pages[14] makes plain that they are lengthy, and that in many ways they are proscriptive. As seen below, compliance is required, and the results of non-compliance could be loss of the licence, by far the most valuable asset the clinic owns.

In order to be able to operate an IVF clinic in Queensland, an owner must obtain accreditation from the Fertility Society. If the clinic wishes to undertake research, then a licence from the NHMRC is required too. In order to be able to retain accreditation from the Fertility Society, an IVF clinic must comply with the Fertility Society’s *Code of Practice*[15]. This in turn demands compliance with audits, quality issues and compliance with the Ethical Guidelines[16].

IVF clinics also must meet ISO qualifications and NATA requirements to operate their laboratories. They are subject to extensive audit and compliance as a result, as would be expected.

It is an offence under both Commonwealth[17] and Queensland[18] law to use an embryo that is not an excess ART embryo, unless that use is carried out by an accredited ART centre. It is an

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[13] National Health and Medical Research Council, *Ethical Guidelines on the use of assisted reproductive technology in clinical practice and research*, 2017.

[14] They can be found here: https://www.nhmrc.gov.au/art .

[15] Fertility Society of Australia and New Zealand, *Code of Practice for Assisted Reproductive Technology Units*, revised October 2021.

[16] *Code of Practice*, 1.3(h).

[17] *Research Involving Human Embryos Act 2002* (Cth), s.11.

[18] *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* (Qld), s.24.

offence under both Commonwealth[19] and Queensland[20] law to use an excess ART embryo unless a licence has been obtained from the NHMRC for research, or use is by an *accredited ART centre*.

Accredited ART centre is defined in section 8 of the *Research Involving Human Embryos Act 2002* (Cth) as meaning:

> *"a person or body accredited to carry out assisted reproductive technology by:*
>
> *(a) the Reproductive Technology Accreditation Committee of the Fertility Society of Australia; or*
>
> *(b) if the regulations prescribe another body or other bodies in addition to, or instead of, the body mentioned in paragraph (a)--that other body or any of those other bodies, as the case requires."*

There is no other body that is otherwise prescribed by regulation. In 2021 the Fertility Society changed its name from the Fertility Society of Australia Limited to the Fertility Society of Australia and New Zealand Limited.

Accredited ART centre is defined in section 21 of the *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003 (Qld)* as meaning:

> *"an entity accredited to carry out assisted reproductive technology by an entity prescribed under a regulation."*

Regulation 2 of the *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Regulation 2015* (Qld) provides:

> *"For the Act , section 21 , definition*
> ***"accredited ART centre"*** *, the Reproductive Technology Accreditation Committee of the Fertility Society of Australia ACN 006 214 115 is a prescribed entity."*

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[19] *Research Involving Human Embryos Act 2002* (Cth), s.10.

[20] *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* (Qld), s.23.

Whilst the Fertility Society's name has changed since the regulation was made, its ACN has not. It would be good for completeness to update the regulation to now refer to the Fertility Society of Australia and New Zealand Limited ACN 006 214 115.

Why there is a Commonwealth/State scheme is simple. The scheme provides universal regulation of IVF clinics in Australia. The Commonwealth's constitutional remit is limited. If for example an individual or a trust operated an IVF clinic in Queensland, then Commonwealth law may not apply. The Commonwealth has clearly intended that the State laws apply concurrently[21]. The scheme arose from an agreement at COAG in April 2002[22].

Under a related Commonwealth[23]/State[24] scheme, all donors of genetic material must be altruistic, with the maximum penalty for a breach of 15 years imprisonment.

A States and Territories scheme regulates the use of human tissue[25], which also requires the donation to be altruistic. It is clear in Queensland that this human tissue regulation applies to egg, sperm and embryo donors- and that the donation must be altruistic[26].

Queensland also regulates altruistic surrogacy, including traditional surrogacy[27] (where the surrogate is the genetic mother) and prohibits commercial surrogacy under the *Surrogacy Act 2010* (Qld).

Table 1: Regulation of IVF clinics in Queensland

Source of regulation	**Law/regulation**
Commonwealth	- *Research Involving Human Embryos Act 2002*

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[21] *Research Involving Human Embryos Act 2002* (Cth), s.42; *Research Involving Human Embryos (Corresponding State Law – QLD) Declaration 2018* (Cth).
[22] Senate Standing Committee of Legal and Constitutional Affairs, Regulation of donor conception practices,
[23] *Prohibition of Human Cloning for Reproduction Act 2002* (Cth), s.21 (offence), s.24 (allowing the operation of concurrent State laws).

[24] *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* (Qld), s.17.

[25] In Queensland, the legislation is the *Transplantation and Anatomy Act 1979* (Qld). Confusingly, the legislation interstate is either that name or the *Human Tissue Act*, or in the case of Western Australia, the *Human Tissue and Transplant Act 1982* (WA).
[26] Definition of *tissue* in section 4, unauthorised buying of tissue: s.40, unauthorised selling of tissue: s.42, and that *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* (Qld), s.17 has primacy as to human eggs, sperm and embryos: *Transplantation and Anatomy Act 1979* (Qld), s.44A.
[27] S.6(2)(b).

	• *Research Involving Human Embryos (Corresponding State Law – QLD) Declaration 2018* • *Prohibition of Human Cloning for Reproduction Act 2002*
Queensland	• *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* • *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Regulation 2015* • *Surrogacy Act 2010* • *Transplantation and Anatomy Act 1979* • *Transplantation and Anatomy Regulation 2017*
NHMRC/Fertility Society	• National Health and Medical Research Council, *Ethical Guidelines on the use of assisted reproductive technology in clinical practice and research*, 2017 • Fertility Society of Australia and New Zealand, *Code of Practice for Assisted Reproductive Technology Units*, revised October 2021

Parentage recognition

Except when there is a transfer of parentage that arises from the making of an adoption order (as recognised by the *Adoption Act 2009* (Qld)) or the making of a parentage order (as recognised by the *Surrogacy Act 2010* (Qld)), who is a parent is determined by one or other of:

- *Family Law Act 1975* (Cth)
- *Status of Children Act 1978* (Qld).

As the High Court made plain in *Masson v Parsons* [2019] HCA 21, there is no scheme between the *Family Law Act* and the States and Territories *Status of Children Acts*. The former prevails where there is an inconsistency.

As the High Court also made plain in that case, who is a parent under the *Family Law Act* is a question of fact. Therefore, someone can be a parent under that Act who is not recognised under the *Status of Children Act*. The *Status of Children Act* recognises that a sperm donor unless married to the recipient has no rights and liabilities as a parent (see for example, s.23).

This language of "no rights and liabilities" of the sperm donor, as seen, for example, in section 23 of the *Status of Children Act*, was taken from a communique of Attorneys-General, as was stated in *B and J* [1996] FamCA 124:

> *"In July 1980 the Standing Committee of Commonwealth and State Attorneys-General determined that uniform legislation on the status of children born as a result of artificial insemination by donor treatments should be enacted in all Australian jurisdictions, and agreed that the legislation should provide that:*
>
> *"a husband who consents to his wife being artificially inseminated with donor sperm shall be deemed to be the father of any child born as a result of the insemination;*
>
> *the sperm donor shall have no rights or liabilities in respect of the use of the semen; and*
>
> *any child born as a result of AID (artificial insemination by donor) shall have no rights or liabilities in respect of the sperm donor."*
>
> *The Standing Committee re-affirmed these recommendations in 1981, 1982 and 1983.*
>
> *It was as a result of this agreement that legislation which is identical for relevant purposes was passed in the States and Territories, designed to provide that the semen donor would incur no liability (nor attain any rights) in respect of a child born as a result of that procedure."*

Only Queensland and the Northern Territory currently have this phrase of *"no rights or liabilities"* in their *Status of Children Acts*. The Northern Territory proposes to replace the provision in its *Status of Children Act 1978* (NT) to this effect, so that the donor is not a parent[28].

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[28] *Surrogacy Bill 2022* (NT), s.73, replacing s.5F *Status of Children Act 1978* (NT).

This was something I advocated for as a member of that government's joint surrogacy working group, which led to the *Surrogacy Bill 2022* (NT).

I advocated that because of the difficulty in Queensland arising from two decisions in the same case, where the court found that under s.23 of the *Status of Children Act 1978* (Qld) the genetic father of the child if not married to the mother is a parent of the child, albeit with no rights or liabilities[29]. A subsequent case[30] held that this case was wrongly decided, and the genetic father is not a parent before the making of a parentage order- and that if the reasoning of the earlier matter were correct, then Parliament would have intended that for women with a female partner undertaking fertilisation procedures, the man would be the third parent, whereas Parliament was quite clear under the *Births, Deaths and Marriages Registration Act 2003* (Qld), s.10A(1)(c) that there are to only be two parents.

The *Status of Children Act 1978* (Qld) has not also kept up with another major change in society. While female married couples are recognised under that Act as the parents of their children born through fertilisation procedures, the same cannot be said if they are married. Instead those couples have to rely on s.60H(1) of the *Family Law Act* so that they are recognised as parents. The *Status of Children Act* should be amended to recognise them as parents if they are married.

Known donation

The underlying assumption in the terms of reference is that donations happen through clinics and that the identity of the donor is not known to the child. If that assumption has been made, it has excluded known donation. I have seen known donation occur through IVF clinics (and I recommend it occur through IVF clinics) both as to egg and sperm donation. I have also seen known embryo donation, from one couple to another.

There ought to be a clear procedure to enable intended parents and known donors to agree on whether the donor is to be a parent or to be a donor. Ideally this would be under the *Family Law Act 1975* (Cth), outside the remit of this committee. Currently intended parents and those who supply their genetic material navigate a no man's land about whether they are parents or not:

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[29] *Lamb & Shaw* [2017] FamCA 769; *Lamb & Shaw* [2018] FamCA 629.

[30] *RBK v MMJ* [2019] QChC 42, in which I appeared for the applicants.

- Unlike overseas jurisdictions, like Ontario, where up to 6 parents may be recognised by agreement, Queensland recognises two.

- In a typical scenario, if a gay man supplies his sperm to a lesbian couple and they agree that all three are to be the parents, only two can be recognised as the parents[31]. Nevertheless, if he has agreed to be a parent (but is not recognised by law to be a parent) he might be liable for his share of the cost of raising the child[32], on the basis of damages for equitable estoppel.

- If that gay man had a partner- and all four agreed to be parents of the child, then the known sperm donor is not a parent, but the partner might be[33].

- If there is agreement that the man who supplied his sperm is not to be a parent, then he might still be considered a parent under the *Masson* test[34], or be someone who can litigate concerning the child under s.65C(c) of the *Family Law Act* if he is found to be someone concerned with the care, welfare and development of the child[35].

- Legal recognition of sperm donor agreements is uncertain. It would be good to give parties legal certainty.

In *Masson v Parsons*, for example, media reports were to the effect that the parties had spent $4 million in legal costs by the time that the High Court had determined the matter- but before it was returned to the Family Court.

If some certainty is given to both sides about what their respective roles are in the child's life, then the child can have certainty- and the parties can have much less stress, and the sums spent on legal costs can instead be devoted to raising the child.

Known donation has been increasing rapidly in recent years. While they were referred to in the Senate inquiry a decade ago, they are much more a feature of the landscape now. This is in part

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[31] *Family Law Act 1975* (Cth), s.60H(1), *Status of Children Act 1978* (Qld), ss. 19C to 19E, *Births, Deaths and Marriages Registration Act 2003* (Qld), s.10A(1)(c).

[32] *W v G* [1996] NSWSC 43.

[33] As the High Court left open the possibility of more than two parents under the Family Law Act: *Masson v Parsons* [2019] HCA 21 at [26].

[34] If the recipient is single.

[35] As was conceded by all parties throughout Masson that Mr Masson was someone concerned under s.65C(c).

due to websites[36] where prospective sperm donors and intended parents meet. Some donors specify "AI" and "NI" as their preferences- i.e, artificial insemination or natural insemination. While ordinarily any man who conceives a child via sex would ordinarily be considered to be the father, there has been a recent Canadian case where he was found not to be, based on intention[37], and a recent South African case where the mother unsuccessfully asserted the same[38].

I see little point in seeking to regulate these websites. They will exist no matter what Parliament may seek to do, by the use of social media. It is better in my view to educate, and to encourage good behaviour. As seen below, even when Parliament legislates to criminalise those who engage in commercial surrogacy overseas, no one has been prosecuted, though without a doubt many Queenslanders have done so.

The most recent notorious case of sperm donation was that of an American donor who went by the pseudonym of Joe Donor, who had *annual* health checks, had conceived 100 children (but did not pay child support for any) either by sex or artificial insemination, and came to Australia to provide sperm. I was highly critical of him[39].

