Legal Responses to Non-Life-Threatening Medical Neglect

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Abbreviations

The following abbreviations are used throughout this dissertation:

COCA	Care of Children Act 2004
CYPFA	Children, Young Persons and their Families Act 1989
CYFS	Department of Child, Youth and Family Services

Chapter 1

Introduction

> "This case lies at the intersection of the rights and responsibility of parents to make sound health care decisions for their children and the duty, indeed, the obligation, of the state to override that right in appropriate circumstances. This court must decide where the correct intersection lies and on which side this case falls."[1]

1.1 Introduction

In 2009, one in every 250 children in New Zealand was found to be suffering from neglect.[2] While that figure is not broken down to type of neglect, a large number of these children will have suffered medical neglect, either on its own or in tandem with other types of neglect. The term medical neglect has no formal legal standing in New Zealand, but is accepted by the Department of Child, Youth and Family Services (CYFS) to consist of a "failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development".[3] Medical neglect therefore covers two main types of situations. The first is the failure to seek or obtain medical care for a child. The second, failure to follow through with medical care, can be generally considered to consist of a refusal to consent to treatment. This dissertation looks at both types of medical neglect.

While the legal situation with regard to medical neglect in life-threatening situations in New Zealand is very clear,[4] that is not true of non-life-threatening situations. The aim

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1 *VM v British Columbia (The Director of Child, Family and Community Service)* 2008 BCSC 449 at [1].

2 Janine Mardani *Preventing Child Neglect in New Zealand* (Office of the Children's Commissioner, 2010) at 39. The figure is based on reported findings of neglect by the Department of Child, Youth and Family Services (CYFS).

3 Department of Child Youth and Family Services *Let's stop child abuse together : an interagency guide to breaking the cycle* (Child, Youth and Family Services, Wellington, 2001) at 9.

4 See *Re J (An Infant): B & B v Director-General of Social Welfare* [1996] 2 NZLR 134 (CA), alt cit *MJB v D-GSW* [1996] NZFLR 337(CA), alt cit *MJB v Director-General of Social Welfare* (1996) 14 FRNZ 389 (CA) for evidence of the willingness of courts to order treatment in life-threatening situations, although note limits as shown in *Auckland Healthcare Services Ltd v L & L* (1998) 17 FRNZ 376, [1998] NZFLR 998 (HC). For the possibility of criminal proceedings against parents where the child has died as a result of medical neglect, see *R v Laufau* HC Auckland T.000759, 2 October 2000 and *R v Moorhead* HC Auckland TO11974, 13 June 2002.

of this dissertation is to examine the state of the law in New Zealand regarding medical neglect when the child's life is not in danger.

1.2 What Constitutes Non-Life-Threatening Medical Neglect?

There are a variety of situations in which parents refuse or fail to treat children in non-life-threatening situations. Arani[5] has identified that the circumstances under which courts can intervene with regard to medical neglect fall into three categories: life-saving, life-prolonging, and quality-of-life-enhancing.[6] Life-prolonging is arguably a variation of life-saving treatment, so the real interest in terms of non-life-threatening medical neglect is the failure to provide treatment that is quality-of-life-enhancing.

There is a moderate amount of case law, both in New Zealand and overseas, involving intervention for quality-of-life-enhancing treatment. Many cases have involved the need for blood transfusions or surgery to prevent disability.[7] Another common category is the administration of medication. Courts have been asked to order the taking of medication for a variety of conditions including epilepsy,[8] attention deficit hyperactive disorder,[9] HIV,[10] and inability to control bowels.[11] As shown by this list, the cases that have come before courts should be considered as only a sample of the possible conditions for which this scenario might arise. It is also possible that the refusal may be for the input of allied professionals. New Zealand examples include an unwillingness to allow a child to have physiotherapy and occupational therapy,[12] and a refusal to allow a child to receive psychiatric treatment.[13] There are again an unlimited number of

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5 Shireen Arani "State Intervention in Cases of Obesity-Related Medical Neglect" (2002) 82 BUL Rev 875 at 878.

6 Although presented by Arani, above n 5, as separate categories, these categories are clearly not mutually exclusive. Many cases will involve both prolonging the child's life as well as improving the quality of that life.

7 *Auckland Healthcare Services v Liu* HC Auckland M812/96, 11 July 1996; *Canterbury District Health Board v L* HC Christchurch CIV-2005-409-1832, 15 August 2005; *VM v British Columbia*, above n 1; *Director of Community Services - re "Matthew"* [2005] NSWSC 132; *Re Green* 292 A 2d 387 (Penn 1972); *Re Jensen* 633 P 2d 1302 (Oregon Ct App 1981); *Re Tara Cabrera, a minor* 552 A 2d 1114 (Pa Super 1988).

8 *Waikato District Health Board v FF* HC Hamilton CIV-2008-419-1471, 5 December 2008.

9 *Re Terence P* 38 AD 3d 254 (NY App Div 2007); *Re Samuel DD* 81 AD 3d 1120 (NY App Div 2011).

10 *Re ELM* [2006] NSWSC 1137, 36 Fam LR 257.

11 *Re JB* 971 A 2d 674 (Vermont 2009).

12 *Health Care Hawkes Bay Limited v C* FC Hastings FAM 020/194/00, 30 June 2000.

13 *Ministry of Social Development v CMC* FC Tauranga FAM-2007-079-126, 7 April 2008.

possibilities of such refusals or failures that could potentially arise, for example, failure to allow dietetic consultations for a malnourished child or anorexic teenager.

Quality-of-life-enhancing treatment does not, however, account for all cases. A further category is needed which can be labelled as preventive or protective. In these cases, the treatment that is not being provided, or is being refused, is aimed at protecting the child's health, rather than treating a condition they are known to have. There is a chance, or even a likelihood, that the risk will never eventuate, so there is no evidence that the treatment will be quality-of-life-enhancing. Examples are immunisations or diagnostic testing of children for particular diseases. There have been a number of cases internationally where courts have been asked to authorise immunisation of children contrary to the parents' wishes,[14] including one in New Zealand.[15] Internationally, the issue of testing arose with regard to an HIV-test for a child of an HIV-positive mother.[16] In another case, authorities sought permission to be allowed to test newborn children for diseases against parental wishes.[17] The preventive category also covers situations where children have no particular medical needs at the time, but where there is a genuine reason to fear that should a need arise, treatment will either not be sought or will be refused.[18]

1.3 The Parental Right to Consent and Refuse Consent

Under the common law, it is uncontentious that the power to consent to the medical treatment of a child is a parental power.[19] In New Zealand, with respect to "medical, surgical, or dental treatments or procedures (including a blood transfusion)", this power

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14 *Re Christine M* 595 NYS 2d 606 (NY Fam 1992); *Diana H v Rubin* 171 P 3d 200 (Ct App Ariz 2007); *Director-General, Department of Community Services; Re Jules* [2008] NSWSC 1193; *Children's Aid Society of Peel Region v H (TMC)* 2008 ONCJ 20; *Re JP* 2010 ABPC 379.

15 *Capital and Coast District Health Board v DRB* FC Wellington FAM-2010-085-595, 26 May 2010.

16 *Re C (a child)(HIV test)* [2000] Fam 48 (Fam).

17 *North Western Health Board v W(H)* [2001] IESC 90, [2001] 3 IR 635.

18 *Child Youth and Family Services v B* FC Dunedin FAM-2005-012-513, 1 July 2005; *Pahulu v Director-General of Social Welfare* (1998) 17 FRNZ 67 (DC).

19 P D G Skegg "Capacity to Consent to Treatment" in P D G Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 171 at 196; Brenda McGivern "Medical Treatment" in Geoff Monahan and Lisa Young (eds) *Children and the Law in Australia* (LexisNexis Butterworths, Chatswood, NSW, 2008) 430 at 445. See also *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (HL) at 184, per Lord Scarman.

is given to guardians.[20] It has been argued that this phrase should be interpreted extensively to include all health services that require consent.[21]

Guardians therefore have the power to consent to medical treatment for children, but this is limited to children under age 16. Once children reach that age, they have the right to consent (or refuse to consent) as if they are of full age.[22] They may also be able to consent or refuse to consent if they are under that age, but have a level of maturity known as "Gillick competency".[23] Although not the subject of decisions in the appeal courts, the doctrine of Gillick competency appears to be accepted in New Zealand.[24]

The right of guardians to consent to treatment is crucial to the concept of medical neglect. It is only because they have the ability to consent to medical care that they have the ability to neglect the provision of it. Guardians also have a right to refuse consent, as every person entitled to give consent on a child's behalf also has the right to refuse consent.[25]

1.4 Addressing Non-Life-Threatening Medical Neglect in New Zealand

Although parents in their role of guardian have the right to determine the medical treatment of their children under the age of 16, this right is not absolute. There are circumstances where society considers this right should be curtailed, reflected in art 24 of the United Nations Convention on the Rights of the Child which states that parties to the Convention, of which New Zealand is one, must:

> recognize the right of the child to the enjoyment of the highest attainable standard of health and ... shall strive to ensure that no child is deprived of his or her right of access to such health care services.

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20 Care of Children Act 2004 (COCA), s 36(3).

21 Skegg, above n 19, at 190. As outlined by Skegg at 197, even if some health services fall outside the ambit of s 36(3) of the COCA, the guardian would still probably have the capacity to consent as a result of ss 15(a) or 15(c) of the COCA, which give guardians all the duties, powers, rights and responsibilities of a parent in relation to the upbringing of a child.

22 COCA, s 36(1).

23 From *Gillick v West Norfolk and Wisbech Area Health Authority*, above n 19.

24 See *Re SO* FC Wellington FAM 2004-085-1046, 3 November 2005 at [25].

25 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Under clause 2 of the Code, right 7(7) gives the right to every consumer to refuse consent. A consumer is defined in Clause 4 of the Code as a "health consumer or a disabilities services consumer" and in relation to right 7(7) includes "a person entitled to give consent on behalf of that consumer".

To enforce this in New Zealand, the legal response falls into two broad categories, both of which will be considered in this dissertation. The first category is the approval of interventions despite lack of parental consent, enabling treatment to occur. In this dissertation these are labelled as remedial interventions, and will be considered in Chapters 2-5. The second category of response is to criminalise the parents. This will be considered in Chapter 6. There is also a third legal response, which is the possibility that children, or someone on their behalf, could sue their parents in tort for medical neglect. It is beyond the scope of this dissertation to consider this, and this remote possibility will not be further discussed.[26]

[26] See Jo Bridgeman *Parental Responsibility, Young Children and Healthcare Law* (Cambridge University Press, 2007) at 95-98 for an overview. For a brief discussion on some of the issues arising in the New Zealand context, see Rachael Irvine "To Bleed or Not to Bleed? An investigation into Mandatory Newborn Screening in New Zealand" (LLB(Hons) Dissertation, University of Otago, 2006) at 25-26.

Chapter 2

Important Concepts Underlying Remedial Intervention in New Zealand

> "There are occasions when professionals (whether medical professionals or social workers) and parents disagree about treatment and in such cases courts have to decide what should happen."[27]

2.1 Introduction

There are three avenues for remedial intervention in New Zealand. These are the Care of Children Act 2004 (COCA),[28] the Children, Young Persons and Their Families Act 1989 (CYPFA),[29] and the High Court's inherent jurisdiction as *parens patraie*. The parameters of each of these will be considered in Chapter 3. In deciding which of these avenues is appropriate, and determining the parameters of them, a number of key concepts must first be understood. This chapter outlines these concepts.

2.2 The Welfare and Best Interests Standard

All three avenues for remedial intervention have as a core principle the welfare and best interests standard. Under the inherent jurisdiction, "it is settled law that the court's prime and paramount consideration must be the best interests of the child".[30] Section 4 of the COCA requires that for any proceedings under the Act, the "welfare and best interests of the child must be the first and paramount consideration", while section 6 of the CYPFA states "the welfare and interests of the child or young person shall be the first and paramount consideration".[31] As can be seen, these are not identical, but there is no indication that courts in New Zealand consider the differences to be material.[32]

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27 John Mitchell "Who Knows Best?" (2005) 73 MLJ 34 at 34.

28 All sections of the COCA referred to in this dissertation appear in Appendix 1.

29 All important sections of the CYPFA referred to in this dissertation appear in Appendix 2.

30 *Re J (a minor)(Wardship: Medical Treatment)* [1991] Fam 33 (CA) at 52 per Taylor LJ.

31 Nothing rests on the fact that young persons are mentioned in the CYPFA but not the COCA. Section 2 of the CYPFA defines those under 14 as a child and those aged 14-17 as young persons, whereas s 8 of the COCA defines anyone under 18 as a child.

32 In the United Kingdom, where similar slight differences occur, the courts have determined that the principles are the same (see Sarah Elliston *The Best Interests of the Child in Healthcare* (Routledge-Cavendish, London, 2007) at 13). In New Zealand, there have been contrary judicial views on whether welfare and best interests mean the same thing (see Mark Henaghan *Care of Children* (LexisNexis NZ, Wellington, 2005) at 3) but no suggestion that this leads to different outcomes.

A major criticism of the welfare and best interests standard is that:[33]

> its very vagueness undercuts its practical utility. Any decision may be justified by labelling the result as being within the broad category of child's best interest.

It has been suggested that this is particularly so with regard to medical treatment decisions, as "medicine is an area where it is notoriously difficult to establish facts with any certainty".[34] A further criticism is that it is impossible to always make decisions that are in the best interests of children, as any decision-making in families requires a balancing of the best interests of different members of the family. A number of academics have therefore suggested that a better test would be a harm or reasonableness principle.[35] This principle allows parental decision-making to be respected, so long as the child is not harmed, even if the best interests of the child would suggest another course of action.[36] When applied to medical treatment, the threshold for state intervention becomes "not when a parental refusal is contrary to a child's best interest, but when the parental refusal places the child at significant risk of serious preventable harm."[37]

As will be seen in Chapter 3, both the COCA and the CYPFA have principles in place that influence the application of the welfare and best interests standard. While the standard suggests that the state should intervene whenever a child's best interests are not being met, the reality as applied in New Zealand is that it is closer to the harm or reasonableness principle.

2.3 Urgent Treatment

A central argument of this dissertation, which will be argued more fully in Chapter 3, is that the appropriate legal response is different for urgent and non-urgent treatment. This distinction is not unique to New Zealand. In South Australia, for instance, medical

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33 Felicia C Strankman "Children's Medical Care in California: Conflicts between Parent, Child and State" (1995-96) 36 Santa Clara L Rev 899 at 922-923.

34 Elliston, above n 32, at 18.

35 Ibid, at 101-111; Douglas S Diekema "Parental Refusals of Medical Treatment: The harm principle as threshold for state intervention" (2004) 25 Theor Med Bioeth 243.

36 Elliston, above n 32, at 106-107.

37 Diekema, above n 35, at 258.

practitioners may carry out treatment in the face of a parental refusal of consent if they consider it necessary "to meet an imminent risk to life or health".[38] A similar provision exists in New Zealand exclusively for blood transfusions, with s 37 of the COCA allowing health practitioners to give blood transfusions without parental consent when they are needed "promptly".[39]

Aside from the special circumstances anticipated in s 37, in determining what constitutes urgency in the New Zealand context the distinction used in this dissertation is that any decision is urgent if it must be decided more quickly than guardianship orders can be made under the CYPFA. This cannot be specified as a particular time period, as there are no such specifications in the CYPFA. However, such orders can legitimately take at least several weeks to achieve.[40] Any treatment that is needed within a few weeks will therefore be categorised as urgent for the purposes of this dissertation.

2.4 Routine Treatment

A unique feature of New Zealand law regarding children's medical care is a distinction between routine and non-routine treatment in s 16(c) of the COCA, with only non-routine treatment being considered as an "important matter affecting the child".[41] The distinction becomes relevant when s 16 is considered as a whole. Section 16(1) states that a duty, power, right, and responsibility of guardianship is having the role of providing day-to-day care of the child. Although nowhere stated as such, this role

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38 Consent to Medical Treatment and Palliative Care Act 1995 (SA), s 13. Section 174 of the Children and Young Persons (Care and Protection) Act 1998 (NSW), has similar, but slightly narrower provisions, where there is "urgency". The NSW Law Reform Commission *Young People and Consent to Health Care* (NSWLRC R119, 2008) at [7.19] considers this section to be working successfully and has recommended that this provision be incorporated into the new legislation that it recommends.

