Law Reform

Australia

Alcohol, drugs and driving

The Law Reform Commission of Australia has now issued a comprehensive report entitled "Alcohol, Drugs and Driving" (Report No. 4, Australian Government Publishing Service, Canberra) which was referred to at (1976) 2 C.L.B. 131. The Attorney-General's reference to the Commission required it to report on a number of vital questions affecting the appropriate legislative means for controlling the use of motor vehicles by those whose ability to drive is impaired by alcohol or other drugs. The report examines the current law in the Capital Territory in relation to that of other states and of other countries, and criticisms of the law with special reference to judicial decisions. It attaches a draft Bill. Among its recommendations are –

(i) the existing offence of driving a motor vehicle with a blood alcohol concentration equal to or exceeding the prescribed level should be abolished;

(ii) in substitution for the above, it should be an offence to drive a motor vehicle, if the concentration of alcohol in the blood of the driver, as recorded by an approved breath analysing instrument or as determined by a blood test is, *at the time the analysis is made*, equal to or more than the prescribed concentration;

(iii) reference to "driving" a motor vehicle or to the "driver" of a motor vehicle should include reference to a person who has started or has attempted to start the engine of a motor vehicle or who has put or has attempted to put in motion a motor vehicle or to a person who is in and in charge of a motor vehicle;

(iv) it should be a defence to a charge arising out of being "in charge of" a motor vehicle for the person charged to establish that he had not started or put the vehicle in motion or attempted to do so, and he did not intend to drive until a time when his blood alcohol concentration would be less than the prescribed concentration;

(v) the prescribed concentration of alcohol in the blood for the purposes of the Ordinance should remain at 80 milligrams (or 0.08 grams of alcohol) per 100 millilitres of blood; by reason of (ii) this may in certain cases amount to a de facto lowering of the limit;

(vi) the offence of "driving under the influence" should be retained but no qualification should be expressed such as would require a particular degree of impairment;

(vii) it should be an offence for a person to drive a motor vehicle while under the influence of alcohol or of a drug. The gravamen of the offence should be "driving . . . under the influence", whether of alcohol or of another drug or of alcohol and a drug. The prosecution should not be required to elect between proceeding upon one or other of these species of the offence, although no person should be convicted of more than one such offence arising out of the same events;

(viii) a member of the police force should have power to require a person to undergo a screening test in accordance with his directions if the person is or shortly before was the driver of a motor vehicle on a public street or in a public place and the member of the police force has reasonable cause to suspect that the person has alcohol or a drug in his body;

(ix) where a motor vehicle has been involved in an accident on a public street or in a public place, a member of the police force should have power to require a person to undergo a screening test in accordance with his directions where he has reasonable cause to suspect that the person was the driver of the motor vehicle at the time of the accident or, if he is in doubt as to who was the driver, if he has reasonable cause to suspect that the person was in the vehicle at the time;

(x) where a member of the police force has reasonable cause to suspect that a person may have committed an offence of culpable driving, he should have power to require that person to undergo a screening test in accordance with his directions. This police power should not be limited to occurrences on a public street or public place;

(xi) a member of the police force should not require a person to submit to a screening test –

  (a) if more than two hours have elapsed since the person was the driver of the motor vehicle;

  (b) if more than two hours have elapsed since the accident occurred or, if the person is taken to hospital, since his arrival at the hospital; or

  (c) in the case of a member of the police force attending at the scene of an accident who is in doubt as to the time of the accident, if more than two hours have elapsed after the person was found or, if he is taken to hospital, after his arrival at the hospital.