Or the oldest sperm donor, John Mayger, then aged 72 who had been rejected by clinics, given his age and cap requirements[40], but continued to donate to lesbian couples, conceiving 50 children. He boasted[41]: *"some people fish…I masturbate."*

Or Alan Phan, 40, from Brisbane who after being rejected by clinics as he had hit the cap, just kept going privately- resulting in *23 children being born in one year*[42].

With the pandemic, there has been a significant increase that I have seen in known donor agreements. This has been attributed by the intended parents in part to their desire for the children to know where they have come from, and in part from a shortage of sperm donors

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[36] For a story about this, see here: https://www.theage.com.au/national/victoria/the-man-behind-australias-private-sperm-donor-boom-20210521-p57u1q.html .

[37] *MRR v JM* [2017] 137 O.R. (3d) 605, found at https://www.canlii.org/en/on/onsc/doc/2017/2017onsc2655/2017onsc2655.html .

[38] *R v S* [2018] ZAKZDHC 23, found at http://www.saflii.org/za/cases/ZAKZDHC/2018/23.html .

[39] On 60 Minutes: https://www.youtube.com/watch?v=NGhbcTGZmkI .

[40] The Ethical Guidelines have a cap on the number of families to donate to, typically 9 in Queensland, and as few as 4 in NSW or WA (the numbers quoted are typically 10 and 5, but these numbers must include the donor's own family, hence I have used 9 and 4.).

[41] https://www.dailymail.co.uk/news/article-9087093/Meet-Australias-oldest-sperm-donor-fathered-50-kids.html .

[42] https://www.news.com.au/lifestyle/real-life/news-life/brisbane-sperm-donor-investigated-after-fathering-23-kids-in-one-year/news-story/dfb0c65c7477a4b9bdaea9fc773928e9 .

through IVF clinics. Most sperm for donation in Queensland IVF clinics is imported from a small number of sperm banks in the US. It must be Queensland compliant, i.e., it must comply with our laws and the *Ethical Guidelines*. The intended parents are primarily single women, or lesbian couples, but also transgender and non-binary people and heterosexual couples. Some are undertaking treatment through IVF clinics, some at home.

There has also been a small number of gay couples undertaking surrogacy where they have needed a sperm donor- but this has been through IVF and therefore necessarily occurred in a clinic.

The current process of reducing (but not eliminating) risk when there is a known donor is:

- Medical checks to be undertaken
- Counselling to be carried out by a specialist fertility counsellor
- Entry into a sperm donor agreement (the same applies for egg or embryo donor agreements, but these are much less common).

RIGHTS OF DONOR CONCEIVED PERSONS, INCLUDING TO KNOW THEIR GENETIC ORIGINS

Australia is a party to the *UN Convention on the Rights of the Child*. Article 7.1 provides:

> *"The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents."*

Article 8.1 provides:

> *"States Parties undertake to respect the right of the child of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference."*

Articles 3.1 and 3.2 provide:

> *"1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.*

> 2. *States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures."*

This right as to identity includes the right to know one's legal, social, genetic and birth parents[43].

Then Chief Justice Pascoe stated[44] in 2018 that the Convention:

> *"Was significant in its recognition of the importance for a child to know his or her origin; not just for medical and other practical reasons, but also for a sense of identity and belonging which that knowledge entails.*
>
> *Numerous studies in relation to adopted children and those conceived by donor gametes have demonstrated how important it is for children to know their parents and their origins. It is fundamental to our sense of identity and self-worth. The term 'genealogical bewilderment' was termed for the sense of distress and confusion that many feel because they do not know their origins. The lack of medical history poses real risks, not just to the children without access to it, but for generations to come.*
>
> *The use of anonymous genetic material mean that many children born through international commercial surrogacy can never learn their genetic heritage. Many countries, including Australia, have now abolished anonymity for gamete donors in recognition of the importance for donor-conceived people to know their history and identity … Parents seek anonymous donors because they want their parental role undisputed. It is selfish and speaks to their own insecurity in their role as a parent. In doing so, these parents lay the foundations of pain, secrecy and confusion in the life of their child."*

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[43] Samantha Besson, *"Enforcing the child's right to know her origins: contrasting approaches under the convention of the rights of the child and the European convention on human rights"* (2012) 21 International Journal of Law, Policy and the Family 137, 143.

[44] https://www.actlawsociety.asn.au/article/sleepwalking-through-the-minefield--commercial-surrogacy-and-the-global-response .

Partner IVF

Partner IVF is a relatively common occurrence. Sometimes called reciprocal IVF, this occurs for a lesbian couple, or a transman/female couple when the eggs of one are fertilised with donor sperm and then implanted in the other to carry. It typically occurs because one of the parties cannot carry, but the partner can, or because the couple have decided that by one being the genetic parent and the other the birth parent that both have a clear commitment to the child as the child's parents.

The definition of donor under legislation will need to take into account the realities of partner IVF- and whether to classify the partner as a parent or donor. Quite clearly when the partner intends to be a parent, then in my view the partner should be treated as a parent, not a donor.

Creeping regulation- and the definition of donor

While a gamete or embryo donor might seem a simple concept, when lawmakers have sought to define who is a donor- and who is not, the difficulties of defining who is a donor comes into stark relief. I urge members of the committee to be concerned about creeping regulation- and to ensure that if legislation is developed from this report - that key stakeholders play an active role in the process when drafting key definitions (as I recently experienced was successfully done by the Northern Territory Government's joint surrogacy working group that led to what is now the *Surrogacy Bill 2022* (NT)).

New South Wales

The *Assisted Reproductive Technology Act 2007* (NSW) defines *gamete provider*, among other terms. Section 17 speaks for itself about the difficulty facing IVF clinics, patients and donors in understanding the law:

"(1) A gamete provider may give an ART provider that obtains, or proposes to obtain, a gamete from the gamete provider a written notice, in the approved form (if any), setting out the gamete provider's wishes in relation to the gamete (the gamete provider's
"consent" *).*

(2) A gamete provider's consent may address such matters as the uses that may be made of the gamete (or an embryo created using the gamete) and whether the gamete or embryo may be stored, exported from this State or supplied to another ART provider.

(3) A gamete provider may modify or revoke his or her consent by giving written notice, in the approved form (if any), of the modification or revocation of consent to:

(a) the ART provider that obtained the gamete from the gamete provider, or

(b) any ART provider that is, or has ever been, in possession of the gamete or embryo to which the modification or revocation of consent relates.

(4) A consent may be modified or revoked at any time up until:

(a) in the case of a donated gamete--the gamete is placed in the body of a woman or an embryo is createdusing the gamete, or

(b) in the case of a gamete that is used to create a donated embryo--the embryo is implanted in the body of a woman, or

(c) in any other case--the gamete is placed in the body of a woman or an embryo created using the gamete is implanted in the body of a woman.

(5) As soon as practicable after an ART provider is given written notice by a gamete provider of the modification or revocation of his or her consent, the ART provider must give written notice of the modification or revocation to any other ART provider to which the ART provider has supplied the gamete or any embryo created using the gamete.

(6) As soon as practicable after an ART provider is given written notice by another ART provider of the modification or revocation of a gamete provider's consent, the ART provider must give written notice of the modification or revocation to any other ART provider to which the ART provider has supplied the gamete or any embryo created using the gamete.

(7) Except as provided by section 17A, a modification or revocation of consent takes effect in relation to an ART provider as soon as the ART provider is given written notice of the modification or revocation in accordance with this section.

(8) A reference in this section to a
***"donated gamete"** does not include a reference to a gamete that becomes a donated gamete only after being used to create an embryo."*

Victoria

The *Assisted Reproductive Treatment Act 2008* (Vic) has just been amended to clarify the definition of donor. The definition has been circular, to say the least, with the absurd result that there was a standoff between VARTA and the IVF clinics- VARTA having taken the view that an intended parent[45] under a surrogacy arrangement by providing their gametes to a third party who was a patient (namely the surrogate) was therefore a donor. The IVF clinics took the view that that approach was absurd. Thankfully the change now means that intended parents under a surrogacy arrangement are not donors.

Victoria only recognises the woman who is having treatment (and her partner) as the parents for the purposes of the *Assisted Reproductive Treatment Act 2008* (Vic). Any co-parenting arrangement, as seen in *Masson v Parsons* [2019] HCA 21, for example, would result under that test as the woman being the parent, and the man being a donor. He would, however, be a parent under the *Family Law Act 1975* (Cth). Imagine being the man supplying his sperm in that circumstance being told: *"You're only a donor"*, but his response that: *"I'm a parent"* being met again with the chant: *"You're only a donor"*.

Western Australia

There is an assumption by Parliaments and regulators that their IVF industry has challenges unique to that State, much as was seen across Australia about companies regulation before the enactment of the *Corporations Law*. This assumption is seen most vividly in Victoria and Western Australia. In both States, a regulator (in Victoria, VARTA, and in Western Australia, the Reproductive Technology Council, must consent to the import and export of donor gametes or embryos created from donor gametes- including to or from other parts of Australia).

This issue was put into stark relief in *GLS v Russell-Weisz* [2018] WASC 79. A widow sought to export the sperm of her late de facto husband to interstate so that she could become a mum. WA, unlike Queensland (which follows the strict protocols of the *Ethical Guidelines*), does not

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[45] As we would call them. In Victoria until recent amendments they have been known as *commissioning parents*.

allow posthumous use. It is lawful in WA to retrieve the sperm, but not to use. The deceased's sperm was retrieved following his being declared brain dead after having had an unexpected cardiac arrest.

The issue before the Court was whether the deceased was a donor. The Court concluded, sensibly enough, through 202 paragraphs that he was not. The regulator had submitted that he was a donor. The parties' respective positions were set out in the judgment:

"The plaintiff contends that 'donation' and its variants in cl 6.5 and cl 6.6 should be construed in accordance with the ordinary legal meaning given to such words - namely, as connoting the transfer of property without consideration.

The defendants contend that the word 'donation' in the clauses should bear the meaning to be drawn from the HTT Act and which should be taken to be the meaning of the same words in the HRT Act. At one point in the defendants' written submissions it is contended that the relevant meaning is 'any tissue removed from a person for use by another'. However, that meaning would, in effect, deprive the restrictions imposed upon the operation of cl 6.5 and cl 6.6 by reference to 'donation' of any meaningful operation because virtually all artificial reproduction procedures will involve the removal of tissue from one person for use by another. Senior counsel for the defendants expressly conceded that the clauses would not apply in a circumstance in which there was a living gamete provider with control over the uses to which the gametes could be put, which is, in effect, the circumstance which I have referred to as Scenario 1. In light of that concession, counsel relied upon the alternative formulation of the meaning given to the word 'donation' in the defendants' written submissions - namely, 'any gametes no longer under the control of the gamete provider'."

Quite simply, the widow should not have had the costs burden and the stress of that case- because who was a donor was unclear.

EXTENT TO WHICH IDENTIFYING INFORMATION ABOUT DONOR SHOULD BE GIVEN TO DONOR-CONCEIVED PERSONS, TAKING INTO CONSIDERATION THE RIGHT TO PRIVACY OF DONORS

The *Ethical Guidelines* set out guiding principles[46]. These are:

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[46] Commencing at page 20.

1. ART activities must be conducted in a way that shows respect to all involved.

2. The interests and wellbeing of the person who may be born as a result of an ART activity must be an important consideration on all decisions about the activity.

3. ART activities must be undertaken in a manner that minimises harm and maximises the benefit to each individual or couple involved in the ART activity, any persons who may be born as a result of the activity, and any other child within the family unit who may be affected by that birth.

4. Decision-making in the clinical practice of ART must recognise and take into account the biological connections and social relationships that exist or may be formed as a result of the ART activity.

5. Decision-making in the clinical practice of ART must recognise and respect the autonomy of all relevant parties, promoting and supporting the notion of valid consent as a fundamental condition of the use of ART.

6. Decision-making in the clinical practice of ART must recognise that social relationships and social context may affect an individual's or a couple's decision-making and be sensitive to cultural and spiritual differences.

7. Processes and policies for determining an individual's or a couple's eligibility to access ART services must be just, equitable, transparent and respectful of human dignity and the natural human rights of all persons, including the right to not be unlawfully or unreasonably discriminated against.

8. The provision of ART must be underpinned by policies that support effective and efficient practices that minimise interventions not supported by evidence of successful clinical outcomes.

9. The provision of ART must be transparent and open to scrutiny, while ensuring the protection of the privacy of all individuals or couples involved in ART and persons born, to the degree that is protected by law.