39 Section 37 does not actually make it legal for health practitioners to give blood transfusions without consent, but protects them from having civil, criminal or disciplinary proceedings brought against them.

40 Guardianship orders can only be made following an application for a declaration that a child is in need of care or protection (s 67), which can only follow a family group conference (s 70). In convening the family group conference, the Care and Protection co-ordinator must make all reasonable endeavours to consult with the child's family regarding the date of the conference (s 21(b)), and then notice of the date must be "given a reasonable time before the conference is to be held"(s 25(3)). If the family group conference fails to reach agreement, an application can then be made to the court for a declaration. Notice of the application must be served on the parents (s 152(1)). Such a process can easily and legitimately take weeks.

41 This distinction was not in the original Bill, but was added by the Select Committee. See Care of Children Bill 2003 (54-2) (select committee report) at 8.

would seem to include making decisions about routine medical treatment.[42] While s 16(5) requires guardians to consult wherever practical, this "does not apply to the exclusive responsibility for the child's day-to-day living arrangements of a guardian exercising the role of providing day-to-day care".[43] It is important to note that the freedom not to consult with other guardians is not given to anyone exercising the role of providing day-to-day care, but only to guardians exercising this role. This section therefore does not give the right to provide routine medical treatment to any person providing day-to-day care.[44] It may still only be consented to by a guardian, but they can consent unilaterally, as long as they are providing day-to-day care at the time.

So long as both parents agree on treatment, the distinction between routine and non-routine treatment is irrelevant, but there are two exceptions. The first is where the parents are not the only guardians. In such situations, any guardian other than the parents would seem to be able to unilaterally consent to routine treatment on behalf of the child.[45] The second situation is where the child is the subject of custody orders or interim custody orders under the CYPFA. In such situations, the holder of the order would seem to have the right to consent to routine treatment.[46]

The COCA itself gives no guidance as to what is routine and what is not, and there has been little judicial discussion of the issue. A rare exception is recent obiter dicta by Judge Moss that routine matters "include consultation for treatment of transitory viral illnesses, wart removal, minor contusions and abrasions arising from household, playground and school time accidents, and acne management."[47] Although not mentioning the issue of routine medical treatment, Asher J in *DP v Department of Child, Youth and Family Services* states that an interim custody order "would not enable the department to determine ... if it arose, which hospital they should go to."[48] As

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42 The definitions in s 8 of the COCA of "day-to-day care" and "the role of providing day-to-day care" are not helpful, although the latter is said to include "while exercising that role, exclusive responsibility for the child's day-to-day living arrangements". See Appendix 1 for the definitions.

43 COCA, s 16(6).

44 For example, this means that there is no authority for a teacher to put a sticking plaster on a child, although of course no-one would suggest that this is inappropriate.

45 As long as they are exercising the role of providing day-to-day care.

46 Section 104(1)(a) of the CYPFA gives the holders of custody orders under that Act the same rights of providing day-to-day care to the child as if given by a parenting order under the COCA. Section 80 of the CYPFA gives these same rights to holders of interim custody orders under that Act.

47 *ARB v KLB* [2011] NZFLR 290 (FC) at [12].

48 *DP v Department of Child Youth and Family Services* [2008] NZFLR 896 (HC) at [94].

interim custody orders allow the making of routine medical treatment decisions, this suggests that this is not a routine decision. With respect, this suggestion does not seem correct. CYFS also does not seem to agree, stating that "when a child or young person presents as unwell or injured it is appropriate for their caregiver to take them to a health professional."[49]

One issue that could be considered on the boundary is immunisations. Without explicitly stating that immunisations were routine, Judge Strettell in *A v S*,[50] seemed to think they were, stating that decisions about immunisation could be made by one parent unilaterally. In contrast, in *Re SO*,[51] CYFS, which was an additional guardian of the child, became aware that the mother opposed immunisation, and sought court orders. Judge Ullrich did not query whether the issue needed to come to court, seemingly accepting that this was not a routine decision.[52] In obiter dicta, Judge von Dadelszen expressed the view that a mother was wrong to have a child immunised without the father's consent, suggesting that his honour considered this to be a non-routine matter.[53] The balance of Family Court cases therefore suggests that immunisations are not a routine treatment. CYFS clearly agrees, stating that routine treatment does not include "immunisation, injections, examinations under anaesthetic and examination of the anal/genital region."[54]

This conclusion is probably correct. Some guidance is given by the Select Committee, which stated that the term day-to-day care:[55]

> is used to distinguish between the daily short-term role of providing care for a child, as opposed to the longer-term interests and role that a guardian has in the development of a child.

Presuming that routine treatment is treatment given in the course of day-to-day care, application of this distinction suggests that treatment that has a short-term impact would

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49 Department of Child, Youth and Family Services "Consenting to medical examination and treatment" < http://practicecentre.cyf.govt.nz/policy>.

50 *A v S* FC Christchurch FAM-1999-009-2203, 5 September 2005 at [18].

51 *Re SO*, above n 24.

52 This issue did not need to be decided, as it was found that the child had sufficient maturity to consent himself.

53 *JLS v KGJT* FC Napier FAM-2000-041-102, 20 September 2005 at [54].

54 Department of Child, Youth and Family Services, above n 49.

55 Care of Children Bill 2003 (54-2) (select committee report) at 8.

be routine, while treatment that will have a longer-term impact on the child will never be routine. Although many would consider immunisations to be part of the daily role of providing care for the child, the decision is made in the longer-term interests of the child, putting it outside the Select Committee's conception of day-to-day care and therefore outside the scope of routine treatment.

Another form of preventive health care that is on the boundary is diagnostic testing. While such tests are probably considered to be routine by the vast majority of the population (for example, it is reported that almost all of the 64,000 babies born in New Zealand every year are tested under the newborn metabolic screening programme),[56] the fact that the decision to test is made in the longer-term interests of the child means they are probably not a decision within day-to-day care, and therefore not routine.

2.5 Guardians and Parents

In most cases, a child's parents will also be his or her joint guardians.[57] There are, however, exceptions. In some cases one or both of a child's parents may not be a guardian, and in other cases a child will have a guardian who is not a parent.[58] For the purposes of this dissertation, unless the context indicates otherwise, use of the term parents is referring to parents in their role as guardians.

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56 National Screening Unit "Newborn Metabolic Screening Programme" <www.nsu.govt.nz/current-nsu-programmes>.

57 COCA, s 17.

58 Both the COCA and the CYPFA have scope for guardians to be appointed or removed. Under the COCA, there are also occasions where the father is not automatically a guardian. With regard to appointment and removal of guardians under the COCA, see Henaghan, above n 58, at 12-18.

Chapter 3

Legal Avenues aimed at Remedial Intervention

> "While the cases recognize a permitted sphere of parental decision-making about children's health care, their discretion is subject to boundaries, defined by the courts and by societal expectations of those charged with the care of those who are most vulnerable. It is not always clear from the limited jurisprudence when parental decision-making will cross the line"[59]

3.1 Introduction

In New Zealand, three legal avenues are available for obtaining health treatment for a child: the CYPFA, the COCA, and the inherent *parens patriae* jurisdiction. In most cases, however, there is little explanation for why the particular avenue has been used. This chapter examines the differences between these legal avenues, and identifies the logic as to when a particular avenue should be used.

3.2 The Children, Young Persons and Their Families Act 1989 (CYPFA)

The CYPFA is "essentially a child protection statute."[60] Its object is to "promote the well-being of children, young persons, and their families",[61] including by "providing for the protection of children and young persons from harm, ill-treatment, abuse, neglect, and deprivation."[62] In deciding when to provide that protection under the CYPFA, Anderson J said that the state "should not intervene unless the parental care has been proven to be unacceptably incompetent."[63] That statement has recently been approved by the Principal Family Court Judge.[64]

The specific instances in which the state can intervene for medical neglect under the CYPFA are covered by ss 14(1)(a)-(b) of the Act. Section 14(1)(a) states that a child or young person is in need of care or protection if he or she "is being, or is likely to be,

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59 Jocelyn Downie, Timothy Caulfield and Colleen Flood *Canadian Health Law and Policy* (3rd ed, LexisNexis Canada, Toronto, 2007) at 454.

60 *E v Chief Executive of the Ministry of Social Development* [2007] NZCA 453, [2008] NZFLR 85 at [21].

61 CYPFA, s 4.

62 Ibid, s 4(e).

63 *E v Department of Social Welfare* (1989) 5 FRNZ 332 (HC) at 334.

64 *WAF v Ministry of Social Development* FC Auckland FAM 2007-004-584, 4 March 2011 at [58].

harmed (whether physically or emotionally or sexually), ill-treated, abused or seriously deprived". None of these criteria are defined. An ordinary definition of harm would cover negative effects on health. This is the approach taken in the Children Act 1989 (UK), which defines harm as "ill-treatment or the impairment of health or development".[65]

Section 14(1)(b) provides that a child is in need of care or protection if their "development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable". As with the previous section, none of these terms are defined. However, failure to provide adequate health care must impair development and/or physical or mental well-being. A crucial factor of this section is that the result of this impairment must be "serious", but there is no clear guidance within the Act itself, or judicially, as to what makes impairment serious.

A feature of both sections is that there is no requirement that those inflicting harm, impairment or neglect intend to do so. This is made explicit in s 71, which states that for a finding that a child is in need of care or protection under ss 14(1)(a) or 14(1)(b), it is irrelevant whether the parents are culpable or not. Such a finding can be made even when parents are found to have the best interests of their child at heart.

Examples of medical neglect resulting in findings that children are in need of care or protection under ss 14(1)(a) and 14(1)(b) include situations where parents have mismanaged the medical needs of their epileptic[66] or diabetic child,[67] an unwillingness to accept that the child has a psychiatric dysfunction requiring therapeutic intervention,[68] and a failure to agree to interventions for a child with developmental issues, such as refusing or not organising sessions with a neuro-developmental therapist and a speech and language therapist.[69] Under similar criteria overseas, a New South Wales court found an anorexic teenager was in need of care and protection where the

65 Children Act 1989 (UK), s 31(9).
66 *Re C* DC Otahuhu CYPF048/03/97, 29 April 1997.
67 *Child Youth and Family Services v DSWH* FC Manukau FAM-2004-092-2249, 7 April 2008.
68 *Ministry of Social Development v CMC*, above n 13.
69 *Director-General of Social Welfare v G* (1995) 14 FRNZ 23 (FC).

parents were failing to agree on an appropriate treatment model,[70] and a Scottish court reached a similar finding with regard to parents who refused conventional blood-related treatment for their haemophiliac son.[71]

Where a child is in need of care or protection, the CYPFA allows for a number of orders constraining the rights of parents.[72] Where merely constraining the rights of parents is not enough, the Act allows the court to appoint a new guardian, either in addition to or in place of existing guardians.[73]

When any person is exercising powers conferred by the CYPFA, the Act requires that they be guided by the principles in s 5, and for the exercise of powers relating to care and protection, s 13 lists further principles. Sections 5 and 13 are both subject to s 6 which places the child's welfare and interests as paramount, and s 13 is also subject to s 5. It is not necessary for the purposes of this dissertation to look at these principles in detail.[74] In summary, s 5 requires the judge to be guided by principles which seek, as much as possible, the support of the family. Section 13 requires the child to be protected from harm and to have their welfare promoted, but encourages solutions that do not involve removal from the family wherever possible. The principles of the CYPFA therefore encourage a non-interventionist approach, but it is important to remember that the principles are subject to s 6. Further, within s 13, s 13(a) states that the child "must be protected from harm, their rights upheld, and their welfare promoted". This is one of the few principles in that section to be stated in imperative terms.

In summary, the CYPFA allows for intervention for medical neglect, if one of the criteria in ss 14(1)(a) or 14(1)(b) are met. If they are, then in deciding what action to

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70 *Re Elizabeth* [2005] CLN 7 (NSWCC).

71 *Finlayson (Applicant)* 1989 SCLR 601 (Sh Ct). The case did not involve Jehovah's Witness parents. The parents were concerned that their child would contract HIV or hepatitis B through contaminated blood.

72 The following orders placing restrictions on the rights of guardians can be made following a finding that the child is in need of care or protection: services orders (s 86), restraining orders (s 87), support orders (s 91), custody orders (s 101). It is also possible to obtain interim custody orders (s 78) and interim support orders (s 92).

73 CYPFA, s 110.

74 For a detailed and thoughtful discussion of the relationship between the principles in ss 5, 6 and 13, see Judge Inglis' extensive discussion in *Re the S Children (No 3)* (1994) 12 FRNZ 430, [1994] NZFLR 971 (FC).

take the court must consider the principles of ss 5 and 13, as well as considering what is in the welfare and interests of the child.

3.3 *Parens Patriae* Jurisdiction

Another judicial means of remedial intervention is for the court itself to take guardianship of the child, and to then authorise treatment. The High Court has an inherent jurisdiction to do this as *parens patraie*.[75] The inherent *parens patriae* jurisdiction is an ancient jurisdiction of the Courts of Equity, by which the court is placed:[76]

> in a position by reason of the prerogative of the Crown to act as supreme parent of children, and must exercise that jurisdiction in the manner in which a wise, affectionate, and careful parent would act for the welfare of the child.

However, there must be good grounds for the court to intervene in this way. Cooke J (as he then was) stated in the Court of Appeal that the inherent jurisdiction "would be sparingly exercised, especially by way of overriding a refusal of consent by a parent".[77]

The inherent jurisdiction is now largely subsumed by the court guardianship provisions of the COCA, and it will be rare for applications to rely solely on it.[78] The inherent jurisdiction can be used in situations also covered by statute, but only "so long as it can do so without contravening any statutory provision."[79] It therefore may be used in situations provided for by the court guardianship provisions in the COCA, but not to

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75 *Pallin v Department of Social Welfare* [1983] NZLR 266 (CA) at 272 per Cooke J. The comment is clearly obiter dicta. The case involved a finding that a child was in need of care or protection on the basis that his mother was falsely reporting symptoms of him having epilepsy. The appeal against this finding was unanimously dismissed by the Court of Appeal, meaning there was no need to consider invoking the inherent jurisdiction.

76 *R v Gyngail* [1893] 2 QB 232 at 241 per Lord Esher MR.

77 *Pallin v Department of Social Welfare*, above n 75, at 272. This comment is obiter dicta. As outlined in n 75 above, the case did not involve refusal of consent by a parent.

78 Patrick Mahony (ed) *Brookers Family Law: Child Law* (looseleaf ed, Thomson Brookers) at [WP1.01].

79 *Taylor v Attorney-General* [1975] 2 NZLR 675 (CA) at 680, per Wild CJ.

achieve a different result than produced under those provisions.[80] It has been suggested that the inherent jurisdiction is useful when "one-off" interventions are required.[81]

3.4 The Care of Children Act 2004 (COCA)

The COCA allows intervention for medical neglect through the court guardianship provisions in ss 30-35.[82] Section 31 allows any eligible person[83] to apply for an order to place the child under the guardianship of the court[84] and for a named person to be the court's agent, either generally or for a specific purpose.[85]

Although s 31 gives the court the right to place a child under the guardianship of the court, the section "gives no guidance as to the circumstances in which the court may make such an order."[86] There are, however, two limits inherent within the Act. One is that, under s 34(2), the rights and powers of the court under s 31 are the same as those held by the High Court in relation to wards of court immediately prior to the commencement of the Guardianship Act 1968.[87] Cooke J's comments on the limits to invocation of the inherent jurisdiction are therefore relevant, and persistent judicial references to such limits have been led by Heath J, who has said the court's guardianship jurisdiction "must be invoked cautiously and after proper inquiry"[88] and is a remedy of last resort.[89] The latter phrase seems to come from *B v L*[90] and was approved by Elias J (as she then was) stating that "the wardship jurisdiction is not to be

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80 The use of the inherent jurisdiction is now largely limited to situations not covered by the COCA. An example is a case involving funeral arrangements for a child who was in imminent danger of death, where the COCA could not be used as it has no coverage once the child has died (see *Chief Executive, Ministry of Social Development v S* (2009) 28 FRNZ 236 (HC)).