(xii) a member of the Police Force should not require a person

to submit to a screening test –

(a) if it appears by reason of injury or otherwise that it would be dangerous to do so;

(b) in the case of a person in hospital, if the attending medical practitioner after being notified by the member certifies in writing his opinion that compliance with the requirement would be detrimental to the person's medical condition; or

(c) in the case of a person at his place of abode, unless he was, or is suspected on reasonable grounds to have been, the driver of a motor vehicle involved in an accident on a public street or in a public place, or to have committed an offence of culpable driving, or following pursuit of the person's vehicle by the police if the member has reasonable cause to suspect that the person has alcohol in his body;

(xiii) the installation of "self assessment" facilities is not recommended;

(xiv) the primary method of ascertaining the presence of alcohol in the body of a suspected person should be by breath analysis, conducted by means of an instrument approved by the Minister as an approved breath analysing instrument. Approval of instruments should be notified in the "Gazette";

(xv) only an approved operator should be empowered to carry out a breath analysis. An "approved operator" should be a member of the police force authorised by the Commissioner of Police to carry out breath analysis;

(xvi) wherever practicable, the model 1000 Breathalyzer should be used, as it contains a facility to print-out the results of tests conducted by it. Other breath analysing instruments exist and there has been insufficient time to complete a comparative scientific evaluation of them;

(xvii) police authorities should not in future, as they are at present, be limited by the terms of the Ordinance itself to the use of particular breath analysing instruments. Such instruments are constantly being improved. It should be possible by amendment of the regulations to take advantage of new instruments as they are developed and approved;

(xviii) a member of the police force should be empowered to require a person to submit to breath analysis by means of an approved breath analysing instrument where –

(a) the person has undergone a screening test which indicates that the concentration of alcohol in his blood is equal to or more than the prescribed concentration;

(b) the person who has been required to undergo a screening test, has refused to do so; or

(c) the person has failed to undergo the screening test in accordance with the directions of the member of the police force.

(xix) for the purpose of carrying out such breath analysis, a member of the police force should be empowered to detain the person and, if he detains him, to take him or cause him to be taken as soon as possible to a police station or some other convenient place for the purpose of submission to breath analysis;

(xx) a member of the police force detaining or taking a person as above should not be liable to action by reason only of such detention or taking;

(xxi) regulation 29 of the Motor Traffic Regulations should be amended to enable any member of the police force to take charge of the vehicle of a person detained as above and to put it in a place of safety until claimed by the owner;

(xxii) only an approved operator should be empowered to carry out a breath analysis. An "approved operator" should be a member of the police force authorised by the Commissioner of Police to carry out breath analysis;

(xxiii) an approved operator carrying out breath analysis should take all steps that are reasonably practicable to ensure that it is not readily apparent to members of the public that the analysis is being carried out;

(xxiv) a member of the police force should not require a person to submit breath analysis after the elapse of the times or in the circumstances referred to in paras (xi) and (xii) above and, if required, the breath analysis should be completed within the relevant time limit;

(xxv) a person who has been required to submit to breath analysis should not be entitled to request a second breath analysis;

(xxvi) as soon as practicable after the breath analysis has been carried out, the approved operator should give to the person tested a written statement showing the results of the test and such other particulars as are required by the regulations. This should contain a statement of the consequences of the test and of the person's rights. If the model 1000 Breathalyzer of similar breath analysing instrument with print-out facility is used, a triplicate serialised certificate should be used. The regulations should provide that one copy of the print-out should be given to the person tested, together with the statement in writing referred to above;

(xxvii) if a breath analysing instrument with the facility of print-

out is used, the approved operator should give the person tested a statement containing the same information as that contained in the print-out;

(xxviii) the formalities to be observed in the carrying out of breath analysis should be contained in the regulations and the approved operator should comply with the procedures specified in the regulations for the particular breath analysing instrument used by him;

(xxix) the option of a blood test in lieu of or following unsuccessful completion of a screening test or breath analysis is not recommended;

(xxx) blood tests should be available to ascertain the blood alcohol concentration of a person only in the limited circumstances referred to below;

(xxxi) a member of the police force should be empowered to require a person to give a sample of his blood to enable a blood test to be carried out only where that person would, but for disqualifying circumstances otherwise be liable to undergo a screening test or to submit to breath analysis;

(xxxii) the disqualifying circumstances in which a person may be required to give a sample of his blood instead of a sample of breath should be –

(a) where it appears to the member of the police force by reason of injury or otherwise that it would be dangerous for the person to undergo a screening test or breath analysis;

(b) where a person is in hospital and the attending medical practitioner after being notified by a member of the police force certifies in writing that a screening test or breath analysis would be detrimental to the person's medical condition; or