As to guiding principle 2, the *Ethical Guidelines* state[47]:

> *"All competent adult participants exercise a choice about their involvement in ART activities. The person who may be born as a result of the activity does not. Although the same can be said when conception is natural, some ART activities offer the potential for greater influence of the desires of the intended parent(s).*
>
> *Some argue that the child would not exist without the desire of the intended parent(s) to become parents and that it is in a child's best interest to be born. Nevertheless, ART may have serious consequences for the person born. Therefore, ART activities should not commence without serious consideration of the interests and wellbeing of the person, who may be born as a result of that activity."*

As to guiding principle 3.4 the *Ethical Guidelines* state[48]:

> *"The significance ascribed to a biological connection varies considerably from person to person. For some people, their connection to their biological parents, surrogate, siblings or other biological family members is very significant. For others, some or all of these biological connections have little or no significance.*
>
> *If a person born as a result of ART is deprived of knowledge about their biological connections, they are also deprived of the ability to decide the level of significance these connections will hold for them. When a person born from donated gametes or an embryo wants to establish contact with their biological parent(s) and/or their other biological family members, but is unable to do so, the effect on that person may be substantial.*
>
> *Consideration of biological connections and social relationships is important for prospective gamete donors or providers, and for those considering the use of donated gametes, donated embryos, surrogacy, or the posthumous use of gametes or embryos. In each of these cases, counselling by a professional with the appropriate training, skills, experience and competency to counsel in reproduction is required to assist those involved in their decision making and to explore the possible implications of such decisions."*

Guideline 5.6-5.10 deals with the issues at the centre of this inquiry:

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[47] At page 23.
[48] At page 24.

"5.6 Persons support the right to know the detail of one's genetic origins.

Persons born from donated gametes are entitled to know the details of their genetic origins. Counselling received by potential gamete recipients must explore the potential significance of the biological connection, the right of persons born to know the details of their genetic origins, and the benefits of early disclosure. Whilst recipients cannot be forced to disclose this information to their children, clinics have a role in encouraging and supporting early disclosure.

5.6.1 Clinics must not use donated gametes in reproductive procedures unless the donor has consented to the release of their identifying information to the person(s) born as a result of the decision (see paragraphs 4.6.1 and 5.5.1).

5.6.2 Clinics must not mix gametes in a way that allows the genetic origins of the person who would be born to be uncertain. That includes the attempted fertilisation of a human egg by human sperm from more than one donor at a time.

5.6.3 Clinics must:

- *Encourage gamete recipients to disclose to their children their genetic origins*
- *Provide ongoing support to parents, to help them to understand the potential significance of the biological connection and the benefits of early disclosure*
- *Assist parents to find effective ways of disclosing to their children their genetic origins*
- *Provide persons born from donated gametes with the supportive environment within which to explore the possibility of meeting with the donor(s) and/or siblings (see paragraph 5.9).*

5.7 Provide gamete donors with relevant information concerning persons born using their donated gametes.

Gamete donors are entitled to some information about any person born as a result of their donation (in particular, to prepare them for possible future approaches by the person born).

5.7.1 Clinics should provide gamete donors, on request, with non-identifying information about the number, age and sex of any persons born as a result of their donation.

5.8 Encourage the update of relevant information

5.8.1 Clinics should inform potential gamete donors (or gamete providers for donated embryos) that it is a donor's ethical responsibility to keep the clinic informed about any changes to their health that may be relevant to any person born or the recipients of their donation and about changes to their contact details.

5.8.2 Clinics should encourage gamete recipients to disclose to the clinic any information about the person born that might be relevant to the health of the donor, the donor's offspring, or other persons born from the donated gametes.

5.9 Provide persons born from donated gametes with information about the gamete donor.

Persons born from donated gametes are entitled to know the details of their genetic origins.

5.9.1 A clinic that is approached by a person born from gametes donated at that clinic, who has reached the age of 18, must arrange for counselling by a professional with the appropriate training, skills, experience and competency to support their decision-making, prior to providing the following information, as a minimum:

- *All information specified in paragraph 4.2.4*
- *Identifying information about the gamete donor (see paragraph 5.6.1)*

- *Any identifying information that any person born from the gametes of the same donor has consented to being released (see paragraph 5.10.2)*

5.9.2 A clinic that is approached by a person born from gametes donated at the clinic, who has not yet reached the age of 18, must arrange for counselling by a professional with the appropriate training, skills, experience and competency to support their decision-making and make a determination on the person's maturity and ability to appreciate the significance of the request (including any implications for any younger siblings).

Should the person born from donated gametes be assessed as sufficiently mature, the clinic must provide the information listed in 5.9.1, as a minimum.

5.10 Respect the privacy of all parties involved in ART procedures.

All individuals and couples involved in ART activities, including gamete donors, and persons born, are entitled to privacy to the degree that is protected by law (see paragraph 3.9).

5.10.1 When approached by a person who is born from donated gametes who now seeks identifying information about their gamete donor, the clinic must examine the consent from the gamete donor and proceed as follows:

- *If the consent form does not include permission for release of identifying information (because the donation was made before the introduction of the 2004 edition of these ethical guidelines and the gamete donor has not come forward in response to the public information campaign, see paragraph 5.14), the clinic should make all reasonable efforts, consistent with the original consent document and the privacy rights of the donor, to contact the gamete donor and request their consent to the release of their information.*

- *If the consent form includes permission for release of identifying information, the clinic should make all reasonable efforts to notify the gamete donor of the request prior to the release of the information. This process should not, however, unreasonably delay the release of such information to the person born.*

5.10.2 When approached by a person who is born from donated gametes who now seeks identifying information about others born from gametes donated from the same donor, the clinic must examine the consent from the individual(s) involved and proceed as follows:

- *If consent has been registered by the individual(s) concern, the information may be released.*
- *If consent has not been registered, clinics must not release identifying information or contact the individual(s).*

5.10.3 Clinics must provide the donor with access to counselling by a professional with the appropriate training, skills, experience and competency, as part of the preparation for the release of identifying information."

It is submitted that these are thorough and well thought through protocols. The Lavarch Committee[49] in considering whether Queensland should permit altruistic surrogacy stated:

> *"The committee acknowledges that Queensland has a well established, industry-driven accreditation process for ART services."*

The Government response to the Lavarch Committee[50] stated:

> *"The Government notes that parties who require access to Assisted Reproductive Technology to give effect to an altruistic surrogacy arrangement would approach private clinics providing Assisted Reproductive Technology services, making the arrangement subject to the safeguards set out in the National Health and Medical Research Council's*

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[49] Queensland Parliament, Investigation into Altruistic Surrogacy Committee Report (2008) p.57

[50] Queensland Government, Government Response to the Report of the Investigation into Altruistic Surrogacy Committee, Investigation into the Decriminalisation and Regulation of Altruistic Surrogacy in Queensland at p.8

> *Ethical Guidelines on the use on assisted reproductive technology and clinical practice and research 2007."*

In response to a recommendation that the Lavarch Committee inquiry for enhanced standards for altruistic surrogacy in ART services in Queensland, the Government responded, in part:

> *"The Queensland Government acknowledges the need to ensure the developments in relation to altruistic surrogacy are evidence based and the policy expertise is developed.*
>
> *In relation to training and professional development opportunities, private clinics offering Assisted Reproductive Technology services are responsible for ensuring that their staff are adequately trained and have access to development opportunities.*
>
> *In addition, as a condition of accreditation, Assisted Reproductive Technology clinics must comply with the National Health and Medical Research Council's Ethical Guidelines on the use of assisted reproductive technology in clinic practice and research 2007, which require clinics to run ongoing training programs for clinicians and other staff involved in the Assisted Reproductive Technology procedures use, and also undertake regular quality assurance activities."*

As to the recommendation of the Lavarch Committee that additional standards be developed under the *Private Health Facilities Act 1999* to include criteria for intending parents and birth mothers seeking assistance from ART, the Government responded, in part:

> *"The Government further notes … that the National Health and Medical Research Council's Ethical Guidelines on the use of assisted reproductive technology and clinical practice in research 2007 address the responsibilities of Assisted Reproductive Technology clinics in relation to these matters."*

The Government further noted[51]:

> *"The National Health and Medical Research Council's Ethical Guidelines on the use of assisted reproductive technology and clinical practice in research 2007 already impose requirements on Assisted Reproductive Technology clinics in relation to the maintenance*

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[51] Page 14.

and disclosure of information about the genetic parentage of children conceived using Assisted Reproductive Technology procedures. The clinics' obligations include:

- *Not using donated gametes unless the donor has consented to the release of their identifying information to the child; and*
- *Providing the child, once they reach 18 years of age, with information about the donor's medical and family history, identifying information about the donor and the number and sex of persons conceived using gametes from the same donor.*

The Government notes that the Standing Committee of Attorneys-General at its April 2009 meeting agreed to the development of a discussion paper (different to the discussion paper referred to in the introduction to the Government response) on a national model for the harmonisation of donor registers in consultation with Health and Community Services Ministers."

LGBTIQ+ openness

ANZICA counsellors do a great job. I have the utmost respect for them. A focal point of discussions they have with intended parents and donors is that for the need for transparency and openness with the child about where the child came from, a principle set out in their requirements and in the *Ethical Guidelines*. The quality of what they do is, in my view, world leading.

This approach is consistent with a guiding principle of the *Surrogacy Act 2010* (Qld) in s.6(2)(a):

"(2) Subject to subsection (1) [paramountcy of best interests], this Act is to be administered according to the following principles—

(a) a child born as a result of a surrogacy arrangement should be cared for in a way that—

(i) ensures a safe, stable and nurturing family and home life; and

(ii) promotes openness and honesty about the child's birth parentage; and

(iii) promotes the development of the child's emotional, mental, physical and social wellbeing."

ANZICA counsellors, who are aware of research and experience concerning heterosexual parents not being honest and open with their children conceived from donation, still emphasise the need to be honest and open with LGBTIQ+ clients. While this ensures consistency, feedback from these clients recognises the absurdity of this approach at times. A child will know when they have two mums or two dads that they are different from all the other children- and will ask questions. LGBTIQ+ parents must necessarily be on the front foot in discussing with their children in an age appropriate way about where they came from.

If there were any doubt, I give the example of my family. My daughter is now aged about 2 1/2 . My husband were extraordinarily lucky to have been able to do surrogacy and egg donation all in Brisbane. Unlike the vast majority of Queenslanders undertaking surrogacy, we did not have to go overseas. Our egg donor is a known donor. We have regular contact with our donor and with our surrogate. Both are extraordinary women who risked their lives[52] in order to give us the gift of becoming parents and having a family. We are forever grateful that their efforts have helped us have the joy of being parents and having a family, which is the central dream of most people. Families in all their forms are, after all, the building blocks of society.

Our daughter goes to a large daycare centre, with over 100 families. My husband and I are the only out LGBTIQ+ couple at her daycare. Of course, she recognised that her family is different to everyone else's. My daughter recognised at 18 months that she had two dads while others had a mum and a dad. She called me "Daddy" and my husband "Dad". These were the names she thought up and applied- not ones we suggested.

My daughter already knows that she was born through surrogacy (although that term has not been used) and will be told in an open and transparent manner about her origins. Her conception, like everyone else's on the planet, is unique- and unique to her. She was conceived from love, and knows that she is deeply loved. In due course we will tell her of her genetic origins. It is her right to know. She should not be lied to, or suffer any surprises about who she is.

THE 2011 SENATE INQUIRY

In 2010-2011 the Senate Standing Committee on Legal Constitutional Affairs conducted an inquiry, *Donor conception practices in Australia.* The terms of reference were:

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[52] A surrogate has the same low risk of death as any other woman being pregnant and giving birth- but doing so for someone else. An egg donor, by having a minor operation to retrieve eggs, has a low risk of death from that, as happens with any operation. A sperm donor does not have the same risk.

> *"The past and present practices of donor conception in Australia, with particular reference to:*
>
> *(a) donor conception regulation legislation across federal and state jurisdiction;*
>
> *(b) the conduct of clinics and medical services, including:*
>
> > *(i) payments for donors;*
> >
> > *(ii) management of data relating to donor conception; and*
> >
> > *(iii) provision of appropriate counselling and support services;*
>
> *(c) the number of offspring born from each donor with reference to the risk of consanguine relationships; and*
>
> *(d) the rights of donor conceived individuals."*

In chapter 2 of its report the committee noted different inconsistencies and approaches to availability of information[53].