81 *Re Norma* [1992] NZFLR 445 (HC) at 450, alt cit *Director-General of Social Welfare v M* (1991) 8 FRNZ 498 (HC) at 503.

82 Although stated in the Care of Children Bill 2003 (54-1) (explanatory note) at 9 that these sections are restatements of the equivalent sections of the Guardianship Act 1968, there are some differences between the current and previous law: see Henaghan, above n 32, at 18-19.

83 Section 31(2) defines eligible persons, and includes any person granted leave by the court to apply.

84 COCA, s 31(1)(a).

85 Ibid, s 31(1)(b).

86 *Waikato District Health Board v FF*, above n 8, at [25].

87 Section 34(2) of the COCA lists two exceptions to this, neither of which is relevant for this dissertation.

88 *Re an unborn child (No 1)* [2003] NZFLR 344 at [43]; *Hawthorne v Cox* [2008] 1 NZLR 490 (HC) at [75].

89 *Fletcher v Blackburn* [2009] NZFLR 354 (HC) at [64]; *Carpenter v Armstrong* HC Tauranga CIV-2009-470-511, 31 July 2009 at [132].

90 *B v L* (1991) 7 FRNZ 400 (HC). Although this case is frequently used as authority for the fact that the jurisdiction is one of last resort, it is difficult to tell in the case whether the statement is a judicial one, or merely a judicial recitation of counsel's argument.

lightly invoked and is a jurisdiction of last resort".[91] Judicial assertions that the jurisdiction is a last resort have been used to refuse applications (unrelated to medical neglect) made under s 31 in both the Family[92] and High[93] Courts.

The second limit inherent in the Act is the requirement in section 4, that the "welfare and best interests of the child must be the first and paramount consideration". In assessing this, s 4(5)(b) requires that, for any proceeding under the Act, any relevant principles in s 5 must be considered. As s 4(5)(b) refers to any proceeding under the Act, the principles must be considered in proceedings under section 31.[94] According to the majority of the Supreme Court (albeit in a case unrelated to medical neglect):[95]

> the ultimate objective is to determine what outcome will best serve the welfare and best interests of the particular child or children in his, her or their particular circumstances. In making that determination the s 5 principles must each be examined to see if they are relevant, and if they are, must be taken into account along with any other relevant matters.

Of the six principles in s 5, three are clearly related to situations where the parents are separated and do not seem relevant to medical neglect,[96] but three are potentially relevant. The first is the principle in s 5(a) that the child's parents and guardians should have the primary responsibility for the child's care, development and upbringing. This will usually point away from intervention occurring. The second is the principle that the child's identity must be preserved and strengthened (s 5(f)). In cases where the

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91 *CMP v Director-General of Social Welfare* (1996) 15 FRNZ 40 (HC) at 86, [1997] NZFLR 1 (HC) at 46.

92 *LIH v CLH* FC Rotorua FAM-2008-063-000513, 9 April 2009. The case involved the determination of parenting orders for children who were living with their maternal grandparents, and where there was considerable acrimony between all the adults involved, as well as between the children and their parents, but it was considered at [39] that "the threshold has not at this stage been reached where an order needs to be made placing them under the guardianship of the Family Court."

93 *DP v Department of Child Youth and Family Services*, above n 48. The case concerned an application for interim custody orders, where CYFS alleged that the children were at risk of being sexually abused if in the custody of their mother. Asher J did not find sufficient evidence for the interim custody order, and stated at [106] that it would be an improper use of the court guardianship jurisdiction for the court to impose its control over the situation pending the full custody hearing.

94 As it is argued that the use of the inherent jurisdiction must be consistent with any statutory provisions (see *Taylor v AG*, above n 79), these principles would also apply to any decision under the inherent jurisdiction, unless the case is one for which the COCA does not have application.

95 *Kacem v Bashir* [2010] NZSC 112, [2011] 2 NZLR 1, [2010] NZFLR 884, alt cit *K v B* (2010) 28 FRNZ 483 at [19].

96 COCA, ss 5(b)-(d).

reason for medical neglect is related to the culture or religion of the child and his or her family, this principle would also seem to mitigate against intervention.

In contrast is the principle in s 5(e) that the child's safety must be protected. This is the only principle to be expressed in imperative terms.[97] Although it refers particularly to safety from violence, it also has wider applicability, which would include safety from medical neglect. It has been accepted by the majority of the Supreme Court that this principle, where relevant, will generally be decisive.[98] Consequently, although the principles in ss 5(a) and 5(f) must be considered, if the court decides that the child's safety is at risk without intervention, intervention is likely to be the result. The key factor in any case will therefore be the court's opinion on whether intervention is necessary for the safety of the child.

A further factor that must be considered is the child's views. Section 6(2) requires that, for cases involving guardianship (which includes all applications under s 31), the child must be given reasonable opportunities to express matters affecting him or her, and those views must be taken into account. In cases involving young infants, there is obviously little possibility to obtain their views. But even for older children for whom health care is sought, New Zealand courts have been unwilling to give any serious consideration to their views, despite s 6.[99] This reflects the judicial attitude to s 6 generally and is not unique to cases of medical neglect.[100]

3.5 Summary

The CYPFA and the COCA both allow for intervention where parents are medically neglecting their children. The key distinction is that where the need for remedial intervention cannot wait several weeks, and requires treatment that is not routine in nature, court guardianship under the COCA, or the use of the High Court's inherent jurisdiction, are the only possible means of intervention. But where treatment is not needed urgently, there is potential for any of the three jurisdictions to be utilised.

97 Henaghan, above n 32, at 6.

98 *Kacem v Bashir*, above n 95, at [22]. The other judgments are even firmer, stating that s 5(e) makes the protection of a child's safety mandatory: Elias CJ at [8]; William Young J at [51(b)].

99 For example, *Waikato District Health Board v FF*, above n 8, which involved a 7 year old child, did not show any signs of even obtaining the child's views.

100 See Antoinette Robinson and Mark Henaghan "Children: Heard but not listened to? An analysis of children's views under s 6 of the Care of Children Act 2004" (2011) 7 NZFLJ 39.

Applying this background, the next chapter will consider interventions in non-urgent situations, and the following chapter will consider situations where treatment is needed more quickly than within a few weeks.

Chapter 4

Remedial Intervention in Non-Urgent Circumstances

> "the CYPF Act 1989 can be used to protect a child ... to ensure the child receives the treatment necessary to preserve the child's life or health."[101]

4.1 Identifying the Appropriate Legal Avenue

For non-urgent situations, the CYPFA, the COCA and the inherent jurisdiction are all, on their face, potentially able to be utilised. Where there is conflict between the inherent jurisdiction and legislation, the response is simple. As outlined in Chapter 3.3, it is widely accepted that the inherent jurisdiction should not be used to produce a result inconsistent with statute. But in terms of the priority of the two statutes, there is no indication in either as to which takes precedence.[102]

An answer for such situations was recently provided by the Court of Appeal in *WAH v WTW* where it stated that "we accept that in most cases, the most appropriate course where a child is at harm will be to consider care arrangements under the CYPF framework."[103] It endorsed *B v The Family Court*, where it was stated that where court guardianship is sought under the COCA in a situation where the CYPFA can be used, there "must be a good reason for that course".[104] This led to the conclusion in that case that the Family Court had erred by not considering whether the welfare and the best interests of the children could have been met through orders under the CYPFA.[105] An example of a good reason, albeit not related to medical neglect, is shown in *WAH v WTW*, where the Court of Appeal thought that court guardianship was appropriate given

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101 Mahony, above n 78, at [NT4.2(8)].

102 Section 117(2) of the CYPFA clearly anticipates that it is possible for a court to place a child under the guardianship of the court under section 31 of the COCA where a guardianship order is already in place under section 110 of the CYPFA, and vice versa.

103 *WAH v WTW* [2010] NZCA 577, (2010) 28 FRNZ 443 at [44].

104 *B v The Family Court* HC Wanganui CIV-2008-483-32, 2 June 2009 at [85]. Similar comments had also been previously made in the High Court by Elias J (as she then was), stating in obiter dicta that "exceptional circumstances are required before the Court should cut across the scheme of a statute such as the CYP Act" (*CMP v Director-General of Social Welfare*, above n 91, at 86). Similarly, in the Family Court, Judge Adams compared the policy of the relevant Acts and stated the CYPFA "signals the direction in which Parliament generally expects care and protection issues to be managed." (*Tipene v Henry* [2001] NZFLR 967, alt cit *T v H and S [guardianship of Family Court]* (2001) 20 FRNZ 673 (FC) at [7]-[12].) The case compared the Guardianship Act 1968 with the CYPFA, but the replacement of the former by the COCA does not affect the analysis.

105 *B v The Family Court*, above n 104, at [167].

that the children were already subject to the guardianship of the court, and although the matter in issue could have used the CYPFA, there was no risk of injustice or unfairness.[106]

It is clear, therefore, that where there is no urgency to resolve an issue of medical neglect, and no good reason not to use the CYPFA, that the CYPFA is the appropriate vehicle for remedial intervention. Perhaps surprisingly, there has been very little examination of the extent to which the CYPFA can be used to counter medical neglect.[107]

4.2 Possible Interventions for Non-Urgent, Non-Routine Treatment

There are a range of orders possible under the CYPFA, as identified in Chapter 3.2. Of particular relevance are support orders, custody orders and guardianship orders.

4.2.1 Support Orders

Support orders or interim support orders,[108] issued under ss 91 and 92 respectively, allow the court to order any organisation or person to provide support for the child for up to 12 months. That person or organisation has the duty, under s 93, to provide or co-ordinate such services and resources needed to provide for the care, protection and control of the child. Such orders may be an appropriate remedy where the issue is failure to treat through ignorance, rather than a refusal to treat. An example is *Child Youth and Family Services v DSWH*.[109] The child in that case had been the subject of a custody order as a result of her diabetes being mismanaged. That custody order was revoked as it was now felt that the parents had the knowledge to adequately manage the child's diabetes. Nevertheless, Judge Hikaka made a s 91 support order, which enabled CYFS "to take a supporting monitoring role".[110] Judge Hikaka stated that the support order was the appropriate way of monitoring the parents' management of their

106 *WAH v WTW*, above n 103, at [44]-[46].

107 For example, Mahony, above n 78, at [NT4.2(8)] goes little further than stating that "the CYPF Act can be used to protect a child...to ensure the child receives the treatment necessary to preserve the child's life or health".

108 Interim support orders are not available until after an application has been made for a declaration that a child is in need of care or protection, which cannot occur until a family group conference has been held. They are therefore only available for non-urgent purposes, albeit at a slightly earlier stage than support orders.

109 *Child Youth and Family Services v DSWH*, above n 67.

110 Ibid at [37].

daughter's diabetes, and that the "Chief Executive in my view is taking a responsible line by making sure the assistance is available, but in a way that intervention into the family life is the minimum necessary".[111]

However, support orders were only able to work in the above case because the parents were willing to treat the child. Section 96(1)(b) allows the court to impose a condition on support orders "that the child or young person shall undergo any specified medical examination and treatment or any specified psychological or psychiatric examination, counselling, and therapy". While this would seem to be an effective way of ensuring that a child receives treatment, its usefulness is substantially limited by s 98(a)(i). Under that section, the court cannot impose any condition under s 96 for the child "to undergo any medical, psychiatric, or psychological examination or treatment, or any psychological or psychiatric counselling or therapy" unless consent is given by a parent or guardian.[112] Consequently, support orders cannot work without parental consent to treatment. They are therefore very unlikely to be helpful in cases of refusal of treatment.

4.2.2 Custody Orders

As stated by Ellis J in *Re J (An Infant)*, a "custody order is not a guardianship order".[113] The mere act of placing a child outside the custody of the parents does not remove their guardianship rights. An example of this is shown in *Re A*,[114] where court intervention was required for the Department of Social Welfare to obtain treatment for a child in its custody, due to parental refusal to consent. As a consequence, custody orders are of no use in enabling non-urgent non-routine treatment to take place.

4.2.3 Guardianship Orders

Guardianship orders under s 110 can only follow a declaration that the child is in need of care or protection,[115] which in turn can only follow a family group conference.[116]

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111 Ibid at [47].

112 The section also states that where the Chief Executive is a guardian, his or her consent is not enough.

113 *Re J (An Infant): Director-General of Social Welfare v B and B* [1995] 3 NZLR 73 (HC) at 78, alt cit *D-GSW v MJB* [1995] NZFLR 692 (HC) at 697, alt cit *Director-General of Social Welfare v B* (1995) 13 FRNZ 441 at 447.

114 *Re A, Director General of Social Welfare v B* HC Hamilton M209-97, 12 June 1997.

115 CYPFA, s 110(1).

116 Ibid, s 70.

Guardianship orders can appoint guardians as additional to the existing guardians, or in place of them.[117] There is no requirement in the CYPFA that appointment of an additional guardian will require removal of the child from the parents' custody.[118]

Section 112 also makes it clear that, where the guardianship order makes the Chief Executive of the Ministry of Social Development an additional guardian, this may be for a particular purpose only. Any doubt that the COCA might have restricted this ability was lifted in *Chief Executive of the Ministry of Social Development v LFT*.[119] In that case, the Chief Executive was made a guardian for the purposes of medical treatment and education only, with the parents remaining the sole guardians for all other matters.

Where parents refuse to allow their child to be treated, guardianship orders are the only means under the CYPFA to obtain that treatment, if the treatment is not routine in nature. Examples of the type of situation in which guardianship orders have been used are *Ministry of Social Development v CMC*[120] where the mother did not accept that her daughter needed therapeutic intervention, and *Director-General of Social Welfare v G*,[121] where Judge von Dadelszen found that the mother did not fully understand her child's needs, which included a need for a neuro-development specialist and speech and language therapy.[122]

4.3 Interventions for Non-Urgent Routine Treatment

For routine treatment, the same issues arise with regard to support orders and guardianship orders as exist for non-routine treatment. Support orders do not enable even routine treatment to be enforced without the consent of guardians, while guardianship orders allow interventions for both non-routine and routine treatment.

Custody orders, however, affect routine treatment and non-routine treatment differently. Although they give no rights for non-routine treatment, they do give rights for routine

117 Ibid, s 110(2).
118 However, if the guardianship order appoints a sole guardian, the child is deemed to be placed in the custody of the sole guardian (s 110(3)(c)).
119 *Chief Executive of Ministry of Social Development v LFT* [2011] NZFLR 569 (FC).
120 *Ministry of Social Development v CMC*, above n 13.
121 *Director-General of Social Welfare v G*, above n 69.
122 Ibid at 33.

treatment. As outlined in Chapter 2.4, any person granted custody of the child under a custody order or interim custody order has the same rights of providing day-to-day care to the child as given by a parenting order under the COCA.[123] This means that the holder of custody under a custody or interim custody order under the CYPFA has the right to consent to medical treatment that is routine in nature. Custody orders can therefore be used to obtain treatment for children where only routine treatment is required. Given the principles of the Act and their focus on taking the least interventionist stance, however, a less interventionist stance than a custody order would seem to be to allow the child to remain in the custody of the parents, but with an additional guardian appointed for the sole purpose of consenting to routine medical treatment. This would enable routine treatment to be provided without the need for any change of custody.

4.4 Conclusion

While the principles behind the CYPFA are that the state will intervene to the least degree possible, the design of the Act means that, for medical neglect, interventions are often greater than they need to be. Because support orders cannot be used to enforce even routine medical procedures, the Act requires the more interventionist approach of either custody orders or guardianship orders for any treatment to take place, even if routine.