(c) breath analysis equipment is not available or is not operating;

(xxxiii) a medical practitioner should not take a blood sample –

(a) if in his opinion it would be detrimental to the medical condition of the person for him to do so;

(b) after the expiration of the period of two hours following arrival of that person at the hospital; or

(c) if the person required to submit to the taking of a sample of his blood objects to doing so and persists in his objection after being informed that such objection may constitute and offence unless based on religious or other conscientious grounds or on medical grounds;

(xxxiv) the introduction of universal blood tests for persons admitted to hospital following motor vehicle accidents is not recommended;

(xxxv) where a person has been required to undergo a screening test or to submit to breath analysis and has been arrested on a charge of driving under the influence or of culpable driving and a member of the police force has reasonable cause to suspect –

(a) the presence of a drug other than alcohol in that person's body; or

(b) that the behaviour of a person does not arise or does not wholly arise from the presence of alcohol in his body

that a member of the police force should be empowered to require that person to submit to a medical examination for the purpose of ascertaining whether his condition is caused or is contributed to by the presence in his body of a drug other than alcohol;

(xxxvi) it should be an offence for a person to refuse or fail to –

(a) submit to breath analysis; or

(b) provide a blood or other body sample for analysis; or

(c) submit to a medical examination

in accordance with the directions of a member of the police force or medical practitioner as the case may be. It should be a defence to a charge of refusal or failure under (b) or (c) above if the person establishes that his failure or refusal is based on religious or other conscientious grounds or on medical grounds;

(xxxvii) except in exceptional circumstances, for example, where a screening test device is not immediately available, a member of the police force should not be entitled to arrest a person without warrant whom he suspects to be guilty of the offence of driving under the influence unless and until he has required that person to undergo a screening test;

(xxxviii) provision should be made to allow the admission of certain certificates in court proceedings, to avoid the necessity for the attendance in court of certain witnesses, unless they are specifically required to attend by notice given by the accused person;

(xxxix) a certificate purporting to be signed to a member of the police force stating that a person named therein was required to provide a sample of his breath for breath analysis and that the person refused or failed to provide such a sample should be prima facie evidence of the matters stated in the certificate and of the facts on which such matters are based;

(xl) a certificate purporting to be signed by a member of the police force stating that a person has been submitted to breath analysis and stating compliance with the formalities

of and the result of the breath analysis should be prima facie evidence of the matters stated therein and of the facts on which such matters are based;

(xli) the following certificates purporting to be signed by the persons stated therein should be prima facie evidence of the matters so certified and of the facts on which they are based –

(a) a certificate by the Commissioner of Police approving a breath analysis operator;

(b) a certificate by a person designated in the regulations as to matters permitted by the regulations to be stated by a certificate;

(c) a certificate by a medical practitioner as to the formalities associated with the taking of a sample of blood or other body sample; and

(d) a certificate by an approved analyst as to the analysis and the results of tests;

(xlii) the accused person should be entitled by giving notice to require the attendance at court of any person by whom a certificate has been given, for the purpose of giving evidence orally and in such a case the persons required to attend should give evidence orally but the certificate should be admissible as evidence and should have such probative value as the court determines, consistent with the other evidence called;

(xliii) in general, heavier fines should be available for offences against the Ordinance; existing provisions for the loss of the driver's licence should be retained and expanded; imprisonment should be available as a penalty of last resort only;

(xliv) the existing "two-tiered" system of penalties based upon different levels of blood alcohol concentrations should be abolished. In the case of fines and imprisonment, the Ordinance should state only the maximum penalties that may be imposed;

(xlv) in addition to the pecuniary penalties and/or imprisonment the court should upon conviction be required to take certain steps in relation to the driver's licence. In the case of a first offence against the breath analysis provisions of the Ordinance, the suspension should be for a minimum period of three months. In the case of a "first offender" convicted of driving under the influence, the suspension should be disqualified from holding a driving licence;

(xlvi) where a person's driving licence has been cancelled it should be necessary for him to apply to a court for restoration of the licence. The court's attention should be drawn

to appropriate criteria to be considered before the licence is restored;

(xlvii) on any such application for restoration of a cancelled licence, the court should hear any evidence of the police, the applicant, the Registrar of Motor Vehicles and any medical evidence to assit it to judge whether the driving licence should be restored, having regard to –

(a) the period of disqualification;

(b) the conduct of the applicant during such period, especially in relation to the consumption of alcohol or drugs;

(c) the physical and mental condition of the applicant;

(d) any evidence of medical or other rehabilitation treatment undergone by the applicant; and

(e) the effect of restoration of a driving licence on the safety of the applicant and the public.