The committee stated:

> *"2.59 A key concern raised by submitters was the differences in access to information for donor conceived people on the basis of the state and the year in which they were conceived.[56] Monash IVF, which operates clinics in both Victoria and Queensland, stated:*
>
> > *[at] this point...the rights of a donor conceived person in Victoria born after 1998 compared to someone born in Queensland [are] vastly different with the Victorian person having the legal right to identifying information about their donor...*

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[53] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/donorconception/report/c02#anc5

> *Due to changes in legislation in Victoria there are some families with donor conceived children who were born under different iterations of the legislation therefore each child/person [has] different sets of rights in terms of what information that person is entitled [to] about their genetic origins.[57]*

2.60 In addition, the Rainbow Families Council stated:

> *...some children in the one rainbow family have been conceived at different times in different clinics across different states or territories using donors with different identity-release provisions. The past practice has created a confusing and often upsetting situation for parents and their donor-conceived children when, for example, only one child has access to the identifying information about their donor while the other child does not.*

2.61 Differences in legislation between the states and territories can result in parties accessing gametes or embryos from different states in order to take advantage of a more favourable release of information. Ms Karen Boyd – a mother of donor conceived children – explained her experience in which donors donated an embryo in one state and made it available in another state, specifically to enable the donor conceived child to access information about those donors:

> *[m]y son was born in 1999 and we have both non-identifying and identifying information available to us when he is 18 years old, thanks to the Victorian Registry. His embryo was conceived in NSW but his donors wanted their information available to a child if a child was born from their donation. So the embryo was made available to [us in Victoria] as Victoria at the time was the only state that had a registry available.[59]*

2.62 As well as variations in the amount of information able to be released depending on where and when a child was conceived, there are differences in the non-identifying information provided about donors to recipients. Solo Mums by Choice (SMC Australia) submitted:

> *[m]embers report great inconsistency regarding information provided about sperm donors. This ranges from a brief physical description regarding height/hair/eye colour to several pages of information relating to the*

> > *donor's physical characteristics as well as medical history, interests/personality and family history. In some cases even minimal information is not provided until after a pregnancy is confirmed. It is not clear what steps clinics take to ensure that information provided by donors is accurate or complete.[60]"*

I also note the committee started at 2.68:

> *"However, at the public hearing in Canberra, Dr Martyn Stafford-Bell from the Canberra Fertility Centre explained that, in his view, the NHMRC Guidelines are enforceable. This is because, if a clinic does not provide evidence of compliance, the RTAC is able to recommend to the Australian Government that the clinic's patients do not receive Medicare benefits until the clinic becomes compliant.[68] Dr Stafford-Bell contended that the NHMRC Guidelines are 'perfectly adequate', but that '[i]t is a question of enforcing them'.[69] He advised the committee that he is aware of at least two clinics which have had their accreditation withdrawn or which have been sanctioned for failure to comply with the NHMRC Guidelines.[70]"*

I would support what Canberra Fertility Centre stated:

> *"The Canberra Fertility Centre supported the development of uniform legislation involving donor conception throughout Australia, including legislation to limit the number of families who achieve a live birth using gametes donated by a single individual. However, the Centre noted that:*
>
> > *[t]he demand for donated gametes in Australia far exceeds the supply, and therefore we recommend that any regulatory or legislative changes regarding donor conception should take the rights and preferences of donors into consideration, in order to encourage donation, thereby allowing more Australians affected by infertility access to treatment with donor gametes."*

Whilst intended parents go to IVF clinics with the hope of finding donors, many do not or give up. Instead, they find donors through word of mouth or on websites which are certainly more prolific now than they were 10 years ago – or go overseas. There are extraordinary shortages of egg donors in Australia which have only been partly relieved by importation of eggs from the United States and Ukraine. In 2016 I visited Cape Fertility Centre in Cape Town. I met the medical director there. It took me approximately 24 hours to fly to Cape Town from Brisbane. I was told by the medical director that the demand from Australian heterosexual couples to access donor eggs in South Africa meant that they were seeing two Australian couples per business day.

I agree with these submissions that were made to the Senate Inquiry:

> *"2.81 IVF Australia, which operates in New South Wales, expressed concern about the potential regulatory and compliance burden for clinics if there is both state and Commonwealth legislation regulating this area.*
>
> *2.82 While most submissions supported further regulation of ART clinics, some submitters noted that changes to state legislation have negatively impacted upon them. These submitters were concerned that further changes may limit the ability for people to access ART services. For example, the mother of a donor conceived child in NSW commented that the introduction of the NSW Act had created difficulties in seeking to have her female partner conceive a child using sperm from the same donor.*
>
> *2.83 In addition, some evidence suggested that further regulation of fertility clinics has the potential to drive donors into unregulated spheres. One submitter noted:*
>
>> *[t]here are more Australian donors donating through unregulated international internet web sites than there are in Australian IVF clinics. Government regulations have totally driven donors away from regulation and monitoring. Donors on these sites are not regulated by regulations covering STD status, [f]ertility, [c]onsanguinity & contact between donors and children."*

The committee stated:

> *"7.2 Evidence presented to the committee by donor conceived people, their parents and those with expertise in the area indicated, among other things, that:*
>
> - *there is a need to improve consistency in donor conception legislation and regulation throughout Australia;*

- *there are inconsistencies between jurisdictions in relation to the regulation of donor conception on issues such as counselling requirements and limits on the number of donations;*

- *there are inconsistencies in relation to access to information about donors by donor conceived people, and many donor conceived people consider it to be inequitable that the amount of identifying information that donor conceived people can access varies depending on when or where they were conceived or born;*

- *it is important to donor conceived people to be able to access information about their donor's identity and medical history, in order to complete their sense of self-identity and to appropriately manage their health;*

- *there is a need for the creation of a national register as a central repository of information about donors' identities, to undertake a regulatory role and to facilitate contact between donors, donor conceived people and their siblings;*

- *there are difficulties in enforcing regulatory requirements on clinics, because requirements vary between jurisdictions and because there is no single overarching body to enforce the requirements, nor any organised system for sharing information; and*

- *a limit should be imposed on the number of donations a donor can make, to mitigate the risk of consanguinity and to minimise the number of siblings a donor conceived person might potentially have.*

I don’t accept the view of the committee:

> *“There are some jurisdictions in which there is no relevant legislation place. In those jurisdictions, issues such as the prohibition of donor anonymity and access by donor conceived people to information about their donor are governed by the unenforceable NHMRC guidelines.”*

I don’t for a second accept that the *Ethical Guidelines* are unenforceable. The biggest IVF chain in Australia is Virtus Health, which in Queensland operates as:

- Queensland Fertility Group/the Fertility Centre – Cairns, Gold Coast, Mackay, Toowoomba, Townsville, Brisbane, Springwood

According to the most recent financial data from Virtus Health as to its statement of financial position for the period to December 2021, of gross assets of $589.5m in tangible assets, goodwill and licenses are worth $427.2m. Virtus Health is a listed company. To lose any of its licences would be financial poison (as has been recently experienced by Crown Casinos). My experience is that IVF clinics operate conservatively to ensure compliance with the NHMRC *Ethical Guidelines* and I've heard it said from numerous IVF doctors and managers that they do not want to be on the front page of the local newspaper (as it will always be bad news, and therefore bad for business).

The second largest national IVF clinic is Monash IVF Group which in Queensland operates in Brisbane, Townsville, Rockhampton, Gold Coast, Sunshine Coast and Bundaberg. Monash IVF is also a listed company. Its annual return shows that it has net assets of $268.9m and that its goodwill and tangibles are worth $260m.

The second largest IVF clinic in Queensland is City Fertility (which also operates in New South Wales and Victoria). City Fertility operates in Brisbane, Sunnybank, Gold Coast and Toowoomba. In 2018 a controlling stake in City Fertility was purchased by Cha Health Care, based in Seoul and Asia's biggest IVF clinic, and Singapore Medical Group.

I have every confidence that Queensland clinics will comply with their requirements under the NHMRC *Ethical Guidelines*.

WHAT HAS HAPPENED SINCE 2011

The differential nature of regulation of donor conception remains throughout Australia. Following the Senate Inquiry report RTAC responded. It issued technical bulletin 3, donor issues in April 2011. The clear purpose of the Bulletin was to correct the perceived shortcomings of the industry as seen by the Senate Inquiry. The Bulletin shows clearly what the role of auditors includes.

The Bulletin states:

> *"Introduction*

This Technical Bulletin extends and replaces Technical Bulletin 2 entitled 'Obtaining Donor Sperm Outside Australia and New Zealand' issued in July 2009. It has been promoted by recent:

- *Letters from RTAC – licensed IVF units asking FSA and RTAC about the legality of importing donor sperm into Australia*
- *Concerns raised by people making submissions to the Australian Senate Inquiry into 'donor conception practices in Australia' and covered in the committee's report*
- *The committee's report stating that units are confused about the interpretation of some aspects of the RTAC code of practice*

This technical bulletin gives advice to units on interpretation of the RTAC code of practice and requests auditors of Certifying Bodies (CB) to pay particular attention to certain aspects of the RTAC code of practice during surveillance audits in 2011-2012 to answer concerns raised in the senate inquiry report.

Advice to Units

1. *Units are reminded that the NHMRC 'ethical guidelines on the use of assisted reproductive technology and clinical practice and research', 2004 revised June 2007, are an integral part of the RTAC code of practice, and contained within Critical Criterion 1.*

   Hence:

   - ***Donors must be identifiable** to their donor offspring (NHMRC 6.1, 7.1), which means the donors recruited from 2002 must consent to the release of identifying information to offspring or their parents.*
   - ***Comprehensive non-identifying information** must be collected about each donor, including the items covered in NHMRC section 6.10 and 10.3.*
   - *Units must have **written donor-recipient linking procedures** (NHMRC 6.11, 6.13)*

2. ***Donors from outside Australia*** *must meet the same requirements as if they donated in Australia. This applies, but is not limited to, donor sperm sourced from outside Australia. Use of imported donor sperm should be supported by written independent legal opinion specific to the origin of the donor's sperm, State and Federal requirements for the State where the sperm is used, and the unit's clinical practice using this sperm. This legal advice should be available to auditors upon request. The legal opinion should cover the type and amount of 'reimbursement' given to the sperm donor by the sperm bank, the availability of identifying and other information for offspring and their parents, retention of records, the maximum number of offspring or donor families possible from each donor.*

3. *The Senate inquiry reported that some units were confused about the RTAC code of practice and NHMRC guidelines relating to the maximum number of offspring for a donor and 'reasonable expenses'.*

   Where state legislation does not apply, the following are advised:

   - ***A maximum of ten donor families per sperm donor****. This is based on the highest limit in existing state legislation (Victoria). The* ***number of families*** *per donor includes all families wherever the donor's sperm is used, not just the number of families from one unit, in one city, or in one country. This interpretation is based on the definition in existing state legislation.*

   - ***Reasonable expenses*** *be based on the principles in the Surrogacy Act 2010 of NSW, which applying to sperm donation would cover:*

     - *Reasonable medical, travel or accommodation costs associated with offering to be a donor and associated with donation.*

     - *Receiving any legal advice associated with donation.*

     A cost is reasonable only if the cost is actually incurred and the amount of the cost can be verified by receipts or other documentation. For the convenience of donors and units, it is suggested that units may decide to waive requiring receipts for individual items below $50.

4. Where state legislation does not apply, ***key information relating to a donor*** *who has donor offspring or to a recipient who has donor offspring must not be destroyed. The key information that must be retained about the donor includes his or her identity, last known address, and relevant medical history about the individual and his or her immediate family. Key information to be obtained about the offspring includes the identity of the donor used.*

ADVICE TO AUDITORS

5. Auditors are reminded that the NHMRC guidelines are an integral part of the RTAC code of practice and are audited as part of Critical Criterion 1. Auditors are requested to pay particular attention in 2011-2012 surveillance audits to:

- *Donors being identifiable*
- *Donor records, especially that are identifying and non-identifying information about donors as available to offspring and their parents*
- *Retention of medical records of donors and donor offspring*
- *The existence and use of donor-recipient linking policies*
- *Policies and their implementation concerning the maximum number of families per donor*
- *Policies and their implementation concerning payment of 'reasonable expenses' to donors."*

CLARK V MACOURT [2013] HCA 56

Dr Clark is a Sydney fertility specialist. She purchased an IVF clinic from Dr Macourt. Amongst the stock of the business was a quantity of donor sperm. This was non-compliant. Dr Clark suffered significant damages. The case arose before the commencement of the relevant New South Wales human cloning legislation, called the *Human Cloning for Reproduction and Other Prohibited Practices Act 2003* (NSW). The *Ethical Guidelines* issued by the NHMRC in 1996 applied. They provided that it was *"ethically unacceptable"* to engage in commercial trading in gametes or embryos and paying donors of gametes or embryos beyond reasonable expenses.

The vendor company delivered some 3,500 straws of frozen sperm to Dr Clark. She would have expected to ultimately have used 2,500 of those over several years in the normal course of her practice. Dr Clark was in fact able to use only 504. The remaining straws were ultimately found to be unusable as a result of the company having breached its warranty concerning the consents, screening tests and identification of donors.

Her damages were significant. The purchase price for the clinic was just under $400,000 of which she only paid $167,000. Dr Clark's damages were in excess of $1.2m.