This can be compared with other jurisdictions. The Children Act 1989 (UK) has very similar principles to the New Zealand CYPFA. Section 8 of that Act allows certain orders, including specific issues orders, which allow the court to make orders "giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child". In *Re R (A Minor)(Blood Transfusion)*,[124] Booth J considered that specific issue orders were an appropriate means for ordering medical treatment where there was no need for the court to further intervene. Even more specific interventions exist in Canada. In Manitoba, for example, s 25(8) of the Child and Family Services Act[125] allows, upon the completion of a hearing, that the "Court may authorize any medical or dental treatment

123 CYPFA, ss 80, 104(1)(a).
124 *Re R (A Minor)(Blood Transfusion)* [1993] 2 FLR 757 (Fam).
125 CCSM c C80.

that the Court considers in the best interests of the child". This is done without requiring any change to guardianship. A similar, but slightly narrower provision exists in British Columbia.[126]

Unlike the CYPFA, these pieces of legislation allow courts to order medical treatment without the need to appoint additional guardians. The CYPFA partially gets around this problem by allowing additional guardians to be appointed for specific purposes only, but it would be a less intrusive option to leave guardianship intact, but enable another person to authorise routine treatment. Given that the ability to consent to routine medical treatment is not always tied to guardianship,[127] there seems no good reason why support orders cannot be amended in this way.

It is also problematic that the Act does not allow any action at all, apart from interim custody orders, prior to the family group conference. Even in non-urgent circumstances, it is difficult to see why the Act provides no means of stabilising the situation pending the full hearing, other than placing the child outside the parents' custody. Interim custody orders give the holder of the order the right to consent to routine medical treatment for the child. A far less intrusive means of achieving this would be to amend interim support orders so that, firstly, they can be made at the same point in time as interim custody orders[128] and secondly, they can allow for the authorisation of routine treatment. This would allow a support worker to authorise routine medical treatment, while maintaining the child in the custody of the parents. Given the focus of the principles of the Act on intervening to the least extent possible, such a situation would seem to far better meet the principles of the Act.

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126 The Child, Family and Community Service Act RSBC 1996, c46, s 29 allows the court to order any medical treatment necessary to prevent serious or permanent impairment of the child's health.

127 As shown by the fact that custody orders allow custodians to consent to routine treatment.

128 Currently, interim support orders can only be made once an application for a declaration has been lodged (s 92). Such applications can only be lodged following a family group conference (s 70). Interim custody orders, by contrast, can be made at any stage in proceedings (s 78).

Chapter 5

Remedial Intervention in Urgent Circumstances

> Society expects any treatment decision to serve a child's welfare and accordingly presumes that 'responsible' parents will accept evidence-based medical opinion.[129]

5.1 Introduction

Where treatment is needed for a child within a matter of weeks, the only legal option available for obtaining the treatment against the wishes of the guardian is an application for court guardianship under s 31 of the COCA, or the less likely option of an application to the High Court under its inherent jurisdiction. Given that most applications will be under the former, this chapter assesses the factors influencing the likely success of applications under the COCA,[130] focussing on refusals of treatment. Where there has been failure to treat, rather than a refusal, the situation can be simply remedied by the guardian giving consent for treatment to begin. It is only if the guardian refuses to do this that it becomes necessary for authorities (or another eligible person) to consider applying to the court for it to take guardianship.

None of the New Zealand cases involving non-life-threatening urgent treatment have clearly articulated the particular factors that have led to the conclusion that the treatment is in the best interests of the child. Two cases go little further than stating that it is obvious that the decision is in the best interests of the child.[131] This is an unsatisfactory basis for decisionmaking, as it fails to address the range of factors which will affect the child's best interests.

In one of the earlier United States cases dealing with non-life-threatening medical neglect, it was stated by the court that:[132]

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129 Sarah L Wooley "The limits of parental responsibility regarding medical treatment decisions" (2011) Online(accepted January 10, 2011 as 10.1136/adc.2010.198432) Arch Dis Child.

130 It is also arguable that, so long as the application could have been made under the COCA, applications under the inherent jurisdiction should be subject to the same limitations as applications under the COCA, as it is widely accepted that the inherent jurisdiction cannot be used to produce a result inconsistent with statute (see Chapter 3.3).

131 *Child Youth and Family Services v B*, above n 18; *Capital and Coast District Health Board v DRB*, above n 15.

132 *Re Phillip B* 92 Cal App 3d 796 (Ct App Cal 1979) at 802.

> Several relevant factors must be taken into consideration before a state insists upon medical treatment rejected by the parents. The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically treating the child; and the expressed preferences of the child".

Since then, a number of academic articles have attempted to build on this to identify the factors that should be taken into account in the judicial decision. These originate mostly from the United States,[133] but an attempt has also been made in New Zealand.[134] Criteria suggested include:

- The nature of the condition;[135]
- the nature of the objection;[136]
- the parents' proposed alternative;[137]
- The prospects of success;[138]
- Risks of the treatment;[139]
- Invasiveness of the treatment;[140]
- Accepted medical practice.[141]

These factors can be further grouped into two simple categories: factors relating to the parents, and factors relating to the health condition and its treatment.

5.2 Interventions for Urgent Non-Routine Treatment

5.2.1 Factors Relating to the Parents

Caldwell[142] suggests that an overriding factor is the extent to which the parents' position deserves respect. Caldwell suggests that where religious beliefs are involved, clinicians

133 Elizabeth Sher "Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State" (1983) 58 NYUL Rev 157; Felicia C Strankman, above n 33; Emily Catalano "Healing or Homicide: When Parents Refuse Medical Treatment for their Children on Religious Grounds" (2010) 18 BuffJGenderLSocPoly 157.
134 John Caldwell "Parents, Courts, and the sick child" (2000) 3 BFLJ 129.
135 Sher, above n 133; Catalano, above n 133.
136 Sher, above n 133; Catalano, above n 133; Strankman, above n 33.
137 Sher, above n 133; Catalano, above n 133; Strankman, above n 33; Caldwell, above n 134.
138 Caldwell, above n 134.
139 Catalano, above n 133; Strankman, above n 33.
140 Strankman, above n 33.
141 Caldwell, above n 134.
142 Ibid at 135.

will make a considerable effort to be supportive and sensitive to the views of parents. This is probably true,[143] but it is equally clear that, in New Zealand, those views are not going to be considered important in determining the child's best interests if the case goes to court. Section 13 of the New Zealand Bill of Rights Act 1990 (NZBORA) gives everyone the right to freedom of religion and beliefs, and section 15 gives the right to manifest that religion or those beliefs, but the Court of Appeal says that, for guardians, these rights are limited "so as to exclude doing or omitting anything likely to place at risk the life, health, or welfare of their children".[144] That comment was made in the context of a life-threatening situation requiring a blood transfusion, so the references to health and welfare are beyond the ratio of the case, although the passage has been relied on in the High Court in a non-life-threatening situation.[145] The reasoning of the Court of Appeal has been subjected to some criticism,[146] but despite the protestations of commentators such as Ahdar and Leigh[147] and Humphrey[148] that courts should be more accommodating of parents' religious motivations, there is little doubt that, even in non-life-threatening situations, parental rights to freedom of religion and beliefs under the NZBORA are not able to stop intervention on behalf of a child's health.

An example is *Canterbury District Health Board v L (CDHB v L)*,[149] which involved a blood transfusion and Jehovah's Witness parents. There was no doubt that the parents were motivated by religion. Fogarty J, however, chose to completely ignore the parents' reasons when coming to his decision to intervene, referring solely to the

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143 See for example the suggestions for how to accommodate parental wishes in Ralph Pinnock and Jan Crosthwaite "When parents refuse consent to treatment for children and young persons" (2005) 41 J Paediatr Child Health 369 at 372.

144 *Re J (An Infant)*(CA), above n 4, at 146.

145 *Auckland Healthcare Services v Liu*, above n 7, at 8.

146 See Rex Ahdar and Ian Leigh *Religious Freedom in the Liberal State* (Oxford University Press, Oxford, 2005) . There are two methods of balancing rights: "definitional balancing", which is the concept that rights have internal limits, and "ad hoc" balancing, which accepts rights are being infringed, but then looks to see if this infringment is justified. The former approach was taken in *Re J (An Infant)*(CA), as well as by the minority in the Supreme Court of Canada in a similar case (*B(R) v Children's Aid Society of Metropolitan Toronto* [1995] 1 SCR 315), while the latter approach was adopted by the majority in *B(R)*. Ahdar and Leigh at 184 and 269 suggest that definitional balancing is the better approach. Nevertheless, the result in *Re J(An Infant)*(CA) was likely to be the same whichever approach was taken, as it was in *B(R)* where the majority and minority agreed on the outcome.

147 Ahdar and Leigh, above n 146.

148 Thomas Humphrey "Children, medical treatment and religion: defining the limits of parental responsibility" (2008) 14 AJHR 141.

149 *Canterbury District Health Board v L*, above n 7.

clinical issues. Similarly, in *Capital and Coast District Health Board v DRB (CCDHB v DRB)*,[150] in which a mother with hepatitis B was refusing to allow her newborn child to be immunised against the disease, the facts stated that the mother was motivated by her belief that God would intervene if the child became unwell. But Judge Whitehead did not even address this issue when concluding that the immunisation must go ahead.

Although neither of the above cases referred to the COCA's s 5 principles, the outcome in each is consistent with them. As long as the court believes the child's safety is at risk, issues relating to the parents will never be able to over-ride the decisive nature of the s 5(e) principle. If the nature of the objection is related to the culture or religion of the child, it will always be trumped by the requirement for safety.

Religion is not always the parents' motivating factor. In *Waikato District Health Board v FF (WDHB v FF)*,[151] the parents were unwilling to consent to the use of a particular medication for their child's epilepsy, partly as a result of his adverse reaction to a previous medication. Despite describing the parents' concerns as "entirely understandable"[152] and seeming to accept that they "have always been entirely dedicated to CC's welfare and treatment",[153] Andrews J proceeded to give those concerns no credit at all, concluding that "the medical evidence supports a conclusion that CC must be treated with anti-convulsants."[154] This case also did not consider the s 5 principles, but as with the cases involving religion, the outcome is consistent with the decisiveness of the s 5(e) principle.

This is not to say, however, that courts will not consider the parents' views. In *Healthcare Hawkes Bay v C*,[155] Judge von Dadelszen devoted several pages to consideration of who could be appointed as the court's agent, due to the mother's distrust of the lead carer. Despite this, his honour appointed the lead carer as the court's agent, but only after eliminating all other possible agents as unsuitable.[156]

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150 *Capital and Coast District Health Board v DRB*, above n 15.
151 *Waikato District Health Board v FF*, above n 8.
152 Ibid, at [34].
153 Ibid, at [33].
154 Ibid, at [34].
155 *Health Care Hawkes Bay Limited v C*, above n 12.
156 The case concerned a mother refusing to consent to her daughter, who suffered spastic quadriplegia, receiving occupational therapy and physiotherapy. This was largely due to concerns about the method to be used in moving her into and out of her bed. At trial, it was conceded by counsel for

One aspect relating to the parents that sometimes receives consideration is their proposed alternative. The logic behind this, as explained by Fogarty J in *CDHB v L*, is that "if there is a range of available management strategies, which will address the patient's needs, the clinicians should endeavour to pursue only those strategies which are supported by the parents".[157] On the facts of the case, Fogarty J found that the parents were not able to show the availability of a strategy not involving a blood transfusion. This was decisive in his finding that the blood transfusion was in the best interests of the child, as a failure to authorise transfusion would severely compromise the child's chances of recovery and leading a normal life.[158] As identified above, Fogarty J did not discuss the principles in s 5, but this finding would be consistent with a balancing of the principles in ss 5(a) and 5(e). Where the parents can show they have an alternative that does not adversely impact the child's safety, the s 5(a) principle would mean that courts should not intervene. Nevertheless, convincing a court that their alternative is better than that advocated by clinicians is a task that is unlikely to be easily achieved.[159]

CDHB v L was used as authority for intervention in *CCDHB v DRB*, with Judge Whitehead stating that there was "no other option that is available in respect of the treatment for Baby B".[160] However, the judge had earlier identified that the mother believed that God would heal her baby if he became unwell.[161] By stating that there was no other option, he obviously did not believe this to be a viable alternative. There is nothing in the judgment to suggest that Judge Whitehead even considered the mother's alternative. But even if it had been considered, the statement that there was no other option would presumably still have been made. Although there is no reference to the s 5 principles, this case can be explained by saying that the safety of the child was the

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the mother that a court guardianship order under the Guardianship Act 1968 could be made, with the only remaining contentious issue being who would be the court's agent.

157 *Canterbury District Health Board v L*, above n 7, at [18].

158 Ibid, at [20]-[21].

159 One of the rare occasions where the parents did manage to do this was the English case of *Re T (a minor) (medical treatment)* [1997] 1 WLR 242 (CA). The case involved a child needing a liver transplant in order to survive, although it was not needed urgently. Even though the court found that the child would eventually die without the intervention, it found in favour of the parents, who argued the pain and suffering of the operation outweighed the benefit. The outcome has been widely criticised: see for example, M Fox and J McHale "In Whose Best Interests?" (1997) 60 MLR 700.

160 *Capital and Coast District Health Board v DRB*, above n 15, at [13].

161 Ibid, at [7].

decisive factor, with the judge not accepting that the mother's alternative could alleviate the safety concerns, making s 5(e) decisive over s 5(a). A similar result was evident in a case predating the COCA and its principles, where the judge in *Auckland Healthcare Services v Liu* referred to the parents' faith that God would intervene and heal their son's eyesight,[162] but preferred the opinion of the clinicians that surgery was necessary for any chance of eyesight being retained.[163]

5.2.2 Factors Relating to the Condition and its Treatment

In *WDHB v FF*, Andrews J tried to frame the decision in the following simple terms:[164]

> It is a question whether there is a real and substantial risk of his condition significantly deteriorating if he is not given the treatment, and whether there is a reasonable prospect that his condition will be improved or at least ameliorated, if he is given the treatment.

This still leaves the not insignificant question of what is a "real and substantial risk" and "a reasonable prospect". Nevertheless, although not discussed in terms of the principles in s 5 of the Act, this test is effectively a test to determine whether the s 5(e) principle is relevant. If the answer to both parts of Andrews J's question is yes, then it is clear that intervention will promote the child's safety, and s 5(e) will be relevant. Intervention will then usually be justified, unless the parents have identified a viable alternative.

An example of a case which went some way in outlining the balancing of these factors is *Auckland Healthcare Services v Liu*, where Tompkins J identified that the operation had a 70-80% chance of success. Because he had also accepted that it was inevitable that there would be some discomfort following the surgery, there was therefore a question as to whether the likelihood of success outweighed this discomfort. His honour decided that it did, resulting in the conclusion that the surgery was justified.

The nature of the treatment, and its likely efficacy, is a particularly relevant factor for preventive treatment. This is because there is no guarantee that the child will actually develop a healthcare issue. As a consequence, it is argued that there must be some

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162 *Auckland Healthcare Services v Liu*, above n 7, at 5.
163 Ibid, at 8.
164 *Waikato District Health Board v FF*, above n 8, at [29].

evidence that the child is at special risk. In the case of immunisations, it is widely accepted that courts cannot intervene when parents do not wish to immunise their children. Bridgeman asserts that "as an issue upon which there is genuine debate, decisions about immunisation are to be made by parents."[165] Similarly, Schweppe[166] and Diekema[167] both conclude that the state is generally incapable of interfering with a parental decision not to immunise their child.

Despite this general conclusion, Schweppe and Diekema both argue that there may be situations in which a court is compelled to immunise, such as where a child is at a particular risk of contracting an illness.[168] This argument has proven to be correct. Three cases in recent years in New Zealand,[169] Australia[170] and Canada[171] have resulted in courts ordering immunisations. All three involved immunisation for hepatitis B, where the mother was a hepatitis B carrier. Children with mothers who are positive for hepatitis B have a 70-90 percent chance of infection if not immunised, and more than 90% of those children will become chronic carriers,[172] potentially leading to cirrhosis of the liver and increased risk of cancer.[173] The Ministry of Health recommends that children of mothers positive with hepatitis B should be immunised within 12 hours of birth,[174] so such cases are certainly urgent, and presuming immunisations are non-routine, are incapable of being dealt with under the CYPFA.