(xlviii) upon an application for the reissue of a cancelled licence the court should be entitled to –

(a) restore the licence;

(b) dismiss the application; or

(c) restore the licence on such terms and conditions and for such period as it thinks fit.

(xlix) in addition to the conventional penalties of fine, imprisonment and suspension or cancellation of the driver's licence, courts should have available to them alternative countermeasures designed to cope specifically with the problem of drivers whose driving is impaired by their consumption of alcohol or other drugs. Treatment, rehabilitation and education programmes should be initiated and developed;

(l) there is an urgent need for the establishment and development in the Australian Capital Territory of programmes for the treatment, rehabilitation and education of offenders. As a start, sufficient funds should be made available for the implementation of a type of scheme outlined to the Commission and detailed in the report;

(li) the introduction of the new Ordinance should be accompanied by a campaign to alert and educate drivers concerning the dangers caused by the consumption of alcohol and drugs and the provisions of the new laws designed to deal with these dangers;

(lii) the training of learner drivers should include specific information concerning the effects of alcohol and drugs on driving and the relevant provisions of the Ordinance. Questions on these matters should be included as a matter of course in tests conducted for the grant of a driving licence;

(liii) consideration should be given to the reduction or total

prohibition of media advertisements for alcohol or such advertisements should be accompanied by warnings of the dangers involved in the consumption of alcohol;

(liv) in addition to the need for research, there is a need for continuing education of the public and of the medical and pharmaceutical professions concerning the effects of drugs on driving, particularly drugs prescribed by medical practitioners and supplied over the counter. Research into the effects of such drugs on and public education concerning such effects should continue and funds should be made available for that purpose.

The Minister for the Capital Territory has announced that the Australian Government has generally accepted the recommendations made by the Australian Law Reform Commission, although it has some reservations about the Commission's criticisms of random breath testing.

Human tissue transplants

The Australian Law Reform Commission has issued its Working Paper No. 5, setting out tentative views for reform in the area of human tissue transplants, the practice and teaching of anatomy, and the conduct of non-coronial autopsies (the practice of the last-named being a subject generally not regulated by statute in Australia). Its provisional proposal are that –

(i) the public interest in Australia would be well served by clear statutory rules dealing with transplantation of tissue from both living and dead persons. The common law, to which resort may often be made in the absence of statute is simply not equipped to provide solutions to the important legal problems created by transplantation;

(ii) the giving of tissue by a living adult person should be specifically permitted by statute, under certain conditions involving proper advice and the capacity to make an informed decision. The giving of tissue by minors and other "incompetents" should as a general rule, be prohibited despite parental wishes. This prohibition should relate mainly to non-regenerative tissue. There is, however, a case for establishing a machinery (e.g. some form of tribunal) for dealing with exceptional cases where there is a high expectation of success and it could be in the *donor's* interest to give tissue (e.g. identical twins);

(iii) the characteristics of transplant procedures for certain organs, e.g. kidney, heart, and liver, necessitate a more accurate diagnosis of death than has been needed in the past. This particularly applies to cases of irreversible coma caused by

permanent cessation of brain function where the patient's body is sustained by support machinery. The Commission proposes that legislation be introduced authorizing or permitting death to be diagnosed by reference to permanent cessation of brain function;

(iv) greater aid to sick and dying persons who could be cured or saved by human tissue transplants would be possible if all dead bodies were available for removal of needed tissue. Some countries (e.g. France, and Hungary) have laws to this effect. Having insufficient evidence at the present stage of its Inquiry, that the Australian public is prepared to countenance such a law, the Commission currently proposes that the following conditions should apply to the removal of tissue from dead persons for transplant –