As Justice Keane said[54] of the then *Ethical Guidelines*:

> *"These guidelines were concerned to prevent commercial trading in human sperms; and they also contemplated that practitioners were entitled to recover their reasonable expenses. The appellant denied that she had made a profit from supplying sperm, and there was no reason to doubt her evidence. The appellant, in providing ART services for a fee, cannot sensibly be said to be engaging in commercial trading in sperm for a profit."*

Dr Macourt sought the basic contention that compliant sperm would have been worthless upon the New South Wales *Human Cloning Act* taking effect, which is identical to the Commonwealth and Queensland versions. His Honour noted that that Act was not in force at the date of making or completion of the sale and it was not suggested that it operated retrospectively and therefore did not affect the lawfulness of the sale or the expectation of the parties to it or claims to enforce those expectations.

Dr Clark was successful with her appeal.

Lockhart Review (2006)

In 1999 Minister Wooldridge asked the House of Representatives Standing Committee on Legal and Constitutional Affairs to review the Australian Health Ethics Committee 1998 Report relating to cloning. In the House of Representatives 2001 report *Human Cloning: Scientific, Ethical and Regulatory Aspects of Human Cloning and Stem Cell Research* the majority recommended:

- The enactment of legislation to regulate human cloning and stem cell research;

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[54] At [121].

- That such legislation should include a ban on cloning for reproductive purposes combined with criminal penalties and loss of an individual's research licence; and

- The establishment of a national licensing body empowered to issue licenses for research involving the isolation, creating and use of embryonic stem cells.

At a COAG meeting in 2002, the Prime Minister and all premiers and chief ministers agreed that the Commonwealth, States and Territories would introduce nationally consistent legislation to ban human cloning and other unacceptable practices in that research be allowed only on existing excess ART embryos, that would otherwise have been destroyed, under a strict regulatory regime, including requirements for the consent of donors.

A review of each Act was undertaken two years after Royal assent was obtained.

Prime Minister Howard in 2006 provided the Government's response to the recommendations to the Lockhart Review, which commenced:

> *"After careful reflection, the Government is not disposed to make any changes to the existing national legislative framework for research involving human embryos, agreed in 2002."*

The Lockhart Report recommended that the NHMRC review the *Ethical Guidelines* in relation to consent to research and access ART embryos and that the principles of consent for participation and medical research must apply to sperm, egg and embryo donors, so as to ensure that decisions are freely made and that the NHMRC should develop guidelines for egg donation. It also recommended that the prohibition of the sale of the sperm, eggs and embryos should continue but the reimbursement of reasonable expenses should continue to be permitted.

The Lockhart Review also recommended a continuation of the role of the *Reproductive Technology Accreditation Committee* in regulation of ART and that trade and human gametes or embryos, or any commodification of these items, should continue to be prohibited.

ETHICAL GUIDELINES

The current version of the *Ethical Guidelines* has been developed following the Senate Inquiry and no doubt has been responsive to the Senate Inquiry. There have been substantial differences between the 2007 and 2017 versions. I have set out above the *Guiding Principles*. To repeat, they are:

2007 *Guiding Principles*	**2017 *Guiding Principles***
5.1 Respect all participants Assisted reproductive technology (ART) procedures must be conducted in a way that is respectful of all involved. Clinical decisions must respect, primarily, the interests and welfare of the persons who may be born, as well as the long-term health and psychosocial welfare of all participants, including gamete donors. 5.1.1 According to the National Statement, any person whose gametes are used for research	3.1 ART activities must be conducted in a way that shows respect to all involved.
5.2 Respect human embryos While there are different views held in our community about the moral status of a human embryo, one very widely shared view is that embryos warrant very serious moral consideration. At all times, any embryos created must be dealt with according to these guidelines and accepted standards of clinical and laboratory practice. In the course of clinical practice, clinicians must limit the number of embryos created to those likely to be needed by the participants in the course of their treatment.	A range of parties may be involved in ART, including the intended parent(s), gamete or embryo donor(s), a surrogate, persons who may be born as a result of ART and any child within the family unit(s) who may be affected by that birth.[4] The interests of these parties are invariably interrelated and interdependent and may be competing. In decision-making about ART every effort should be made to consider the interests of all relevant parties in order to reconcile, as far as possible, these individual and collective interests

5.2.1 To limit the number of embryos created, clinicians should: minimise ovarian stimulation; limit the number of ova fertilised and embryos stored; and not start new treatment cycles for patients when clinically suitable embryos are in storage.	
5.3 Use open and consistent decision making Participants in ART are entitled to understand and participate in the decision making about their care. Clinics must use an open and consistent approach to ethical issues that arise in practice. 5.3.1 Clinics should maintain documented practices and procedures, identifying the line of responsibility for each. For example, specific protocols should be developed for the following: the range of treatments and laboratory procedures; access to, and eligibility for, treatment; gametes and embryo donation (including selection, counselling and screening of both recipients and donors); • storage and disposal of gametes and embryos; • information giving and counselling;	3.2 The interests and wellbeing of the person who may be born as a result of an ART activity must be an important consideration in all decisions about the activity.

- obtaining consent to treatment; - record keeping and data reporting; - investigation and resolution of complaints.	
5.4 Provide information and counselling Participants in ART are entitled to detailed information about proposed procedures and any alternatives and to receive counselling about the consequences of those procedures. Clinicians must strive to ensure that all participants (and, where relevant, their spouses or partners) in ART are informed about all aspects of the procedures and receive professional counselling. Section 9 provides guidelines on information giving and counselling.	All competent adult participants exercise a choice about their involvement in ART activities. The person who may be born as a result of the activity does not. Although the same can be said when conception is natural, some ART activities offer the potential for greater influence of the desires of the intended parent(s). Some argue that the child would not exist without the desire of the intended parent(s) to become parents and that it is in a child's best interest to be born. Nevertheless, ART may have serious consequences for the person born. Therefore, ART activities should not commence without serious consideration of the interests and wellbeing of the person, who may be born as a result of that activity.
5.5 Obtain consent Participants in ART have the right to decide for themselves whether or not to take part in the proposed procedures. Clinics must obtain the consent of all participants in ART procedures (and, where relevant, their spouse or partner). Section 9 provides guidelines on obtaining consent.	3.3 ART activities must be undertaken in a manner that minimises harm and maximises the benefit to each individual or couple involved in the ART activity, any persons who may be born as a result of the activity, and any other child within the family unit who may be affected by that birth.

5.6 Maintain privacy and confidentiality All participants in ART are entitled to privacy. Clinics must respect the privacy of participants and confidentiality of all records and must have a privacy policy that ensures compliance with relevant legislation and guidelines.	Decisions regarding any procedures or the use of gametes or embryos should take into account any potential harm to any relevant party, the views of the intended parent(s), any medically relevant factors, and the likelihood of a successful live birth. In deciding whether to proceed, clinics should carefully consider potential harms to the person who may be born, or any child who may be affected by that birth. Clinics may refuse or delay treatment (pending further review by the clinical team) if there are concerns about the physical, psychological and/or social wellbeing of any relevant party.
5.7 Keep detailed records Good record keeping is an essential component of clinical practice and vital for ART because of the long-term consequences of procedures involving ART on the health and psychosocial wellbeing of the persons who are born and on the participants in ART procedures themselves (and their spouses and partners, if any). Clinics must keep accurate records of all gametes and embryos in their care in accordance with Section 10.	3.4 Decision-making in the clinical practice of ART must recognise and take into account the biological connections and social relationships that exist or may be formed as a result of the ART activity.
5.8 Collect and report outcomes data	The significance ascribed to a biological connection varies considerably from person

Participants in ART are entitled to accurate information about the risks of the procedures they will undergo. To monitor the short-term and longterm risks of ART procedures, and to provide accurate information for prospective participants, clinics must collect and make public data on the outcomes of ART procedures in accordance with Section 10.	to person. For some people, their connection to their biological parents, surrogate, siblings or other biological family members is very significant. For others, some or all of these biological connections have little or no significance. If a person born as a result of ART is deprived of knowledge about their biological connections, they are also deprived of the ability to decide the level of significance these connections will hold for them. When a person born from donated gametes or an embryo wants to establish contact with their biological parent(s) and/or their other biological family members, but is unable to do so, the effect on that person may be substantial. Consideration of biological connections and social relationships is important for prospective gamete donors or providers, and for those considering the use of donated gametes, donated embryos, surrogacy, or the posthumous use of gametes or embryos. In each of these cases, counselling by a professional with the appropriate training, skills, experience and competency to counsel in reproduction is required to assist those involved in their decision making and to explore the possible implications of such decisions.
5.9 Respect conscientious objections Conscientious objectors are not obliged to be involved in the procedures	3.5 Decision-making in the clinical practice of ART must recognise and respect the autonomy of all relevant parties, promoting

or programs to which they object. If any member of staff or student expresses a conscientious objection to the treatment of any individual patient or to any ART procedures conducted by the clinic, the clinic must allow him or her to withdraw from involvement in the procedure or program to which he or she objects. Clinics must also ensure that staff and students are not disadvantaged because of a conscientious objection.	and supporting the notion of valid consent as a fundamental condition of the use of ART.
	Individuals and couples involved, or considering involvement in, ART activities have the right to decide for themselves whether or not to take part in the proposed activities. To support their decision-making, individuals and couples seeking ART are entitled to the provision of detailed, accurate, contemporary and relevant information about proposed procedures or treatment and access to counselling about the potential consequences or risks, by a professional with the appropriate training, skills, experience and competency to counsel in reproduction. Valid consent must be obtained from all relevant parties for each specific procedure or treatment. The process of obtaining consent for ART activities is ongoing and not a single event.

	When the individual involved does not have the capacity, or is not able, to provide valid consent (e.g. children, people with impaired decision-making capacity, or the deceased), a representative (as defined by relevant legislation, or as identified by the Ethical Guidelines) must be involved in the discussions and decision-making. Although it is important to respect autonomy, an individual's or a couple's autonomy may be constrained by ethical and legal parameters.
	3.6 Decision-making in the clinical practice of ART must recognise that social relationships and social context may affect an individual's or a couple's decision-making and be sensitive to cultural and spiritual differences.
	It is important to recognise that social relationships and social context may enable, shape, or constrain an individual's or a couple's autonomy (i.e. autonomy is relational). Attitudes towards some of the more controversial practices and aspects of ART differ considerably, and are shaped by an individual's own particular set of values, preferences, and beliefs, or those of their family and/or community. Whilst it is important that the clinical team recognise the role that social factors play in

	decision-making, assumptions should not be made based on the personal circumstances, cultural background or spiritual beliefs of an individual or a couple seeking ART.
	3.7 Processes and policies for determining an individual's or a couple's eligibility to access ART services must be just, equitable, transparent and respectful of human dignity and the natural human rights of all persons, including the right to not be unlawfully or unreasonably discriminated against.
	In determining an individual's or a couple's eligibility to access ART services, there must be no unlawful or unreasonable discrimination, for example, on the basis of: • race, religion, sex, sexual orientation, relationship status, gender identity or intersex status, social status, disability or age5 • the reason(s) for seeking assisted conception • refusal to participate in research. The right of an individual or a couple to accept or reject specific procedures or treatments should be respected. However, where the choice of an individual or a couple is in conflict with current clinical evidence and practice, is likely to have an adverse effect on the person who would be born, or has demonstrable adverse social impacts (e.g. the transfer of multiple

	embryos at the one time), then it is appropriate that these factors are taken into account in decision-making regarding the procedure. There are circumstances where it is reasonable for a clinician to delay treatment or decline to treat an individual or couple. Conscientious objection A member of staff or a student who expresses a conscientious objection to the treatment of an individual patient or to an ART procedure is not obliged to be involved in that treatment or procedure, so long as the objection does not contravene relevant anti-discrimination laws and does not compromise the clinical care of the patient (e.g. the patient is referred to someone without a conscientious objection and is willing to accept their care). The clinic must allow a member of staff or a student who expresses a lawful conscientious objection to withdraw from involvement and ensure that the member of staff or student is not disadvantaged because of their lawful conscientious objection.
	3.8 The provision of ART must be underpinned by policies that support effective and efficient practices that minimise interventions not supported by evidence of successful clinical outcomes.
	The principle of effectiveness requires that waste is reduced, practices that clearly do

	not work are not used, and proven measures that are likely to succeed are implemented. Effectiveness is linked to the concept of efficiency, which requires that limited resources be used in the most productive manner possible.
	3.9 The provision of ART must be transparent and open to scrutiny, while ensuring the protection of the privacy of all individuals or couples involved in ART and persons born, to the degree that is protected by law.
	Clinics must practise an open and consistent approach to ART activities. Clinics must maintain policies for each treatment and procedure available at the clinic. These policies must identify the line of responsibility in each circumstance. For example, specific policies should be developed and implemented in relation to: • the range of treatments and procedures available • access to, and eligibility for, treatment • gametes and embryo donation (including allocation, counselling and eligibility of both donors and recipients) • use, storage and discard of gametes and embryos • provision of information and counselling to assist decision-making

	• obtaining consent for treatment • record keeping and data reporting • investigation and resolution of complaints. Detailed records must be maintained so that the short and long-term outcomes of ART activities can be assessed in order to document benefit and harm. The objectives of this are to maximise the availability of data for research, monitoring and professional oversight and to identify risks — and facilitate their correction — in order to minimise harm to all parties, including to the persons born. Clinics must also have processes in place for the audit and/or peer review of clinical decisions.