None of these cases addressed the general presumption that parental wishes regarding immunisation should not be interfered with. All three proceeded on the basis that immunisation could be administered as it was in the best interests of the child, but the underlying rationale seems to be that the child was at particular risk. It is notable that a later Canadian case involving immunisations, used the fact that the children were not at

165 Bridgeman, above n 26, at 114.
166 Jennifer Schweppe "Best to Agree to Disagree? Parental Discord, Children's Rights and the Question of Immunization" (2008) 37 Comm L World Rev 147 at 162.
167 Diekema, above n 35, at 258.
168 Ibid at 257-258; Schweppe, above n 166,at 162.
169 *Capital and Coast District Health Board v DRB*, above n 15.
170 *Director-General, Department of Community Services; Re Jules*, above n 14.
171 *Children's Aid Society of Peel Region v H (TMC)*, above n 14.
172 Ministry of Health *Immunisation Handbook 2011* (Ministry of Health, Wellington, 2011) at 88.
173 Ibid at 87.
174 Ibid at 88.

any particular risk to distinguish, and not follow, the Canadian case involving hepatitis B.[175]

A similar distinction has been accepted in the United States. The majority in an Arizona Appeals Court refused to order immunisation because the evidence suggested that the health risks were common to all children, not specific to the particular child. But they stated that "we would not hesitate to find a compelling state interest had the Department shown that Cheyenne was especially vulnerable to the diseases prevented by immunization".[176]

With respect to immunisation, therefore, the clear situation appears to be that courts will generally not feel free to intervene, but will do so where the child is at particular risk, which would seem to require compelling evidence such as in the hepatitis B cases. If the child is at particular risk, it is also very likely that the need for intervention will be urgent.[177] Presuming immunisations are non-routine, this means intervention must be under the COCA or the inherent jurisdiction.

Similar issues arise with regard to diagnostic testing. There do not appear to have been any such cases in New Zealand.[178] Overseas cases, however, can be reconciled with the conclusion reached regarding immunisations. In *Re C (a child)[HIV Test]*, an English court ordered a child to be tested for HIV, where the mother had the disease and was breastfeeding.[179] The risk of the child having HIV was found to be 20-25%.[180] This case can stand for the principle that intervention will occur where the child is thought to be at particular risk. In another English case, a mother refused consent for her daughter to undergo an MRI scan, where doctors considered this necessary to investigate her symptoms.[181] The child was considered to be at special risk due to her sickle cell disease which required symptoms to be investigated promptly, and the court agreed that

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175 *Re JP*, above n 14, at [50].
176 *Diana H v Rubin*, above n 14, at 208.
177 The urgency may also be related to the need for prompt immunisation to achieve maximum efficacy. This is the reason for urgency in the hepatitis B cases.
178 There have been a number of cases where blood tests have been ordered, but these have been for paternity testing, not for health-related reasons.
179 *Re C (a child)(HIV test)*, above n 16. Leave to appeal was refused by the Court of Appeal (*Re C (A child)* [1999] 2 FLR 1004 (CA)).
180 *Re C (a child)(HIV test)*, above n 16, at 54.
181 *Re O (A Child)* [2010] EWCC 53 (Fam).

intervention was necessary.[182] In contrast, the Supreme Court of Ireland decided the state does not have authority to undertake standard tests on newborn babies, where there is no suggestion the child is at particular risk.[183] Nevertheless, the test is still urgent, as the test, for maximum effectiveness, needs to be administered within 120 hours of birth.[184] The latter case is long and involves different reasoning in its various judgments, much of which is specific to the Irish constitution, but the outcome fits the general proposition that even where a test is urgent, the child must be at special risk before courts will intervene.

After a thorough discussion of whether a New Zealand court would intervene to require newborn screening on parents who refused consent, Irvine concluded that the court would not intervene.[185] In her discussion, she raises the scenario of a sibling of a child with PKU, which is one of the diseases tested for by New Zealand's newborn screening programme. Such a sibling would have a 25% chance of having the disease, and in this situation she suggests a New Zealand court could order the test.[186] This conclusion fits with the suggestion here that where a child is known to be at particular risk, intervention can be justified, and the 25% risk is consistent with the level of risk considered enough in *Re C (a child)[HIV test]*.[187]

A third category of preventive intervention is where there are some grounds to believe that the parents of a child will not seek, or will refuse, treatment for the child. Two cases in New Zealand have addressed this situation, and in both there was considered to be urgency. In *Child Youth and Family Services v B (CYFS v B),*[188] the Court was asked to place a child under its guardianship. The child had been born prematurely, and was already the subject of interim custody orders under the CYPFA. The child had required treatment during its first month of life, but Judge Smith accepted that there was no current indication that further treatment was required. The child's mother was mentally unwell and hospitalised. The application sought pre-emptive authorisation of any treatment that became necessary. Judge Smith approved the application, on the basis

182 Ibid, at [4].
183 *North Western Health Board v W(H)*, above n 17.
184 Ibid at 670.
185 Rachael Irvine, above n 26, at 21.
186 Ibid, at 17.
187 *Re C (a child)(HIV test)*, above n 16.
188 *Child Youth and Family Services v B*, above n 18.

that there was a possibility the child would need urgent medical attention and "a situation cannot be allowed to develop where no clear authority is given to anyone to make those decisions."[189] Although her honour did not mention the s 5 principles, the outcome is consistent with the s 5(e) principle being decisive, although the fact that there was no current need for treatment means the case must be close to the boundary.

Another case in which the court intervened due to the possibility that parents would not seek medical treatment for their children was *Pahulu v Director-General of Social Welfare*.[190] The case involved a family in hiding to avoid deportation. Judge Robinson identified that:[191]

> The parents are reluctant to consult medical practitioners when the children are ill for fear of being discovered. On an occasion when one of the children was referred to the Starship Hospital for specialist treatment, the parents chose not to take the child to the Starship Hospital because of fear of being located.

Judge Robinson therefore declared that the children were in need of care and protection under the CYPFA because:[192]

> The risk of permanent injury to them as a result of illness or accident because their parents are in hiding and do not wish their location to be known to the authorities, which could happen if they sought medical attention, is too great.

As a result, interim custody orders were made placing the children in the custody of the Director-General until the family were to be deported.[193] In normal circumstances, these orders could not achieve the desired effect. Interim custody orders will have enabled medical attention to be sought, but the parents would still have needed to consent to any treatment. To ensure that treatment was received when necessary, the case really needed to address guardianship, which would normally be done through s 31 of the COCA.[194]

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189 Ibid at [18].

190 *Pahulu v Director-General of Social Welfare*, above n 18.

191 Ibid at 73.

192 Ibid at 74.

193 Ibid. The case was appealed, but this finding was not challenged on appeal: see *Pahulu v Director-General of the Children and Young Persons Service* (1998) FRNZ 436 (HC) at 441, alt cit *P v Director-General of CYPS* [1998] NZFLR 977 (HC) at 983.

194 The case was decided prior to the COCA, but the Guardianship Act 1968 had an equivalent section. On the facts of the case, because a family group conference had been held, it would have been

What these two cases have in common is that there was some evidence that the children were at particular risk, based on previous experience. What is unclear is the extent to which the cases can be extrapolated to further situations. An extension of the principle would be that court guardianship orders could be made for all children of Jehovah's Witnesses at birth, on the basis that they are known to be at particular risk should they need a blood transfusion. Such an outcome is clearly implausible. The boundary, therefore, must be not only that the child is at particular risk should it need treatment, but there must also be a particular risk of the child needing treatment. Such a test would account for the result in *CYFS v B*. On the other hand, *Pahulu v Director-General of Social Welfare* does not fit within that test.[195] It is probably best left considered as a case decided on a set of very unusual facts.

5.3 Interventions for Urgent Routine Treatment

Where the treatment that is required is routine, but still urgent, an issue of the appropriate statute arises. This may, of course, be an academic argument, as the uncertainty surrounding the boundary between routine and non-routine is such that there may not be any routine treatments that are truly urgent. Nevertheless, on the assumption that there may be such treatment, there is an ability within the CYPFA to intervene. Courts have power under s 78 of the CYPFA to make interim custody orders, placing the child under the custody of any person or certain types of organisation, prior to a declaration that the child is in need of care or protection, and therefore before a family group conference has been held. As identified in Chapter 2.4, the holder of an interim custody order can consent to routine medical treatment for the child.

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possible to make a guardianship order under the CYPFA. It is also possible, on the facts of the case, that this is a rare situation where interim custody orders may have been enough to enable non-routine treatment, due to the fact that the parents were in hiding. It was quite likely that if the need for consent arose, the parents would not have been able to have been contacted. Under s 36(3)(b) of the COCA (and equivalent provisions in the Guardianship Act which applied at the time), there is provision for the person acting in the place of a parent to consent to treatment when the guardian cannot be found with reasonable diligence.

195 On the facts of the case as reported, there was evidence that one of the three children had been referred for specialist treatment, but there was nothing to suggest the other two children, who were also found to be in need of care or protection, were at any particular risk of needing medical treatment.

In *Child Youth and Family Services v DSWH*,[196] where the health needs of a diabetic child were being mismanaged, interim custody orders (later followed by custody orders) were sufficient for the child's health to be stabilised. It is unclear from the case whether this was because the treatment required was routine in nature, or because the parents co-operated. Similarly, in *Re C*,[197] the health care of an epileptic child was being mismanaged. Following the granting of an interim custody order, the child was admitted to hospital immediately. This case preceded the COCA, but it is still likely that custodians can admit a child to hospital, as that step would be a decision of day-to-day living. But the custodian would not, of course, be able to consent to any treatment at the hospital beyond the routine. However, by providing the means to admit the child to hospital, interim custody orders can pave the way to identify if non-routine treatment, and hence further action under either the CYPFA or the COCA, is needed. An alternative means of achieving the same is provided by s 49 of the CYPFA, which allows the court to order a medical examination to ascertain if a child is suffering from neglect, where there are reasonable grounds to suspect this.

It is suggested, though, that if a case involving routine treatment does arise, the court would be justified in using the COCA rather than the CYPFA. Interim custody orders require the removal of the child from the custody of the parents. This would appear to be one of those situations described by the Court of Appeal in *WAH v WTW*[198] where there is "good reason" for the use of court guardianship in a situation where the CYPFA can also be used. Allowing a child to receive routine treatment without removing him or her from the custody of the parents, would seem to be a good reason to use the court guardianship provisions of the COCA in place of the CYPFA. A case where this could have been tested was *CCDHB v DRB*,[199] involving immunisation, but Judge Whitehead was not invited to, and did not, consider the issue of whether immunisations were routine, or whether the CYPFA should have been used.

196 *Child Youth and Family Services v DSWH*, above n 67.
197 *Re C*, above n 66.
198 *WAH v WTW*, above n 103, at [44].
199 *Capital and Coast District Health Board v DRB*, above n 15.

5.4 Conclusion

Where treatment is needed within a few weeks, the appropriate route is the COCA, or the inherent jurisdiction. This is regardless of whether the treatment required is routine or not. To determine whether treatment is in the best interests of the child, the principles of the COCA must be considered. In particular, courts must balance the principle of safety in s 5(e) against the principles that parents and guardians should have the primary responsibility for the child's development and upbringing (s 5(a)) and that the child's identity, including culture and religion, should be preserved and strengthened (s 5(f)). The outcome of that balancing will be case-specific, but any case that fails to attempt this balancing is failing to apply the Act, as s 4(5)(b) requires that this be done. It is unacceptable that, to date, none of the refusal of medical treatment cases in non-life-threatening situations considered under the COCA have even mentioned the existence of the principles in s 5, even though the outcomes have been consistent with the principles.

The decisive nature of s 5(e) means that the key question will always be whether the safety of the child is at significant risk without intervention. If the answer to that question of fact is yes, the principles of the Act are such that intervention should always be the option chosen by the court. This issue becomes particularly acute in the case of preventive treatment. The important component in determining safety in such cases requires a determination as to whether the child is at special risk so as to justify intervention.

Chapter 6

Medical Neglect and the Criminal Law

"Criminal law and family law serve different, incompatible purposes."[200]

6.1 Introduction

Parents who fail or refuse to provide medical care for their children in non-life-threatening situations are potentially liable under the criminal law. Until March 2012, they can face charges of failing to provide necessaries (ss 151 and 152 of the Crimes Act 1961) or wilful neglect (s 195 of the Crimes Act 1961 and s 10A of the Summary Offences Act 1981). Another potential, but unlikely possibility, is criminal nuisance (s 145 of the Crimes Act 1961).[201]

The Crimes Amendment (No 3) Act 2011,[202] which is a partial implementation of the Law Commission's recommendations for reform of Part 8 of the Crimes Act 1961,[203] makes numerous changes, which will take effect in March 2012. The impact of these changes with regard to medical neglect will be discussed in this chapter. Firstly, however, the chapter considers the differing role of the criminal law to the remedial law considered in the previous chapters.

6.2 Appropriateness of the Criminal Law

Fortin notes that "child protection laws can probably achieve far more than the criminal law in terms of ensuring that a child's right to healthcare is fulfilled."[204] She claims that this is because criminal sanctions may "be too late to protect the child's health".[205]

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200 Samuel V Schoonmaker "Criminal Law or Family Law: The Overlapping Issues" (2010) 44 FamLQ 155 at 155.

201 All relevant sections of the Crimes Act 1961 and Summary Offences Act 1981 appear in Appendix 3.

202 All relevant sections of the Crimes Amendment (No 3) Act 2011 appear in Appendix 4.

203 Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, 2009).

204 Jane Fortin *Children's Rights and the Developing Law* (3rd ed, Cambridge University Press, Cambridge, 2009) at 366.

205 Ibid.

Nevertheless, the criminal law is used in cases of medical neglect, and there is no bar on criminal proceedings and remedial interventions both occurring. Otherwise, there would be the absurd situation where the ability to prosecute parents is dependent on whether or not authorities have intervened to protect the child.[206] The role of prosecutions, however, are not to protect the child, but to penalise the parents, and more generally, to act as a deterrent for other parents.

6.3 Failure to Provide Necessaries

The law relating to the failure to provide necessaries in s 152 of the Crimes Act 1961 will change substantially in March 2012. Currently, s 152 applies only to parents already under a legal duty to provide necessaries. According to the Law Commission, the source of such a parental duty is unclear, and they were not able to find any authority which identified it,[207] although it is clear from the number of successful convictions under s 152 that the duty must exist. Nevertheless, the Law Commission considered the situation undesirable, and recommended codification of the duty.[208] The new s 152 will impose a legal duty to provide necessaries on all parents, or persons in the place of a parent, who have actual care or charge[209] of a person aged under 18 years. It is considered uncontentious that medical care falls within the concept of necessaries,[210] and New Zealand courts have accepted this to be the case since at least 1954.[211]

The scope of the new duty will be much greater than that which currently incurs criminal responsibility.[212] Further, it extends the duty to a requirement to take

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206 *Appellant (AP 69 94) v Police* HC Hamilton AP69/94, 14 February 1995 at 21-22.

207 Law Commission, above n 203, at [5.44].

208 Ibid.

209 The Crimes Act 1961 does not define "charge" and there do not seem to be any New Zealand cases on point, but a guardian who does not have actual care would still be likely to have "charge" of a child. This is certainly the case in the United Kingdom. The Children and Young Persons (Scotland) Act 1933, s 27, defines a person to have charge of a child if they have parental responsibilities (equivalent to guardianship in New Zealand) in relation to the child.

210 Bruce Robertson (ed) *Adams on Criminal Law* (online looseleaf ed, Brookers) at [CA151.02]; Law Commission, above n 203, at [5.33].

211 See *R v Moore* [1954] NZLR 893 (CA).

212 Currently, s 152 only imposes criminal responsibility if the omission causes the death of the child, or causes its life to be endangered or health to be permanently injured. The new s 152 does not contain these limitations.

reasonable steps to protect the child from injury.[213] Although the Law Commission states that this latter requirement covers more than omissions to save the child from illegal violence,[214] it is difficult to think of any situations involving medical neglect where the duty to take reasonable steps to protect the child from injury will add anything not already required by the duty to provide necessaries.