(a) removal may occur if the person has expressed a request or consent to that effect. Such a request or consent will prevail over the view of relatives,

(b) the request or consent may be expressed either orally or in writing,

(c) the request or consent may be withdrawn at any time before death,

(d) if there is no knowledge of a wish, request, consent, or objection by the deceased, a hospital may remove tissue for transplant after first inquiring for objections from the spouse. In the absence of a spouse, inquiry should be made of close relatives (parents, children, brothers, sisters). The obligation to inquire should cease when the first such person indicates "no objection". If an objection from any close relative is made, removal may not occur,

(e) coroners' powers to give consent to removal of tissue for transplant should be modernised to enable pre-death informal communication, along lines pioneered in Queensland;

(v) there appears to be no special reason for specific legislation directly regulating recipients of human tissue for transplant except possibly in relation to recipients who are minors or otherwise lacking in legal capacity. On balance, the Commission considers that legislation is not called for even for recipients of this lastmentioned class;

(vi) the Commission does not recommend the establishment of an Australian national register of donors of human tissue for transplant. However, there are good reasons for the creation and continuation of systems such as existing donor card systems, and the endorsement of driving licences to indicate willingness to give such tissue;

(vi) the sale by and remuneration of donors of human tissue should be forbidden. Special government compensation for a living

donor who may lose income because of his gift of tissue, or the indemnification of such a person against medical expenses, present or future, is not required in Australia in view of existing social service, and medical benefits;

(vii) disclosure of personal information about a donor or recipient of transplanted human tissue or his family (including his identity) should be forbidden except with the consent of the person himself;

(viii) specific protection should be extended to the medical profession and persons involved in transplantation against damages for any act done in good faith and without negligence;

(ix) anatomy legislation would benefit from amendment to reflect modern conditions. The same principles which apply to consent to use cadaver tissue for transplant could, with advantage, apply to the use of a dead body for anatomy teaching and practice. Legislation should restrict anatomy teaching and practice to authorized schools, and teachers and practitioners should be licensed. Registered medical practitioners should be automatically licensed. Legislation should clearly describe conditions of removal of a dead body to an anatomy school, and related record-keeping. Burial (and cremation) after completion of the medical purposes should also be regulated. In view of the requirements of modern medicine and medical education, a right, by agreement, to extend the time for burial should be created. New legislation for the A.C.T. is required, and should include the principles described above;

(x) hospital autopsies are a valuable educative practice, serving to uphold high medical standards of hospitals and medical practitioners. The primary function of autopsy is to confirm or determine with accuracy, the cause of death. There is little legislation in Australia on this subject. The Commission proposes the adoption of the same principles for consent to autopsy as for anatomical examination. Autopsy should be performed promptly and with due regard for the dignity of the deceased and the feelings of his relatives. A regulation-making power should be created, authorizing the retention and use for therapeutic or scientific purposes of prescribed tissue available during autopsy, when the public interest is thereby served.

Publications and the protection of privacy

The Law Reform Commission of Australia has published Discussion Paper No. 2: "Privacy and Publication—Proposals for Protection". The Paper explains why it favours the separate consideration of defamation on the one hand [see Discussion Paper No. 1 noted in

(1977) 3 C.L.B. 478] and publication privacy on the other, but recognises that it might be undesirable to have a new defamation law without simultaneous privacy protection in the realm of publication. It suggests that the issue of publication privacy should be considered as an issue separate from other privacy questions and dealt with as such in legislation although, for convenience, defamation and publication privacy might be dealt with in separate parts of a single new statute.