The 2007 version does not have a discussion after each ethical principle. It is obvious on looking at a side by side comparison of the 2007 and 2017 version that the 2017 version is much more comprehensive and has a comprehensive discussion with each guiding principle as to the relevant issues, some of which I have outlined above.

2017 ETHICAL PRINCIPLES

The current *Ethical Guidelines* are approximately 30 pages longer than the previous and are certainly much more detailed about consent, counselling and the use of donated gametes in ART activities. In my view, the 2017 *Ethical Guidelines* clearly responded to the issues raised in the Senate Inquiry report.

GOVERNMENT/REGULATORY FRAMEWORKS INCLUDING REGISTERS ESTABLISHED INTERSTATE

The *Assisted Reproductive Treatment Act 2008* (Vic) has dealt with the removal of anonymity retrospectively. The sections are certainly comprehensive but very long, commencing at section 49 right through to section 73C.

In my view, the provisions of the *Assisted Reproductive Technology Act 2007* (NSW) which set up the Central Register is a workable model. It is considerably shorter than the Victorian version (but admittedly does not cover the retrospective aspect) but is otherwise fit for purpose. I have dealt with the Central Register relating to provision of information for surrogacy matters (required under the *Assisted Reproductive Technology Act 2007*). The central register, managed by the Ministry of Health, is efficient to deal with.

In Victoria there are two entities that have management of the process – Victorian Assisted Reproductive Treatment Authority (VARTA) and the Registrar of Births, Deaths and Marriages.

Counsellors to assist with implications arising are funded by the taxpayer- in Victoria through VARTA, and in NSW by the Ministry of Health.

In addition, Victorian and NSW clinics are still obliged to make counsellors available- at their cost- for implications counselling.

A way to save cost to the taxpayer, and decrease duplications, would be for the counselling to be provided by counsellors funded by the relevant clinic that had provided treatment- as they are required to fund in any case under the *Ethical Guidelines*, and for the State to only fund counsellors in the unusual event that the IVF clinic is out of business (and there is no successor clinic) , or when there has been a private donation (if the latter is to be part of the scheme).

I do not have any firm views about whether the donor registry should be managed by Queensland Health or by the Registrar of Births, Deaths and Marriages. From a cost perspective, I would suggest the latter. As I set out below, we should be proud of our Registrar of Births, Deaths and Marriages.

SHOULD THE MODEL INCLUDE INFORMATION FROM PRIVATE DONOR ARRANGEMENTS?

It is next to impossible to compel people with private donor arrangements to provide documents to Government, particularly if they are being asked to pay for that. These are often made by friends or family members and often do not involve clinics when there has been sperm donation. There have been any number of cases litigated in the Family Court which involved a private donation[55]. I would have no objection to an opt in model- so that those taking part in private donation can opt in to a central register if they wish.

COSTS OF ANY PROPOSAL INCLUDING TO ESTABLISH AND MAINTAIN ANY REGISTER IN OPTIONS FOR EFFICIENCIES, INCLUDING A USER-PAYS MODEL

As I suggest above, for efficiency and to save costs, counselling should be funded by clinics, as occurs now.

Queenslanders should be very proud of the Registry of Births, Deaths and Marriages. I understand that it is fully funded from fees and is reputed to be the most efficient registry in Australia. My experience with dealing with staff from there over many years is that they are friendly, approachable and efficient.

A CONTRAST OF TWO STATES

When a parentage order is made, the birth register needs to be altered and then a second birth certificate issued for the child, with the names of the intended parents now shown on the birth certificate as the parents.

Once a parentage order is issued by the Childrens Court of Queensland, a form is filled out either in paper form or online with a copy of the court order provided to the Queensland Registrar of Births, Deaths and Marriages. The sealed order is issued by the Court in typically two days.

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[55] For example, *Lowe and Barry* [2011] FamCA 625 – a private surrogacy matter prior to Tasmanian legislation; *Parker & Irwin* [2013] FCCA 658 (which was a dispute between two mothers about their children and there was a known sperm donor. The judge commented that there were three parents. I acted for the birth mother; *Masson v Parsons* [2019] HCA 21; *Re Patrick* [2002] FamCA 193 where according to various sources I was told that the birth mother killed herself and the child after the court outcome; *Groth and Banks* [2013] FamCA 430 (not a private arrangement – but the man and the woman falsely told the Victorian IVF clinic that they were a couple, as they were fearful that otherwise they would not receive treatment; *Verner & Vine* (2005) FamCA 763 (not a private arrangement, but it was alleged that two women had falsely stated to a Sydney IVF clinic that they were a couple so that they could receive treatment; *Reiby & Meadowbank* [2013] FCCA 2040.

Experience over the last 10 years has been that at absolute worst, the delay by the Registrar of Births, Deaths and Marriages in issuing the new birth certificate has been one week, the shortest has been two hours, but typically 1-2 business days.

By contrast, the process in New South Wales is that a parentage order is made by the Supreme Court of New South Wales and then sent direct to the Registrar of Births, Deaths and Marriages there. It typically takes *six weeks* from when the order is made before the new birth certificate issues. It is woefully slow. I cannot understand why there is such an extraordinary time difference between the experience in Queensland and that in New South Wales.

The worst case I had with the New South Wales Registry was 10 years ago after the surrogacy legislation commenced. Despite the *Surrogacy Act 2010* (NSW) making clear allowance for an interstate parentage order, the relevant officer of the New South Wales Registry refused to process a Queensland order (where the intended parents lived in Queensland and the children (twins) were born in New South Wales) because she did not know whether she had the authority to process. She clearly did not speak to a superior despite my and my colleague's urging. It took *nine months* for the birth register to be altered, the same as the pregnancy.

WHETHER REGULATING DONOR CONCEPTION PRACTICES AND ASSISTED REPRODUCTIVE TECHNOLOGY SHOULD ALSO BE CONSIDERED AS PART OF ESTABLISHING A DONOR CONCEPTION REGISTER

I would be opposed to the enactment in Queensland of an *Assisted Reproductive Treatment Act*. One should be concerned about creeping regulation. Our IVF clinics are currently well regarded internationally. The requirement for them to publish their outcomes to both the Australian and New Zealand Assisted Reproductive Database (ANZARD) and www.yourivfsuccess.com.au through the lens of transparency helps keeps them that way.

In my view, IVF clinics in Queensland work efficiently and in clear compliance with the *Ethical Guidelines*. I do not sit on the board of any of the clinics. My experience in dealing with clinics in New South Wales, Victoria, and Western Australia (and to a lesser extent South Australia) is that adding State requirements on top of the *Ethical Guidelines* adds to cost and complexity. Costs are compounded for those clinics that operate across State borders which our three biggest clinics do, namely, Virtus Health, City Fertility and Monash IVF.

The view has been expressed from time to time in other quarters that having corporate ownership of IVF clinics is a bad thing. The implication is that the clinics are driven solely by profit. IVF clinics have always been driven by profit, whether they are doctor owned or not. In my view, having corporate ownership is not necessarily a bad thing, and in many ways is a good thing, because of the need to innovate, to ensure consistent quality over several sites, to be responsive to the requirements of consumers, and to be compliant with legal and compliance requirements- especially when operating in several States.

Invariably, an increase in cost will be passed on to the consumer. Ideally, there should be a national model of regulation of IVF clinics. Sadly, it is likely not to be any time soon. In the meantime, the default model of regulation of IVF clinics is the *Ethical Guidelines*. In my view they are a more than adequate means of regulation, and should remain the prime means of regulation of IVF clinics in Queensland.

Queensland fertility doctors have at times been sharply critical of interstate models, which have increased costs and compliance requirements, reduced flexibility, and reduced options for patients. In my view the doctors are right, as was the Lavarch Committee and the Government in response- that the *Ethical Guidelines* set out clear requirements that IVF clinics must follow.

HUMAN RIGHTS ACT 2019

Section 12 of the Act recognises that a right or freedom not included, or only partly included, in the Act that arises or is recognised under another law must not be taken to be abrogated or limited only because the right of freedom is not included in this Act or is only partly included. Four examples of other laws are:

- The common law.
- Rights under the international covenant on civil and pollical rights not stated in this Act.
- Rights under other international conventions.
- Other international laws.

Section 26 provides:

> *"(1) Families are the fundamental group unit of society and are entitled to be protected by society and the State.*
>
> *(2) Every child has the right, without discrimination, to the protection that is needed by the child, and is in the child's best interests, because of being a child.*
>
> *(3) Every person born in Australia has the right to a name and to be registered, as having been born, under a law of the state as soon as practicable after being born."*

This section takes up the *UN Convention on the Rights of the Child* which I have referred to above which also includes in that convention the right of a child to an identity.

Section 37(1) provides:

> *"Every person has the right to access health services without discrimination."*

A Freedom to Reproduce

It is recognised under the common law in Australia that there is a freedom to reproduce.

In *Skinner v State of Oklahoma, ex rel. Williamson,* 316 US 535 (1942), the US Supreme Court held that there was a right to procreate. The basis of that decision was in turn reliant upon the US constitution. Oklahoma law provided that if defendants received two or more convictions for crimes involving moral turpitude, they could be ordered to be sterilised as habitual offenders who had criminal genetic treys. After his third conviction, Mr Skinner was determined to be a habitual offender, in order to be sterilised. He argued that the law was unconstitutional. Douglas J held[56]:

> *"But the instant legislation runs afoul with the equal protection clause, though we give Oklahoma that large deference which the rule of the foregoing cases require. We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilise, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands, it can cause races or types which are inimicable to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches.*

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[56] At p.541.

> *Any experiment which the state conducts is irreparable injury. He is forever deprived of a basic liberty."*

At the time of that decision, sperm donation was in its infancy (excuse the pun) and IVF was not dreamed of. Nevertheless, it has been long considered in the United States that there is a right to procreate.

In *Re Jane* [1998] FamCA 57, the acting public advocate of Victoria sought an injunction against Jane's parents from permitting to be performed upon her any hysterectomy or other operation calculated to sterilise her or her reproductive organs unless and until approved by the court. The court approved the operation. Jane was aged 17 but had a mental age of a child of 2 and there were negligible prospects that she would improve beyond her present state. Chief Justice Nicholson stated:

> *"First, it may, I think, be said to be accepted that the common law recognises a fundamental principle that every person's body is inviolate, but it is also obvious that such a wide principle must be subject to exceptions …, children may be subjected to reasonable punishment; people may be subjected to the lawful exercise of the power of arrest; and reasonable force may be used in self defence or for the prevention of crime but, apart from these special instances where the control or constraint is lawful, a broader exception has been created to allow for the exigencies of everyday life. Generally speaking, consent is a defence to battery; and most of the physical contacts of ordinary life are not actionable because they are impliedly consented to by all who move in society and so expose themselves to the risk of bodily contact. So nobody can complain to the jostling which is inevitable from its presence in, for example, a supermarket, an underground station or a busy street; nor can a person who attends a party complain if his hand is seized in friendship or even if his back is (within reason) slapped …*
>
> *It appears that in England the courts have also recognised a right to reproduce. In Re D (a Minor) (1976) Fam.l.r.185; (1976) 1 All ER 326 Heilbron J. said at p.332 (All ER):*
>
>> *'The type of operation proposed is one which involves the deprivation of basic human right, only the right of a woman to reproduce and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right.'*

Although her Honour did not cite authority for this proposition, it appears to have been accepted by the House of Lords in Re B and by the Supreme Court of Canada in Re Eve (1986) 25S.C.R.388. In the former case, the passage cited from the judgment of Heilbron J. was expressly approved in the court of appeal and by Lord Hailsham p.213, Lord Bridget p.214, Lord Templeman p.215 and Lord Olivo p.219.

This view, has been the subject of some criticism. See, for example, the article "Sterilization and The Cause", Grubb & Pearl 46 Cambridge Law Journal 439 at pp 446-448. The learned authors point out that such a 'right' does not appear to have been explicitly recognised in international humanitarian law and suggested that the right concerning cases such as this, is not a right to reproduce as such, but rather an aspect of the right to determine what is done with one's own body.