The new s 152 will not constitute an offence in itself.[215] For cases involving medical neglect in non-life-threatening situations, the only relevance of s 152 will be that it can form the basis for a conviction under s 195, or possibly s 145.

Section 151 also imposes a legal duty to provide necessaries, to those who have care and control of someone for various reasons, including their age.[216] Section 151 is slightly narrower than s 152, in that it only applies when the person over whom care and charge is held is not able to provide themselves with necessaries. As with s 152, s 151 currently constitutes an offence in itself, but from March 2012 will not.

6.4 Criminal Neglect

Section 195 of the Crimes Act 1961 currently provides for imprisonment for up to five years for any person having custody, control or charge of a child under 16 years, who wilfully neglects such a child in a manner likely to cause "unnecessary suffering, actual bodily harm, injury to health, or any mental disorder or disability." This provision is based on United Kingdom statutes.[217] An important element of the offence is that neglect must be wilful. In considering the equivalent offence in the United Kingdom,

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213 This amendment is aimed at creating a codified duty to protect children from violence: see Law Commission, above n 203, at [5.34]. In *R v Lunt* [2004] 1 NZLR 498 (CA) at [23], the Court of Appeal found that protecting a child from violence from others was not a necessary, and instead turned to a common law duty. The amendment codifies that common law duty.

214 Law Commission, above n 203, at [5.35].

215 This is a substantial change from the previous law. Section 152 was previously an offence in itself, with the possibility of up to 7 years imprisonment. There are numerous examples of convictions under s 152 on the basis of failing to provide a child with medical care, for example, *R v Laufau*, above n 4; *R v Hirchkop and Anor* CA CA506/05, 6 July 2006; *R v Tiatoa* HC Auckland CRI-2009-055-1007, 11 October 2010.

216 Section 151 currently refers to "necessaries of life", which will be amended to "necessaries" in March 2012. Also, the new s 151 will refer to those who have care or charge of vulnerable adults. A vulnerable adult will be defined to include "a person unable, by reason of ..., age,..., to withdraw himself or herself from the care or charge of another person". A child will therefore meet the definition of a vulnerable adult. But for parents, there will be no need to invoke the s 151 duty, as the new s 152 will cover all circumstances covered by the new s 151.

217 Children and Young Persons Act 1933 (UK), s 1; Children and Young Persons (Scotland) Act 1937, s 12.

the House of Lords in *R v Sheppard* determined that the requirement for wilfulness required the neglect to be either deliberate or reckless,[218] and this was adopted in New Zealand by the Court of Appeal.[219]

In March 2012, s 195 will change substantially, including doubling the maximum sentence to 10 years imprisonment and increasing the age from 16 to 18.[220] Section 195 currently refers to the grounds leading to liability, namely neglecting the child, or permitting the child to be ill-treated. Although the new section will be called "Ill-treatment or neglect of child or vulnerable adult", it makes no mention of either ill-treatment or neglect. It refers instead to an omission to perform any legal duty. The omission to provide necessaries as required by the new s 152 will almost certainly be the omitted legal duty most commonly relied upon.

Section 150A of the Crimes Act 1961 states that for the purposes of Part 8 of the Act, a person can be criminally responsible for an omission to perform the duty in s 152 only if the omission is, in the circumstances, "a major departure from the standard of care expected of a reasonable person to whom that legal duty applies".[221] Section 195 is in Part 8, so s 150A will be relevant from March 2012 when s 195 will refer to legal duties. Section 150A serves two purposes: on one hand it imposes an objective standard, but on the other hand it absolves minor departures from that objective standard from incurring criminal liability.[222] According to the Court of Appeal, this requirement means the prosecution must show gross negligence rather than mere negligence.[223] In addition, the new s 195 will impose a very similar test.[224] This is a

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218 *R v Sheppard* [1981] AC 394 (HL) at 405 per Lord Diplock and at 418 per Lord Keith, with a concurring judgment from Lord Edmund-Davies and with Lord Fraser and Lord Scarman dissenting.

219 *R v Hende* [1996] 1 NZLR 153 (CA) at 155, reaffirmed in *R v R (CA165/2009)* [2009] NZCA 356 at [19].

220 The change of age makes no difference for cases involving parental refusal of consent. This is due to s 36(1) of the COCA, under which children over 16 have the right to consent themselves, meaning there is no scope for parents of 16 and 17 year olds to refuse consent, and therefore no scope to be liable for such refusals. The change will, however, affect cases of failure to treat. It creates the unusual situation that parents will be criminally liable for medical neglect of 16 and 17 year olds, when under the COCA they have no ability to control the child's ability to consent (or refuse to consent) to any treatment that is offered. Nevertheless, this was already the position with regard "Gillick competent" minors.

221 The wording listed is that which will take effect in March 2012, which is slightly, but immaterially, different to the current wording. See Appendix 3 for the current wording.

222 See Joanna Manning "The Required Standard of Care for Treatment" in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 61 at 69-72 for a discussion of the history and function of s 150A.

223 *R v Fenton* [2003] 3 NZLR 439 (CA) at [13].

legislative response to *R v Shepphard*[225] and the New Zealand Court of Appeal cases that have accepted its application to s 195,[226] with the Law Commission stating that ignorance, thoughtlessness, or lack of deliberateness will no longer absolve a defendant from liability under s 195.[227]

In many cases involving refusal of treatment, this amendment will have little effect, as it is implicit in the fact of refusal that there is an awareness of the need for treatment. In blood transfusion cases, for instance, the parents are usually fully aware that the refusal is likely to affect the child's health adversely.[228] This is not, however, always the case. For example, in *Re Norma*,[229] Tompkins J accepted that the parents believed their child could be cured by applying traditional Samoan medicine, despite the medical evidence that she had cancer and needed chemotherapy to have a chance of survival. Similarly, the parents in *Auckland Healthcare Services v Liu*[230] believed that God would heal their son's sight, despite the clinical evidence that spontaneous improvement in people with the condition was unheard of. If criminal charges had been laid under s 195 in either of these cases, it is highly possible that convictions would not have resulted.[231] As the parents in both cases felt that their actions were sufficient to cure the child, a finding of a lack of wilfulness would have been very possible. In contrast, there seems little doubt that under the new test, most if not all juries, like the judges in the guardianship applications, would accept the medical evidence. As such, the parents in such cases would fail the objective test and be liable for conviction.

While the Law Commission considers the objective test to be a lower threshold for conviction than recklessness,[232] this is a simplification. As recognised by the Court of Appeal, albeit in obiter dicta, although most cases of recklessness will also be a major

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224 The new s 195 applies to conduct intentionally engaged in, as well as omissions to perform legal duties. While the latter will be covered by s 150A, the former will not be. This seems to explain why it considered necessary for the objective standard to appear in s 195. It also means that the objective standard will apply in the unlikely event that a legal duty other than one covered by s 150A is being relied upon.

225 *R v Sheppard*, above n 218.

226 *R v Hende*, above n 219 at 155; *R v R (CA165/2009)*, above n 219, at [19].

227 Law Commission, above n 203, at [5.17]. The Minister of Justice, the Hon Simon Power made a very similar comment during the third reading of the Bill ((15 September 2011) 675 NZPD 21393).

228 For example, *Re J (An Infant)*(CA), above n 4.

229 *Re Norma*, above n 81.

230 *Auckland Healthcare Services v Liu*, above n 7.

231 As far as I am aware, criminal charges were not laid in either of these cases.

232 Law Commission, above n 203, at [4.11].

departure from the standard of care expected, it is conceivable for an omission to be reckless but not a major departure from the standard of care required.[233] This means that some cases of medical neglect that could previously have resulted in convictions no longer will.

An example may be minor health issues. Several cases under the old s 195 concerned relatively minor conditions. In one case the child suffered from serious skin problems, with persistent rashes on his arms and legs which he would scratch until he bled.[234] Similar types of issues were one of the grounds for conviction in *R v R*,[235] where the child was infected with head lice, had unhealthy skin and hair, and had had her health needs ignored for approximately one year, and also in *Appellant (AP 69 94) v Police*,[236] where the children had head lice, open and infected sores, and one had mouth ulcers. In all three of these cases, the failure to provide healthcare was not the only factor constituting neglect; it is unclear in the judgments if the neglect of these arguably minor ailments would have been sufficient for conviction without the additional factors. However, the wording of the provision suggested that they would have been, as these factors on their own were causing unnecessary harm or injury to health. With the new requirement that the neglect must be a "major departure" from the standard of care expected, rather than merely result in injury to health, it is quite conceivable that these cases would no longer result in convictions under s 195. This result seems to be unintended; there was certainly no mention in the Law Commission's Report that the imposition of the major departure test would remove minor injuries from the realms of the section.[237]

On the other hand, many cases that have always fallen within s 195 will continue to do so. For example, in *Morgan v R*,[238] the appellants were caregivers of a child who was badly burned in a bath. They treated the child by putting him in ice, then cold water,

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233 *R v Andersen* [2005] 1 NZLR 774 (CA) at [66].

234 *R v Ahotau* HC Auckland CRI-2009-092-7420, 23 June 2009.

235 *R v R (CA165/2009)*, above n 219.

236 *Appellant (AP 69 94) v Police*, above n 206.

237 The only suggestion that the Law Commission, above n 203, considered that s 195 may miss cases of minor neglect is in its statement at [5.42] that its proposals "if adopted, will ensure that offences are available to capture the whole range of cases in which the [s 152] duty might be breached, from relatively minor endangering cases under new section 157A, to more serious consequences for which sections 157B or section 195 might be invoked". Parliament has not enacted the Law Commission's proposals for new ss 157A and 157B.

238 *Morgan and Anor v R* HC Hamilton CRI 2008-419-000032, 13 June 2008.

then wrapping him in towels in bed. He was not taken to hospital until 14 hours later: he remained there for the next 63 days. Failure to seek medical attention for a child with burns also resulted in conviction in *R v Martin*.[239] In *Police v L,*[240] three children were found to be neglected. Among other factors, one of the children was missing a part of a toe on each foot, which doctors concluded was as a result of an untreated infected chilblain. Cases similar to these will continue to fall within the bounds of s 195.

6.5 Preventive Health Care and Criminal Neglect

For a conviction under the new s 195 for the omission of a legal duty will require that the omission "is likely to cause suffering, injury, adverse effects to health, or any mental disorder or disability".[241] The word "likely" is particularly important when considering preventive interventions. According to the Court of Appeal, "likely" in s 195 "means such as might well happen; it connotes a real or substantial risk".[242]

Generally, omissions to undertake immunisations are unlikely to meet this threshold. But there may be situations where the omission does result in a real or substantial risk of adverse effects to health, and the omission meets the objective test. An example is cases involving hepatitis B immunisations. As seen in Chapter 5.2.2, children whose mothers are hepatitis B carriers have a 70-90% chance of infection, and a 90% chance of becoming a carrier if infected. In such situations, it is likely that the elements of s 195 will be met.

Diagnostic testing cases are similar. In general, the failure of a parent to have a child tested for any particular medical condition is not, of itself, likely to cause suffering or injury. It is only if the child is known to be at particular risk of having a condition, that failing to test could be said to lead to a "real or substantial risk" of the child suffering adverse effects to health.

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239 *R v Martin* HC Whangarei CRI 2009-088-4050, 5 October 2010.
240 *Police v L* [1993] DCR 617.
241 This wording is not substantially different to the current wording. See Law Commission, above n 203, at [5.21] for an explanation for the changes.
242 *R v Hende*, above n 219, at 156.

In the case of both immunisations and testing, therefore, the point at which the court considers adverse effects to health to be likely, are probably similar to the point at which a court considering section 5(e) of the COCA would consider that the child's safety is at risk. In both situations, therefore, the point at which the criminal law will intervene is probably similar to the point at which the court will invoke the court guardianship provisions of the COCA. Further, given that the child must be known to be at special risk before it can be said that adverse effects to health are likely, once that threshold is met it is difficult to perceive the objective test not being satisfied.

The general protective category is more complex. In both such cases discussed in Chapter 5.2.2,[243] there was no evidence that the child was likely to require treatment. Court intervention was based on the possibility, rather than the likelihood, of treatment being needed. Furthermore, there is no suggestion, in *CYFS v B*[244] at least, that the performance of any legal duty had been omitted. Where the parents have not yet failed to provide treatment, there has been no omission of the duty to provide necessaries, and therefore the new s 195 will not apply. It is therefore improbable that the parents in such cases would be liable under the new s 195. This is different to the current situation, where s 195 does not require omission of a legal duty, although such cases probably struggle to meet the requirement that unnecessary suffering is likely.[245]

The inability of the criminal law to intervene where there is reason to suspect that medical neglect will occur in the future means that there is therefore no direct correlation between when courts can and will intervene to protect the child, and when guardians are liable under the criminal law.

6.6 Criminal Nuisance

It is possible that the newly codified duty in s 152 could be used to form the basis for a conviction under s 145 (criminal nuisance). That section, which will remain unchanged, states that every one commits an offence who omits to discharge any legal

243 *Pahulu v Director-General of Social Welfare*, above n 18; *Child Youth and Family Services v B*, above n 18.

244 *Child Youth and Family Services v B*, above n 18.

245 Another change to the law is that from March 2012 it will require "suffering" to be likely, not "unnecessary suffering". This change reflects the recommendations of the Law Commission, above n 203, but the Law Commission gave no indication of why the word unnecessary was to be omitted. However, it does not seem to be likely to make any substantial difference.

duty, if he or she knew that the omission would endanger the life, safety, or health of any individual. There seems little doubt that this broad section can cover parental failure to provide necessaries. The offence carries a maximum sentence of one year of imprisonment. Currently, any medical neglect that would come under s 145, would also come within s 195 as well as s 10A of the Summary Offences Act 1981. From March 2012, it will still mostly be the case that cases that fall within s 145 will also fall within s 195. The exception may be cases involving minor health issues, if they are found to not be a "major departure" from the standard of care expected. Because s 145 is not in Part 8 of the Crimes Act 1961, s 150A does not seem to apply,[246] meaning recklessness is sufficient.[247] Therefore, so long as the medical neglect is reckless, s 145 will seemingly apply. As the wilful element of the current s 195 is said to be equivalent to recklessness or deliberateness,[248] it would seem that any cases that currently meet the s 195 criteria, but are not covered by the new objective standard, will continue to be covered by s 145 with its requirement of recklessness.

6.7 Summary

The criminal law, by its nature, is penal in nature, rather than protective. There is no doubt that, after the amendments taking effect in March 2012, medical neglect in non-life-threatening situations will continue to fall within the ambit of ss 145 and 195 of the Crimes Act 1961. In chapter 3.4, it was shown that the court guardianship jurisdiction is seen as a remedy of last resort, and in Chapter 3.2, that for a finding that a child is in need of care and protection under the CYPFA, the parental care must be unacceptably incompetent. It would seem, therefore, that in most cases where the court intervenes under those remedies, the parents will almost certainly also fail the objective test in s 195. The exception, however, is cases where it is suspected that medical care will not be provided, but where that omission has not yet occurred. As was seen in Chapter 5.2.2, courts will on occasion intervene on behalf of a child in such situations, but as the parent has not yet omitted their legal duty to provide necessaries, no action will be available under the criminal law from March 2012.

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246 Although this is what a plain reading of s 150A would suggest, the Court of Appeal in *R v Andersen*, above n 233, at [63] left the point open, despite stating at [64] that it "is undeniable that Parliament did not intend s 150A to be applied in s 145 cases."

247 The Court of Appeal ruled in *R v Andersen*, above n 233, at [55] that s 145 creates an offence of recklessness.

248 *R v Sheppard*, above n 218.

Chapter 7

Conclusion

> "The crucial issue, it seems to me, is when and on what basis the law should prioritise *either* the claims of parents *or* those of children."[249]

7.1 The Ability of the State to Intervene

It is clear that, under New Zealand law, the state has wide-ranging powers to intervene with regard to non-life-threatening medical neglect. It does this both through intervening on behalf of the child, and criminalising the parents.

7.2 Remedial Interventions

In terms of remedial interventions on behalf of children, the crucial distinctions in New Zealand are between urgent and non-urgent situations, and routine and non-routine treatment. Although there are means for the state to intervene in each, the process is different.

7.2.1 Non-Urgent Remedial Interventions

Where any treatment needed by the child is non-urgent, the appropriate jurisdiction would seem to be the CYPFA. This is because the Court of Appeal in *WAH v WTW*[250] has accepted that, barring good reasons to the contrary, the CYPFA should be used over the COCA whenever it can be. Although the CYPFA does not specifically identify medical neglect as grounds for intervention, there is little doubt that it can form the basis for a finding that a child is in need of care or protection, under the grounds in ss 14(1)(a) or 14(1)(b).

Although a complex piece of legislation, with multiple principles, the overall feature is that the CYPFA favours non-intervention,[251] unless intervention is necessary to protect

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249 Andrew Bainham "Non-Intervention and Judicial Paternalism" in Peter Birks (ed) *The Frontiers of Liability* (Oxford University Press, Oxford, 1994) 161 at 173.

250 *WAH v WTW*, above n 103.

251 CYPFA, ss 5 and 13.

the child's safety.[252] In terms of medical neglect, guardianship orders under s 110 are the only truly useful remedial intervention in the absence of parental co-operation. Such orders allow the court to appoint new guardians, who can then consent to treatment. These guardians can be additional to or instead of the existing guardians, and can be for the specific purpose of providing medical treatment. But guardianship orders can only be made consequent upon a delcaration that the child is in need of care and protection, evidenced by meeting one of the criteria in ss 14(1)(a) or 14(1)(b). Section 14(1)(b) requires that likely impairment be "serious", and more generally, the courts appear to be reluctant to make a declaration unless the parents are "unacceptably incompetent".[253] Therefore, despite the CYPFA stating that the welfare and interests of the child are the first and paramount consideration,[254] the reality is that the CYPFA is incapable of intervening in the best interests of the child in all situations of medical neglect. There is parental discretion regarding non-urgent medical treatment for their children, and it is only when use of that discretion is well below societal norms that intervention under the CYPFA is likely to occur.

7.2.2 Urgent, Non-Routine Remedial Interventions

The lack of emergency guardianship orders in the CYPFA means that, for non-routine urgent treatment, the COCA or the inherent *parens patriae* jurisdiction needs to be utilised. While the unspecific wording of the court guardianship provisions in the COCA seem to leave a broad discretion to the courts, this discretion is not as great as it seems, due to the principles in s 5 of the Act. Under s 4(5)(b), these must be taken into account if they are relevant. By formulating the principles in s 5 so that the requirement for the safety of the child is stated in imperative terms, but by also recognising in other principles that parents should have the primary responsibility for their child's development and that the child's identity should be preserved and strengthened, Parliament has in effect adopted the harm principle as promoted by commentators such as Diekema,[255] whereby parental decision-making will not be interfered with except where it puts the child's safety at risk. This is a different threshold to a test based solely on the child's welfare and best interests, as it may still be considered in the child's best interests to intervene even if his or her safety cannot be shown to be at appreciable risk.

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252 Ibid, s 13(a).
253 *E v Department of Social Welfare*, above n 63, at 334.
254 CYPFA, s 6.
255 Diekema, above n 35.

Although this may be seen as watering down the welfare and best interests test, it is in fact more an application of the long-standing judicial approach under the inherent *parens patraie* jurisdiction for courts to over-ride parental rights "sparingly".[256]

Proponents of the harm or reasonableness threshold have identified preventive health treatment as a key place where the welfare and best interests test does not work well.[257] Once it is realised that the test applied in New Zealand is akin to the reasonableness threshold, it becomes easier to identify the point at which the law can intervene for preventive treatment. The test seems to be that where a child is considered to be at particular risk, the court will override the non-intervention principle. While such cases will always be fact-specific, the boundary essentially comes down to identifying if there is a real, rather than speculative, possibility that non-intervention will harm the child.

7.2.3 Urgent, Routine Remedial Interventions

The COCA would seem to be the appropriate vehicle for intervening to obtain urgent routine treatment. Courts are still to determine the precise nature of "routine treatment", but it seems possible that cases could arise in which a failure to provide urgent routine treatment could constitute medical neglect. The CYPFA can deal with such situations through the making of interim custody orders, but it is suggested that such situations would fall within the good reasons exception in *WAH v WTW*,[258] giving grounds to use the COCA, and thus being able to keep the child in the custody of the parents. An insistence on using the CYPFA would seem contrary to the child's best interests. An alternative, of course, would be for Parliament to amend the CYPFA to allow courts to make routine medical treatment orders at the same point in time as interim custody orders are able to be made.

7.3 The Criminal Law

The state is also able to take criminal action against parents who medically neglect their children. From March 2012, s 152 of the Crimes Act 1961 will contain a codified duty for parents to provide necessaries (which includes medical treatment). Failure to perform this duty will leave parents liable for conviction under s 195. The

256 *Pallin v Department of Social Welfare*, above n 75, at 272, per Cooke J.
257 See Elliston, above n 32, at 106-108.
258 *WAH v WTW*, above n 103.

circumstances in which parents can receive criminal convictions are largely similar to the circumstances in which the state can intervene on behalf of the child. An exception is purely preventive interventions where there has not yet been a refusal to consent to treatment. In these cases, because there has not yet been any omission to perform a legal duty, there will not be any possibility of conviction once the amendments to the Crimes Act 1961 come into force.

7.4 Concluding Comments

It can be seen that the state has considerable power to intervene on behalf of children suffering from medical neglect, and to criminalise their parents. While the welfare and best interests standard would seem to suggest that the state has a flexible and arbitrary ability to intervene, the reality is that the principles in both the COCA and CYPFA decrease this arbitrariness. As stated by Andrews J, whether or not the state can intervene boils down to:[259]

> a question whether there is a real and substantial risk of his [or her] condition significantly deteriorating if he [or she] is not given the treatment, and whether there is a reasonable prospect that his [or her] condition will be improved or at least ameliorated, if he [or she] is given the treatment.

If the answer is yes to both parts of this question, and the parents are failing to provide the child with the treatment, then the state will usually be likely to be able to intervene on behalf of the child, and to prosecute the parents.

[259] *Waikato District Health Board v FF*, above n 8, at [29].

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Appendix 1

Care of Children Act 2004 (Selected Sections)

4 Child's welfare and best interests to be paramount

(1) The welfare and best interests of the child must be the first and paramount consideration—
   (a) in the administration and application of this Act, for example, in proceedings under this Act; and
   (b) in any other proceedings involving the guardianship of, or the role of providing day-to-day care for, or contact with, a child.

(2) The welfare and best interests of the particular child in his or her particular circumstances must be considered.

...

(5) In determining what best serves the child's welfare and best interests, a court or a person must take into account—
   (a) the principle that decisions affecting the child should be made and implemented within a time frame that is appropriate to the child's sense of time; and
   (b) any of the principles specified in section 5 that are relevant to the welfare and best interests of the particular child in his or her particular circumstances.

(6) Subsection (5) does not limit section 6 (child's views) or prevent the court or person from taking into account other matters relevant to the child's welfare and best interests.

5 Principles relevant to child's welfare and best interests

The principles referred to in section 4(5)(b) are as follows:

(a) the child's parents and guardians should have the primary responsibility, and should be encouraged to agree to their own arrangements, for the child's care, development, and upbringing:

(b) there should be continuity in arrangements for the child's care, development, and upbringing, and the child's relationships with his or her family, family group, whānau, hapu, or iwi, should be stable and ongoing (in particular, the child should have continuing relationships with both of his or her parents):

(c) the child's care, development, and upbringing should be facilitated by ongoing consultation and co-operation among and between the child's parents and guardians and all persons exercising the role of providing day-to-day care for, or entitled to have contact with, the child:

(d) relationships between the child and members of his or her family, family group, whānau, hapu, or iwi should be preserved and strengthened, and those members should be encouraged to participate in the child's care, development, and upbringing:

(e) the child's safety must be protected and, in particular, he or she must be protected from all forms of violence (whether by members of his or her family, family group, whānau, hapu, or iwi, or by other persons):

(f) the child's identity (including, without limitation, his or her culture, language, and religious denomination and practice) should be preserved and strengthened.

6 Child's views

(1) This subsection applies to proceedings involving—
   (a) the guardianship of, or the role of providing day-to-day care for, or contact with, a child; or

...

(2) In proceedings to which subsection (1) applies,—
   (a) a child must be given reasonable opportunities to express views on matters affecting the child; and
   (b) any views the child expresses (either directly or through a representative) must be taken into account.

8 Interpretation [Selected definitions only]

In this Act, unless the context otherwise requires,—

child means a person under the age of 18 years

day-to-day care includes care that is provided only for 1 or more specified days or parts of days

guardian and ***guardianship*** have the meanings given to them by section 15

role of providing day-to-day care for a child—

(a) means the role, under this Act, an order under this Act, or an order made by a court in a prescribed overseas country, of providing day-to-day care for the child; and

(b) includes, while exercising that role, exclusive responsibility for the child's day-to-day living arrangements

15 Guardianship defined

For the purposes of this Act, ***guardianship*** of a child means having (and therefore a ***guardian*** of the child has), in relation to the child,—

(a) all duties, powers, rights, and responsibilities that a parent of the child has in relation to the upbringing of the child:

(b) every duty, power, right, and responsibility that is vested in the guardian of a child by any enactment:

(c) every duty, power, right, and responsibility that, immediately before the commencement, on 1 January 1970, of the Guardianship Act 1968, was vested in a sole guardian of a child by an enactment or rule of law.

16 Exercise of guardianship

(1) The duties, powers, rights, and responsibilities of a guardian of a child include (without limitation) the guardian's—
   (a) having the role of providing day-to-day care for the child (however, under section 26(5), no testamentary guardian of a child has that role just because of an appointment under section 26); and

(b) contributing to the child's intellectual, emotional, physical, social, cultural, and other personal development; and
(c) determining for or with the child, or helping the child to determine, questions about important matters affecting the child.

(2) ***Important matters affecting the child*** include (without limitation)—

...

(c) medical treatment for the child (if that medical treatment is not routine in nature); and

...

(3) A guardian of a child may exercise (or continue to exercise) the duties, powers, rights, and responsibilities of a guardian in relation to the child, whether or not the child lives with the guardian, unless a court order provides otherwise.

...

(5) However, in exercising (or continuing to exercise) the duties, powers, rights, and responsibilities of a guardian in relation to a child, a guardian of the child must act jointly (in particular, by consulting wherever practicable with the aim of securing agreement) with any other guardians of the child.

(6) Subsection (5) does not apply to the exclusive responsibility for the child's day-to-day living arrangements of a guardian exercising the role of providing day-to-day care.

30 Concurrent jurisdiction under section 31

(1) The following courts have jurisdiction under section 31:
(a) the High Court:
(b) each Family Court.

...

31 Application to court

(1) An eligible person may make an application to a court with jurisdiction under this section for—
(a) an order placing under the guardianship of the court a child who is not married, in a civil union, or in a de facto relationship:
(b) an order appointing a named person to be the agent of the court either generally or for any particular purpose.

(2) In this section, ***eligible person***, in relation to a child, means any of the following persons:
(a) a parent or guardian of the child:
(b) a grandparent or an aunt or an uncle of the child:
(c) a sibling (including a half-sibling) of the child:
(d) a spouse or partner of a parent of the child:
(e) the child himself or herself (who may apply without any litigation guardian):
(f) the chief executive:
(g) any other person granted leave to apply by the court.

33 Orders of court

(1) A court to which an application is made under section 31 may—
(a) make an order described in section 31(1)(a); or
(b) make orders described in section 31(1)(a) and (b); or
(c) make—
(i) an order described in section 31(1)(a); and
(ii) an order appointing any person whom the court thinks fit to be the agent of the court either generally or for any particular purpose.

(2) An order under subsection (1) in respect of a child ceases to have effect when the first of the following events occurs:
(a) the court orders that the order ceases to have effect; or
(b) the child turns 18 years; or
(c) the child marries or enters into a civil union; or
(d) the child lives with another person as a de facto partner.

34 Powers of court

(1) A court to which an application is made under section 31 has the rights and powers specified in subsection (2)—
(a) between the making of the application for an order and its disposal; and
(b) while an order is in force.

(2) The court has the same rights and powers in respect of the person and property of the child as the High Court had in relation to wards of court immediately before the commencement, on 1 January 1970, of the Guardianship Act 1968, except that the court may not—
(a) direct any child who is of or over the age of 16 years to live with any person unless the circumstances are exceptional; or
(b) commit for contempt of court a child or the child's spouse for marrying without the court's consent while the child is under the guardianship of the court.

(3) The High Court has all the powers of a Family Court in relation to who has the role of providing day-to-day care for, or contact with, a child who is the subject of an application under section 31 or an order under section 33. An order of the High Court about providing day-to-day care for, or contact with, any child of that kind may be enforced under this Act as if it were an order of a Family Court.

35 Further provisions relating to powers of court

(1) This section applies to a court if it is a Family Court or the High Court hearing or otherwise dealing with proceedings under section 31.

(2) The court may, before or by or after the principal order, make any interim or final order it thinks fit about the role of providing day-to-day care for, or about contact with, or about the upbringing of, a child who is the subject of the proceedings.

...

(4) The court may, if in all the circumstances it thinks it appropriate to do so, make an order vesting the sole guardianship of the child in 1 of the parents, or make any other order with respect to the guardianship of the child that it

thinks fit. However, if the court makes no order with respect to the guardianship of the child, every person who was a guardian of the child continues to be a guardian of the child.

(5) An order may be made under this section, and an order made under this section may be varied or discharged, even though the court has refused to make the principal order or to give any other relief sought.

36 Consent to procedures generally

(1) A consent, or refusal to consent, to any of the following, if given by a child of or over the age of 16 years, has effect as if the child were of full age:
  (a) any donation of blood by the child:
  (b) any medical, surgical, or dental treatment or procedure (including a blood transfusion, which, in this section, has the meaning given to it by section 37(1)) to be carried out on the child for the child's benefit by a person professionally qualified to carry it out.

(2) A child's consent, or refusal to consent, to any donation of blood, or to any medical, surgical, or dental treatment or procedure (including a blood transfusion), whether to be carried out on the child or on any other person, has the same effect as if the child were of full age if the child is or has been—
  (a) married or in a civil union; or
  (b) living with another person as a de facto partner.

(3) If the consent of any other person to any medical, surgical, or dental treatment or procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given—
  (a) by a guardian of the child; or
  (b) if there is no guardian in New Zealand or no guardian of that kind can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent; or
  (c) if there is no person in New Zealand who has been so acting, or if no person of that kind can be found with reasonable diligence or is capable of giving consent, by a District Court Judge or the chief executive.

(4) If a child has been lawfully placed for the purpose of adoption in the home of any person, then, for the purposes of subsection (3), that person must be treated as a guardian of the child.

(5) Nothing in this section affects an enactment or rule of law by or under which, in any circumstances,—
  (a) no consent or no express consent is necessary; or
  (b) the consent of the child in addition to that of any other person is necessary; or
  (c) subject to subsection (2), the consent of any other person instead of the consent of the child is sufficient.

(6) Except to the extent that this section enables a blood transfusion to be administered to a child without the consent of any other person, nothing in this section affects section 37.

(7) Subsection (1) is subject to subsection (6).

37 Immunity of health practitioners administering certain blood transfusions without consent

(1) In this section and section 36,—
blood transfusion, or ***transfusion***, means the injection of whole human blood, or any constituent part or parts of it, into the bloodstream of a person
health practitioner has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003.

(2) Except by leave of a Judge of the High Court, no civil, criminal, or disciplinary proceedings may be brought against a person in respect of the administration by a health practitioner of any blood transfusion to a person under the age of 18 years (in this section called the ***patient***) by reason of the lack of consent of a person whose consent is required by law.