In the case of Re Grady N.j.426A 2(d) 467, Pashman J. in giving the principal judgment of the Supreme Court of New Jersey said:

'Sterilization may be said to destroy an important part of a person's social and biological identity – the ability to reproduce. It affects not only the health and welfare of the individual, but the well being of all society. Any legal discussion of sterilization, must begin with an acknowledgement that the right to procreate is fundamental to the very existence and survival of the race. Skinner v Oklahoma [1942] … this right is a basic liberty of which the individual is forever deprived through unwanted sterilization.'

His Honour went on to say that in the USA at least, there is also a constitutional right to be sterilized as part of the right to control one's own body… his Honour pointed out that although the US Supreme Court had not as yet specifically recognised such a right, it has been recognised by a number of small state appellate courts in the USA. His Honour continued:

> *'Having recognised that both a right to be sterilized and a right to procreate exists, we face the problem … that L is not competent to exercise either of her constitutional rights. What is at stake is not simply a right to obtain contraception or to obtain procreation, implied in both these complementary liberties, is a right to make a meaningful choice between them.'*

> *I find the analysis of Pashman J. to be a useful one for present purposes. It involves a clear recognition of the right to procreate or reproduce as being a basic human right recognised by the common law. In view of the fact that such a right appears to have been recognised by superior appellant courts in the United Kingdom, Canada and the United States, I am confident that such a right would also be recognised as forming part of the common law of Australia.*
>
> *I also consider, however that in Australian law as in US law, there is no reason to suggest that there is not a right to refuse to procreate, i.e. a right to contraception whether by chemical means or sterilization …*
>
> *I consider that the rights in question may better characterised as liberties to reproduce or not reproduce as the case may be. If characterised as rights simpliciter, it is difficult to see how a sterilization operation carried out for non-therapeutic purposes (in the expression 'therapeutic' is condoned in the treatment of some disease of malfunction) could ever be lawful. Characterised as liberties, the question of the lawful justification for such operations becomes clearer. If a person is capable of exercising a liberty, they may lawfully do so either by procreating and using methods of contraception, including sterilization. If a person is incapable of choice, then consent may be given on their behalf."*

In the marriage of F and F [1989] FamCA 41, counsel for the husband said that the right of the husband to seek to prevent the abortion was founded upon the common law right of every human being to procreate or reproduce in accordance with the ruling in *Re Jane*. He conceded that right, or perhaps more accurately that liberty, must be exercised with the concurrence and consent of some member of the opposite sex. He also conceded that if every human being has a legal right to procreate, then he or she also has a right to refuse to procreate and that these competing rights are of equal strength.

He contended, however, that the choice whether to procreate or to refuse to procreate must be made at a point prior to conception and that when a man and woman have freely chosen to join in the act of procreation, and that act has been successful to the extent that conception has occurred, neither of these parties can unilaterally elect to terminate the pregnancy without good cause. He submitted that on the facts of this case there was no good cause shown for the abortion proposed by the wife and therefore the husband's right to procreate may be protected by the court.

The wife's counsel contended that if the husband had a legal right to procreate, the wife had an equal right to refuse to procreate and that the husband's right does not extend to giving him the right to insist that the wife carry his child through to birth in order to preserve his right. He submitted that there was never such a right recognised by the common law.

Lindenmayer J. felt himself:

> *"unable to conclude that the husband's so-called right to procreate extends to giving a right to force the wife to carry through her pregnancy to the birth of the child, contrary to her wish not to do so."*

Human rights implicated by donation include:

- **Right to equality and non-discrimination**, for example, Universal Declaration of a Human Rights, Article 2; International Covenant on Civil and Political Rights, Article 26; International Covenant on Economic, Social and Cultural Rights, Article 2; Convention for the Elimination of Discrimination Against Women, Article 2; Convention on the Rights of People with Disabilities, Articles 5 & 6.

- **Right to Health** e.g. Universal Declaration of Human Rights, Article 25; International Covenant on Economic Scientific Cultural Rights, Article 12; Convention on the Elimination of Discrimination Against Women, Article 12;

- **Right to Privacy** e.g. Universal Declaration of Human Rights, Article 12; International Covenant on Civil and Political Rights, Article 17

- **Bodily Autonomy** e.g. International Covenant on Civil and Political Rights, Articles 7 & 17; Convention on the Elimination of Discrimination Against Women Article 12 and General Report 24

- **Reproductive Autonomy** e.g. Convention on the Economic Scientific and Cultural Rights, General Comment 22; Convention on the Elimination of Discrimination Against Women Article 24 and General Report 24

- **Right to Decide the Number and Spacing of Children**: Convention on the Elimination of Discrimination Against Women Article 16

- **Right to Found a Family**: Universal Declaration of Human Rights, Article 16; Convention on the Rights of People with Disabilities, Article 23
- **The Right to Information** e.g. Universal Declaration of Human Rights, Article 19; International Convention on Civil and Political Rights, Article 19
- **Right to Benefit from Scientific Progress** e.g. Universal Declaration of Human Rights, Article 27; International Convention on Economics Scientific Cultural Rights, Article 15(b)
- **Rights of Persons with Disabilities** e.g. Convention on the Rights of Persons with Disability, Articles 5, 6, 7, 12, 17 and 23.

I also note Yogyakarta Principle 24- the right to found a family:

> Everyone has the right to found a family, regardless of sexual orientation or gender identity. Families exist in diverse forms. No family may be subjected to discrimination on the basis of the sexual orientation or gender identity of any of its members.
>
> States shall:
>
> a) Take all necessary legislative, administrative and other measures to ensure the right to found a family, including through access to adoption or assisted procreation (including donor insemination), without discrimination on the basis of sexual orientation or gender identity;
>
> b) Ensure that laws and policies recognise the diversity of family forms, including those not defined by descent or marriage, and take all necessary legislative, administrative and other measures to ensure that no family may be subjected to discrimination on the basis of the sexual orientation or gender identity of any of its members, including with regard to family-related social welfare and other public benefits, employment, and immigration;
>
> c) Take all necessary legislative, administrative and other measures to ensure that in all actions or decisions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration, and that the sexual orientation or gender identity of the child or of any family member or other person may not be considered incompatible with such best interests;
>
> d) In all actions or decisions concerning children, ensure that a child who is capable of forming personal views can exercise the right to express those views freely, and that such views are given due weight in accordance with the age and maturity of the child;
>
> e) Take all necessary legislative, administrative and other measures to ensure that in States that recognise same-sex marriages or registered partnerships, any entitlement,

privilege, obligation or benefit available to different-sex married or registered partners is equally available to same-sex married or registered partners;

f) Take all necessary legislative, administrative and other measures to ensure that any obligation, entitlement, privilege or benefit available to different-sex unmarried partners is equally available to same-sex unmarried partners;

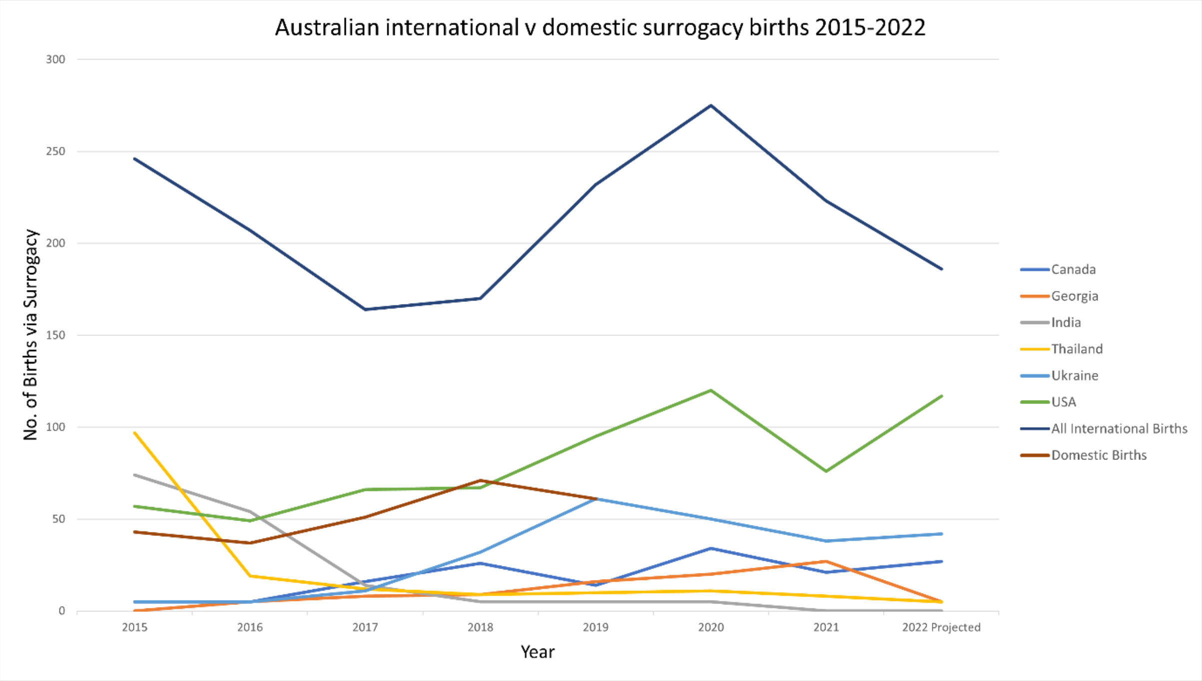
g) Ensure that marriages and other legally-recognised partnerships may be entered into only with the free and full consent of the intending spouses or partners.

SURROGACY STATISTICS

Only a small number of those who need an egg or sperm donor undertake surrogacy. Nevertheless, egg or sperm donation is closely tied up with surrogacy, as many intended parents need an egg or sperm donor. Since 1988, I have advised in over 1750 surrogacy journeys for clients throughout Australia, and at last count 32 countries overseas. About half of that number are heterosexual couples, and half are gay couples, with a small number of single men, single women, transgender and lesbian couples. All of the gay couples and single men, and I would estimate that about half of the heterosexual couples, needed the help of an egg donor.

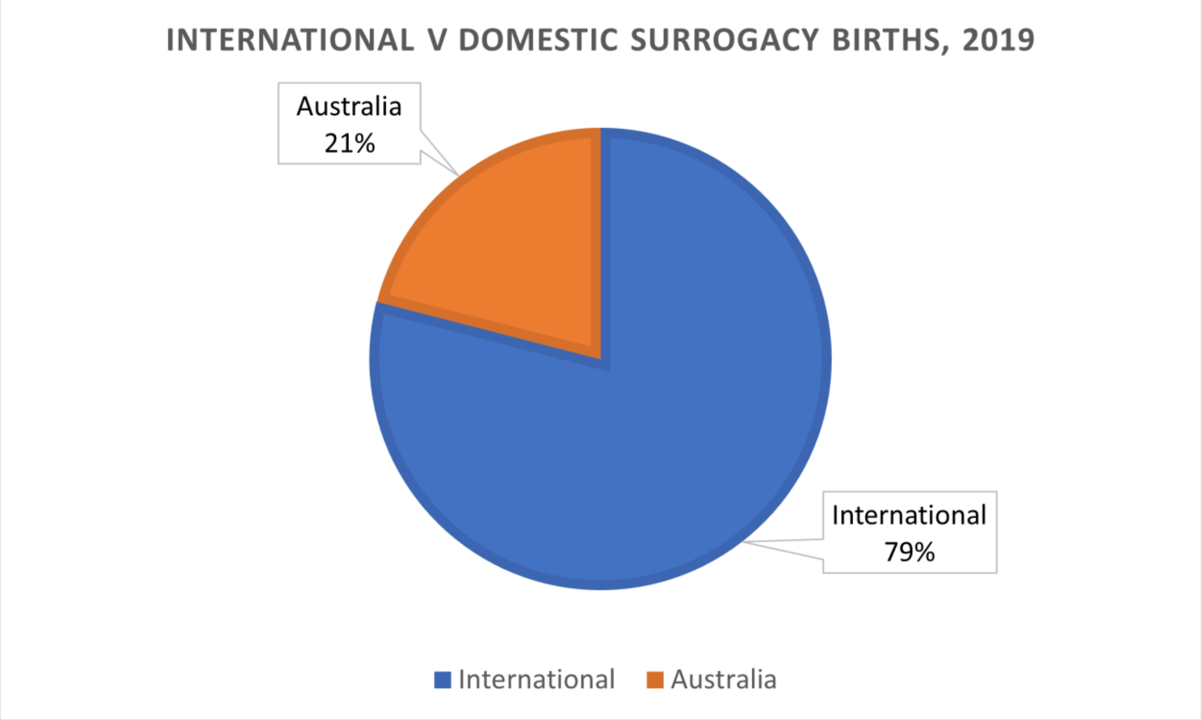
The regime of altruism applies for both gamete donation and surrogacy. The vast majority of children who are born to Australian intended parents are born overseas. Intended parents behaviour with surrogacy is indicative of what people will do if they perceive the barriers to becoming parents being too big: they will vote with their feet and go elsewhere.