(3) The Judge must not grant leave if the Judge is satisfied—
  (a) that the transfusion was, in the opinion of the health practitioner who administered it, necessary to save the life of the patient or to prevent permanent injury to the patient's physical or mental health, or to save the patient from prolonged and avoidable pain and suffering, and that the opinion of the health practitioner was reasonable; and
  (b) that—
    (i) reasonable attempts were made to obtain the consent of the person appearing to be legally entitled to consent to the transfusion; or
    (ii) the circumstances were such that it was necessary to administer the transfusion promptly and it was impracticable, in the time available, to attempt to obtain the consent of the person appearing to be legally entitled to consent; and
  (c) that in all the circumstances it was reasonable to administer the transfusion.

(4) In considering the reasonableness of the opinion of the health practitioner referred to in subsection (3)(a), the Judge must take into account the following:
  (a) the condition of the patient before the transfusion:
  (b) the circumstances in which it was administered:
  (c) whether, in the circumstances, it was reasonably practicable for the health practitioner to consult any other health practitioner before administering the transfusion:
  (d) any opinion given by any health practitioner who was so consulted:
  (e) all other circumstances the Judge considers relevant.

(5) Nothing in this section affects any enactment or rule of law relating, in respect of the performance of any operation,—

(a) to the protection of any person from any civil, criminal, or disciplinary liability; or

(b) to any matter of justification or excuse.

Appendix 2

Children, Young Persons and Their Families Act 1989

(Selected Sections)

2 Interpretation [selected definitions only]

(1) In this Act, unless the context otherwise requires,—

child means a boy or girl under the age of 14 years

custody means the right to possession and care of a child or young person

guardianship has the meaning given to it by section 15 of the Care of Children Act 2004; and ***guardian*** has a corresponding meaning

young person means a boy or girl of or over the age of 14 years but under 17 years; but does not include any person who is or has been married or in a civil union

5 Principles to be applied in exercise of powers conferred by this Act

Subject to section 6, any court which, or person who, exercises any power conferred by or under this Act shall be guided by the following principles:

(a) the principle that, wherever possible, a child's or young person's family, whanau, hapu, iwi, and family group should participate in the making of decisions affecting that child or young person, and accordingly that, wherever possible, regard should be had to the views of that family, whanau, hapu, iwi, and family group:

(b) the principle that, wherever possible, the relationship between a child or young person and his or her family, whanau, hapu, iwi, and family group should be maintained and strengthened:

(c) the principle that consideration must always be given to how a decision affecting a child or young person will affect—

(i) the welfare of that child or young person; and

(ii) the stability of that child's or young person's family, whanau, hapu, iwi, and family group:

(d) the principle that consideration should be given to the wishes of the child or young person, so far as those wishes can reasonably be ascertained, and that those wishes should be given such weight as is appropriate in the circumstances, having regard to the age, maturity, and culture of the child or young person:

(e) the principle that endeavours should be made to obtain the support of—

(i) the parents or guardians or other persons having the care of a child or young person; and

(ii) the child or young person himself or herself—

to the exercise or proposed exercise, in relation to that child or young person, of any power conferred by or under this Act:

(f) the principle that decisions affecting a child or young person should, wherever practicable, be made and implemented within a time-frame appropriate to the child's or young person's sense of time.

6 Welfare and interests of child or young person paramount

In all matters relating to the administration or application of this Act (other than Parts 4 and 5 and sections 351 to 360), the welfare and interests of the child or young person shall be the first and paramount consideration, having regard to the principles set out in sections 5 and 13.

13 Principles

Subject to sections 5 and 6, any court which, or person who, exercises any powers conferred by or under this Part or Part 3 or Part 3A or sections 341 to 350 shall be guided by the following principles:

(a) the principle that children and young persons must be protected from harm, their rights upheld, and their welfare promoted:

(b) the principle that the primary role in caring for and protecting a child or young person lies with the child's or young person's family, whanau, hapu, iwi, and family group, and that accordingly—

(i) a child's or young person's family, whanau, hapu, iwi, and family group should be supported, assisted, and protected as much as possible; and

(ii) intervention into family life should be the minimum necessary to ensure a child's or young person's safety and protection:

(c) the principle that it is desirable that a child or young person live in association with his or her family, whanau, hapu, iwi, and family group, and that his or her education, training, or employment be allowed to continue without interruption or disturbance:

(d) where a child or young person is considered to be in need of care or protection, the principle that, wherever practicable, the necessary assistance and support should be provided to enable the child or young person to be cared for and protected within his or her own family, whanau, hapu, iwi, and family group:

(e) the principle that a child or young person should be removed from his or her family, whanau, hapu, iwi, and family group only if there is a serious risk of harm to the child or young person:

(f) where a child or young person is removed from his or her family, whanau, hapu, iwi, and family group, the principles that,—

(i) wherever practicable, the child or young person should be returned to, and

protected from harm within, that family, whanau, hapu, iwi, and family group; and

(ii) where the child or young person cannot immediately be returned to, and protected from harm within, his or her family, whanau, hapu, iwi, and family group, until the child or young person can be so returned and protected he or she should, wherever practicable, live in an appropriate family-like setting—

(A) that, where appropriate, is in the same locality as that in which the child or young person was living; and

(B) in which the child's or young person's links with his or her family, whanau, hapu, iwi, and family group are maintained and strengthened; and

(iii) where the child or young person cannot be returned to, and protected from harm within, his or her family, whanau, hapu, iwi, and family group, the child or young person should live in a new family group, or (in the case of a young person) in an appropriate family-like setting, in which he or she can develop a sense of belonging, and in which his or her sense of continuity and his or her personal and cultural identity are maintained:

(g) where a child or young person cannot remain with, or be returned to, his or her family, whanau, hapu, iwi, and family group, the principle that, in determining the person in whose care the child or young person should be placed, priority should, where practicable, be given to a person—

(i) who is a member of the child's or young person's hapu or iwi (with preference being given to hapu members), or, if that is not possible, who has the same tribal, racial, ethnic, or cultural background as the child or young person; and

(ii) who lives in the same locality as the child or young person:

(h) where a child or young person cannot remain with, or be returned to, his or her family, whanau, hapu, iwi, and family group, the principle that the child or young person should be given an opportunity to develop a significant psychological attachment to the person in whose care the child or young person is placed:

14 Definition of child or young person in need of care or protection

(1) A child or young person is in need of care or protection within the meaning of this Part if—

(a) the child or young person is being, or is likely to be, harmed (whether physically or emotionally or sexually), ill-treated, abused, or seriously deprived; or

(b) the child's or young person's development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable; or

...

49 Court may order medical examination of child or young person

(1) Where the court is satisfied—

(a) that there are reasonable grounds for suspecting that a child or young person is suffering ill-treatment, abuse, neglect, deprivation, or serious harm; and

(b) that it is expedient that a medical examination of that child or young person be carried out for the purpose of determining whether that suspicion is well-founded,—

the court may order the child or young person to attend for a medical examination by a medical practitioner.

...

51 Court may impose conditions on order for medical examination

Any order under section 49 may be made on such terms and conditions as the court thinks fit, including restrictions on the nature of the medical examination that may be carried out and the procedures that may be used to carry out that examination.

67 Grounds for declaration that child or young person is in need of care or protection

A court may, on application, where it is satisfied on any of the grounds specified in section 14(1) that a child or young person is in need of care or protection, make a declaration that the child or young person is in need of care or protection.

70 No application to be made unless family group conference has been held

(1) Subject to subsection (2), no application for a declaration that a child or young person is in need of care or protection may be made unless a family group conference has been held under this Part (or, in the case of an application on the ground specified in section 14(1)(e), under Part 4) in relation to the matter that forms the ground on which the application is made.

...

78 Custody of child or young person pending determination of proceedings

(1) In any proceedings in a court under Part 2 in relation to a child or young person, the court may, on the application of any party to the proceedings, or a barrister or solicitor representing the child or young person, or of its own motion, make an order relating to the custody of the child or young person pending the determination of the proceedings.

...

91 Support orders

(1) Where the court makes a declaration under section 67 in relation to a child or young person, it may make an order directing the chief executive or any other person or organisation named in the order to provide support to that

child or young person for such period (not exceeding 12 months) as is specified in the order.

...

92 Interim support orders

Where an application is made to the court for a declaration under section 67 in relation to a child or young person, the court may, on application by the applicant, or a barrister or solicitor representing the child or young person, or of its own motion, make such an order as it is empowered to make under section 91 pending the determination of the application.

101 Custody orders

(1) Where the court makes a declaration under section 67 in relation to a child or young person, it may make an order placing that child or young person in the custody of any of the following persons for such period as may be specified in the order:
   (a) the chief executive:
   (b) an iwi social service:
   (c) a cultural social service:
   (d) the director of a child and family support service:
   (e) any other person.

(2) Any such order may be made on such terms and conditions as the court thinks fit.

...

102 Interim custody orders

(1) Where the court makes a declaration under section 67, it may, instead of making a final order under section 101, make an interim custody order under that section.

...

104 Effect of custody order

(1) Where the court makes an order under section 101 placing a child or young person in the custody of any person,—

(a) that person has the role of providing day-to-day care for the child or young person as if a parenting order had been made under section 48(1) of the Care of Children Act 2004 giving that person the role of providing day-to-day care for the child or young person; and

...

110 Guardianship orders

(1) Where the court makes a declaration under section 67 in relation to any child or young person, it may make an order appointing any of the following persons to be a guardian of the child or young person:
   (a) the chief executive:
   (b) an iwi social service:
   (c) a cultural social service:
   (d) the director of a child and family support service:
   (e) any other person.

(2) Subject to subsection (3), where the court makes an order under subsection (1) appointing any person to be a guardian of a child or young person, the court shall appoint that person to be—
   (a) the sole guardian of the child or young person; or
   (b) a guardian of the child or young person in addition to any other guardian.

(3) The court shall not make an order under subsection (1) appointing the director of a child and family support service as the sole guardian of a child or young person.

114 Effect of guardianship order

(1) Where the court makes an order under section 110 appointing any person as a guardian of any child or young person (whether as sole guardian or as a guardian in addition to any other person),—
   (a) that person shall be a guardian of that child or young person as if that person had been appointed under section 27 of the Care of Children Act 2004; and
   (b) if the child or young person is, at the time of the making of the order, under the guardianship of the court under an order made under the Care of Children Act 2004, that guardianship is suspended during the time when the person appointed under section 110 is the guardian (subject to section 117(2)).

(2) Where the court makes an order under section 110 appointing any person as the sole guardian of any child or young person,—
   (a) except to the extent that they are preserved by any other order made under this Act, all of the rights, powers and duties of every other person who is the guardian of that child or young person, or who may become a guardian during the time when the person appointed under that section is the guardian, shall be suspended and shall have no effect; and
   ...
   (c) subject to any custody order made by the court under section 101, the child or young person shall be deemed to have been placed in the custody of that person pursuant to that section, and the provisions of sections 104 to 107, so far as applicable and with all necessary modifications, shall apply accordingly.

Appendix 3

Crimes Act 1961 & Summary Offences Act 1981 (Selected Sections)

Crimes Act 1961

145 Criminal nuisance

(1) Every one commits criminal nuisance who does any unlawful act or omits to discharge any legal duty, such act or omission being one which he knew would endanger the lives, safety, or health of the public, or the life, safety, or health of any individual.

(2) Every one who commits criminal nuisance is liable to imprisonment for a term not exceeding 1 year.

150A Standard of care required of persons under legal duties

(1) This section applies in respect of the legal duties specified in any of sections 151, 152, 153, 155, 156, and 157.

(2) For the purposes of this Part, a person is criminally responsible for—

(a) omitting to discharge or perform a legal duty to which this section applies; or

(b) neglecting a legal duty to which this section applies—

only if, in the circumstances of the particular case, the omission or neglect is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies in those circumstances.

151 Duty to provide the necessaries of life

(1) Every one who has charge of any other person unable, by reason of detention, age, sickness, insanity, or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (whether such charge is undertaken by him under any contract or is imposed upon him by law or by reason of his unlawful act or otherwise howsoever) under a legal duty to supply that person with the necessaries of life, and is criminally responsible for omitting without lawful excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured, by such omission.

(2) Every one is liable to imprisonment for a term not exceeding 7 years who, without lawful excuse, neglects the duty specified in this section so that the life of the person under his charge is endangered or his health permanently injured by such neglect.

152 Duty of parent or guardian to provide necessaries

(1) Every one who as a parent or person in place of a parent is under a legal duty to provide necessaries for any child under the age of 16 years, being a child in his actual custody, is criminally responsible for omitting without lawful excuse to do so, whether the child is helpless or not, if the death of the child is caused, or if his life is endangered or his health permanently injured, by such omission.

(2) Every one is liable to imprisonment for a term not exceeding 7 years who, without lawful excuse, neglects the duty specified in this section so that the life of the child is endangered or his health permanently injured by such neglect.

195 Cruelty to a child

Every one is liable to imprisonment for a term not exceeding 5 years who, having the custody, control, or charge of any child under the age of 16 years, wilfully ill-treats or neglects the child, or wilfully causes or permits the child to be ill-treated, in a manner likely to cause him unnecessary suffering, actual bodily harm, injury to health, or any mental disorder or disability.

Summary Offences Act 1981

10A Ill-treatment or wilful neglect of child

Every person is liable to imprisonment for a term not exceeding 6 months or to a fine not exceeding $4,000 who,—

...

(b) being a person to whom the care or custody of a child under the age of 17 years has been lawfully entrusted, ill-treats or wilfully neglects that child.

Appendix 4

Crimes Amendment (No 3) Act 2011 (Selected Sections)

Date of Assent 19 September 2011

2 Commencement
This Act comes into force 6 months after the date on which it receives the Royal assent.

4 Interpretation
(1) Section 2(1) is amended by inserting the following definitions in their appropriate alphabetical order:
"***unlawful act*** means a breach of any Act, regulation, rule, or bylaw
"***vulnerable adult***, for the purposes of sections 151, 195, and 195A, means a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person".

6 New sections 150A to 152 substituted
Sections 150A to 152 are repealed and the following sections substituted:

"**150A Standard of care applicable to persons under legal duties or performing unlawful acts**
"(1) This section applies in respect of—
"(a) the legal duties specified in any of sections 151, 152, 153, 155, 156, and 157; and
"(b) an unlawful act referred to in section 160 where the unlawful act relied on requires proof of negligence or is a strict or absolute liability offence.
"(2) For the purposes of this Part, a person is criminally responsible for omitting to discharge or perform a legal duty, or performing an unlawful act, to which this section applies only if, in the circumstances, the omission or unlawful act is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies or who performs that unlawful act.

"**151 Duty to provide necessaries and protect from injury**
Every one who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—
"(a) to provide that person with necessaries; and
"(b) to take reasonable steps to protect that person from injury.

"**152 Duty of parent or guardian to provide necessaries and protect from injury**
Every one who is a parent, or is a person in place of a parent, who has actual care or charge of a child under the age of 18 years is under a legal duty—
"(a) to provide that child with necessaries; and
"(b) to take reasonable steps to protect that child from injury."

7 New sections 195 and 195A substituted
Section 195 is repealed and the following sections are substituted:

"**195 Ill-treatment or neglect of child or vulnerable adult**
"(1) Every one is liable to imprisonment for a term not exceeding 10 years who, being a person described in subsection (2), intentionally engages in conduct that, or omits to discharge or perform any legal duty the omission of which, is likely to cause suffering, injury, adverse effects to health, or any mental disorder or disability to a child or vulnerable adult (the ***victim***) if the conduct engaged in, or the omission to perform the legal duty, is a major departure from the standard of care to be expected of a reasonable person.
"(2) The persons are—
"(a) a person who has actual care or charge of the victim; or
"(b) a person who is a staff member of any hospital, institution, or residence where the victim resides.
"(3) For the purposes of this section and section 195A, a ***child*** is a person under the age of 18 years.
...

10 Amendment to Summary Offences Act 1981
(1) This section amends the Summary Offences Act 1981.
(2) Section 10A is repealed.