Parliament has to be careful not to make whatever laws may arise from this Inquiry that the effect is that Queenslanders go overseas instead.



As can be seen, international surrogacy births have for a decade always exceeded domestic surrogacy births.

In 2019, the most recent year for domestic figures, the comparison of international and domestic surrogacy is as follows:



It now appears that more Australian children are born in the United States via surrogacy each year than are born in Australia:

	2018	**2019**	**2020**	**2021**
Australia	71	61[57]		
USA	67	95	120	76

The top 5 overseas countries in 2021 were:

Ranking	**Country**	**No of Australian children born via surrogacy**
1.	USA	76
2.	Ukraine	38
3.	Canada	28
4.	Georgia	27
5.	Mexico	9

My projections for overseas surrogacy births in the year ended 30 June 2022[58]:

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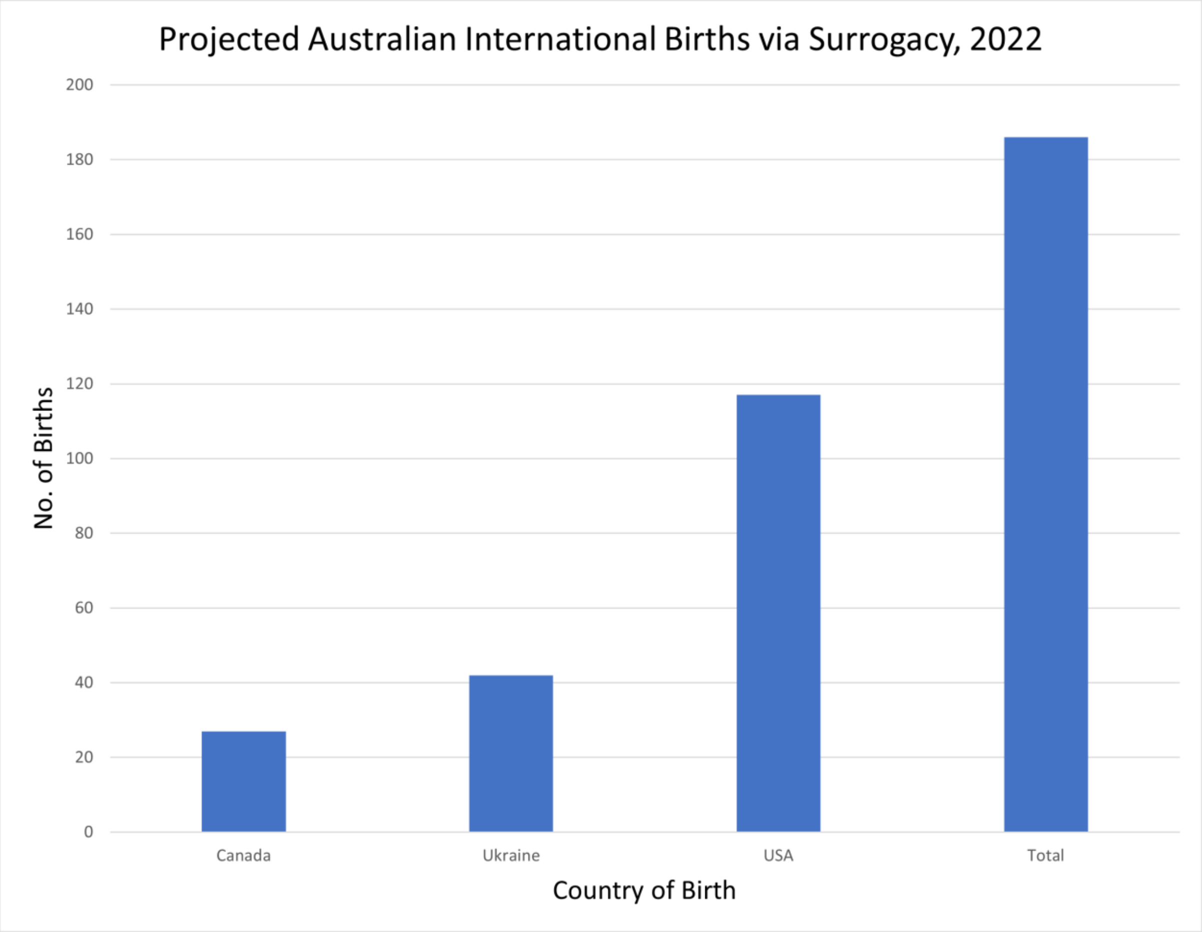
[57] Most recent

[58] Based on the latest figures I have obtained from the Department of Home Affairs, for the period 1 July 2021 to 31 October 2021.



There are two sources for this data. When Australian intended parents seek to apply for citizenship for their child, they must apply to the Department of Home Affairs. The Department says that there were 223 applications in the year ended 30 June 2021. This is roughly consistent with previous years, for example, 232 births in 2019 financial year and 275 births in the 2020 financial year.

Domestic births are a bit harder to work out. A unit of the University of New South Wales, the Australian New Zealand Assisted Reproductive Database,[59] keeps data on births through Australia and New Zealand IVF clinics. This includes the number of births through gestational surrogacy. There are four issues with the figures from ANZARD in that:

- They don't capture births from traditional surrogacy (where the surrogate is the genetic mother) and therefore capture only the births through clinics.
- They are two years behind, the most recent year being the calendar year ending 31 December 2019.

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[59] Disclosure: although I am a lecturer at the University of New South Wales, I have no connection with ANZARD.

- They don't give a breakdown between Australia and New Zealand.
- The Department's figures are for the year ending 30 June, whereas ANZARD is for a calendar year. They are always 6 months out from each other.

In the 2019 year there were 73 births through gestational surrogacy in Australia and New Zealand IVF clinics. If Australians and New Zealanders undertake surrogacy at the same rate domestically, then based on population, the proportion of those that are Australian domestic births are 61. The total international births in the year ended 30 June 2019 was 232. The most recent comparison is therefore – 79% of children born through surrogacy are born overseas and 21% born in Australia. Or to put it another way, for every child born in Australia via surrogacy, almost 4 children are born overseas via surrogacy.

Australian intended parents vote with their feet.

COMPARISON OF WHERE QUEENSLANDERS GO FOR SURROGACY[60]

Year	Queensland Domestic Surrogacy Births	International Surrogacy Births for Queenslanders
2012	11	6
2013	13	53
2014	13	53
2015	14	49
2016	14	41
2017	9	33
2018	5	34
2019	10	46
2020	6	55
2021[61]		47

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[60] The years concerned are the years ended 30 June of each year. The Queensland figure is taken from annual reports of the Childrens Court of Queensland. The international births column is taken from the statistics supplied under Freedom of Information from the Department of Home Affairs of applications for citizenship by descent for children born overseas via surrogacy divided by five, as the Queensland population is approximately 20% of the Australian population.

[61] 2021 figures are not yet available from the Childrens Court

One of the drivers of intended parents going overseas for international surrogacy, as reported to me, is that they cannot locate a local egg donor.

Queensland intended parents vote with their feet. In the period between 1 July 2011 and 30 June 2020, there were a total of 95 applications for parentage orders in the Childrens Court of Queensland. An allowance has not been made if any of those were for twins. I have acted in two cases where a parentage order was made for twins. Let us assume that there have been say 97 children born via surrogacy in Queensland. By contrast, there were 370 born overseas. To put it another way, for every child born via surrogacy in Queensland, three were born overseas. The Queensland statistic reflects the national statistic: 21% of births occurred domestically, and 79% internationally.

Since 1988 it has been an offence to undertake commercial surrogacy overseas. Not one Queenslander has ever been charged, let alone convicted, despite it being evident that many do so. There would appear to be no appetite to prosecute, which therefore renders that law seemingly unenforceable- making a mockery of the law. If it is considered that there ought to be new offences concerning assisted reproductive treatment, great care should be taken that they are not seeking to criminalise behaviour as a tubthumping approach, which is not enforceable and make a mockery of the law.

ABOUT ME

I am a dad through surrogacy and egg donation, all undertaken in Queensland. I have also suffered infertility.

I was admitted as a solicitor in 1987 in Queensland, in the High Court in 1989 and in South Australia in 2013.

Since 2012 I have been an international representative on the Assisted Reproductive Technologies Committee of the American Bar Association. I am the founder of the LGBT Family Law Institute in Australia. I am a Fellow of the International Academy of Family Lawyers, including of its Parentage, LGBT and Forced Marriage Committees. I am a Fellow of the Academy of Adoption and Assisted Reproduction Attorneys, the first outside the US and Canada.

For many years I have been an independent children's lawyer on the panel of Legal Aid Queensland, being appointed to parenting matters in the Federal Circuit and Family Court of Australia. I am concerned that I have a child centred approach to my work.

I lecture in Ethics and the Law in Reproductive Medicine in the Masters of Reproductive Medicine course at the University of New South Wales. I received an excellence in teaching award from that university in 2019.

In 2015 I received the LGBTIQ activist of the year from the Queen's Ball Award. I also received the Rainbow Keys award from the LGBTI Legal Service that year. In 2016 my then firm received an Equity and Diversity Award from the Queensland Law Society.

In 2020 I was the recipient of the inaugural Pride in Law Award. The judges for this award included the President of the Queensland Law Society and the President of the Bar Association of Queensland. The Queensland Law Society described my receiving the award as:

> *"Leading Queensland in internationally renowned surrogacy solicitor Stephen Page has been named winner of the inaugural Pride in Law award in recognition of stellar contribution of LGBTIQ+ practitioners in the profession."*

I have appeared in many judgments concerning surrogacy, including: *Re Grosvenor* [2017] FamCA 366, *Sigley & Sigley* [2018] FamCA 3, *Rose* [2018] FamCA 978, *Allan & Peters* [2018] FamCA 1063, *LWV & LMH* [2012] QChC 26 (the first case in the world to define conception), *RBK v MMJ* [2019] QChC 42, *KRB & BFH v RKH & BJH* [2020] QChC 7 (in which the court cited article 8 of the *International Convention on the Rights of the Child* as to the child's right to an identity).

I have written and spoken about assisted reproductive treatment, including surrogacy and presented about assisted reproductive treatment, including surrogacy around the world including:

- Guest lecturer Monash University.
- Guest lecturer Hong Kong University.
- Guest lecturer University of the Western Cape.
- International Bar Association.

- American Bar Association.
- Family Court of Australia.
- Women Judges Association of Australia.
- International Academy of Family Lawyers.
- LawAsia.
- Canadian Fertility and Andrology Society.
- Fertility Society of Australia and New Zealand.
- Family Law Practitioners Association of Western Australia.
- Law Society of South Australia.
- Hunter Valley Family Law Practitioners Association.
- Queensland Law Society/Family Law Practitioners Association of Queensland.
- American Society for Reproductive Medicine.
- Royal Australian College of Obstetricians and Gynecologists.
- Family Law Section of the Law Council of Australia.
- South African family law conference.

My first surrogacy client was in 1988, shortly after the enactment of the *Surrogate Parenthood Act 1988* (Qld). Since about 2010 I have prepared sperm donor agreements and more recently, egg and embryo donor agreements.

I have advised clients concerning posthumous use of gametes. Queensland has a more flexible regime which allows posthumous use (within tightly prescribed guidelines of the *Ethical Guidelines*, which is not always available interstate).

I am a director of Access Australia's Infertility Network Limited, a charity focused on the needs of the consumer in dealing with assisted reproductive treatment. I am a director of the Fertility Society of Australia and New Zealand. I have in the past given advice concerning assisted reproductive treatment regulation to a number of IVF clinics, a sperm bank and proposed egg and embryo banks throughout Australia.

The opinions in this submission are mine alone.

I have no objections to my submission being published. If it is of any assistance to the committee, I would be willing to give oral evidence.

I have previously made submissions to the following inquiries:

- New South Wales Surrogacy Review 2014.
- Tasmanian Surrogacy Bill 2011.
- Amendments or proposed amendments to South Australian surrogacy law 2014, 2015, 2016, 2017 and 2019.
- Victorian Assisted Reproductive Treatment and Surrogacy Review (the Gorton Review) 2018 and ongoing.
- The Western Australian Assisted Reproductive Treatment and Surrogacy Review (the Allen Review) (2018).
- Member of the Northern Territory Joint Surrogacy Working Group for the Northern Territory Government resulting in the Surrogacy Bill 2022 (NT).

My most recent publication is chapter 4 *Australian Surrogacy Law: Recommendations for Reform* with Ronli Sifris in *Critical Perspectives on Human Rights Law in Australia Volume 2*, Gerber and Castan (Ed), Thomson Reuters, 2021, published the week before Easter 2022.

Yours faithfully

Stephen Page
Page Provan
family and fertility lawyers
Accredited Specialist Family Law
Email: [redacted]