The following is a brief summary of some of the Commission's tentative views—

(i) the existing legal gaps are such as to require legislation to grant some protection against publications which infringe privacy;

(ii) the creation of a general right of privacy is undesirable, at least at this stage. The time lapse before general concepts may be satisfactorily refined is unpredictable but likely to be great. The financial stakes in privacy actions are not so high as to encourage appeals. In the meantime there is a real risk of undue interference with freedom of speech. Any restrictions on expression should be by precise, readily understandable, rules;

(iii) the restrictions presently appropriate should be only those which clearly pertain to the private realm. The legislation should be tightly drafted so as to catch only those cases where privacy is necessarily invaded. Debatable areas should be left unrestricted. This will necessarily mean that some people will regard the suggested restrictions as inadequate; indeed they will not cover all of the examples cited in the Paper;

(iv) it follows that many objectionable publications will not be prohibited by legal restriction. Editorial responsibility will remain, to be exercised in accordance with individual judgment of legitimate public interest and canons of good taste. If experience shows that the particular restrictions now proposed are too narrow, and that editors insensitively exercise discretion, further legislation may be required;

(v) publication restrictions should be uniform throughout Australia. The media operates on a national basis. In this field, as in defamation, inter-state confusion and conflict of laws is undesirable;

(vi) jurisdiction to enforce the restrictions should be vested in courts. Persons whose privacy is invaded should be given the remedies of injunction, a declaration where appropriate, correction of proved false statements and damages. The possibility should be left open, if a Privacy Commission or like body is established, of empowering that body to approach the court for either damages or penalties in respect of the breach of the suggested restrictions.

It is tentatively proposed that publications prima facie actionable would be those which relate to—

(a) private behaviour, home life or personal or family relationships, photographs of persons in a private place;
(b) health, photographs of persons in an injured, ill or distressed condition;
(c) criminal prosecution, except by contemporaneous report, legal report or legal writing.

The following defences to an action are tentatively suggested—

(a) consent, express or implied;
(b) legal authority;
(c) privilege, as understood in defamation law;
(d) fair report of parliamentary or court proceedings;
(e) protection of the interests of the publisher;
(f) public interest—non-exhaustively defined so as to include matter relating to—
  - public, commercial and professional activities,
  - suitability for public, commercial or professional office,
  - decisions taken or likely to be taken on a public, commercial or professional question,
  - goods and services offered to the public,
  - conviction of offenders, enforcement of the law and public safety,
  - any other matter of legitimate concern (i.e., not merely prurient or morbid interest) to the public or any section of the public.

A draft of possible legislation is set out at the end of the Discussion Paper.

Child abuse and day care

The Australian Law Reform Commission has published Discussion Paper No. 12 under the title "Child Welfare: Child Abuse and Day Care". Discussion Paper No. 9 which relates to the same reference (dealing with the treatment of children in trouble, young offenders in the criminal system and neglected and uncontrollable children) was noted at (1979) 5 C.L.B. 1204.

The present Discussion Paper deals with the position of children at risk of neglect or abuse by their parents and by their caretakers (day care services) within the wider context of a consideration of the rights and obligations of children, of parents and of other persons who have or assume rights or obligations in respect of children and of the community.

The Commission considers that child abuse, a serious and disturbing problem, is the most extreme example of parents' failure to provide the care and affection which their children need. It was

therefore necessary to view their proposals within the broader context of a system for dealing with those children at present described as neglected or uncontrollable. With regard to these troubled and troublesome children, two principles should guide society's response to their plight. The first principle was that court action should be avoided wherever possible. Any new legislation should provide a framework which discouraged resort to court action and facilitated the exploration of informal solutions. The second principle was that when it was necessary to take a matter to court, the procedure employed should be quite different from that used for alleged offenders.

The following is a summary of the tentative proposals advanced by the Commission for the purpose of eliciting comment—

Children in need of care

1. The present procedure of charging a child with being neglected or uncontrollable should be abolished and replaced by a procedure by which an application is made to the court to declare the child to be a "child in need of care". A child may be so declared if he—

(a) is being cared for in circumstances such that his physical health is being seriously impaired or there is a substantial risk that it will be seriously impaired;
(b) has no appropriate person to care for him because he has been abandoned, because his parents or guardians cannot be located, or because his parents or guardians are dead or incapacitated;
(c) has suffered serious, non-accidental physical injury or there is a substantial risk that he will suffer such injury;
(d) has been sexually abused or there is a substantial risk that he will suffer such abuse;
(e) has suffered serious psychological damage, evidenced by significant emotional or intellectual impairment, or there is a substantial risk that he will suffer such damage;
(f) is not being adequately controlled by his parents or guardian and his behaviour is seriously harmful to himself; or
(g) is living in a situation in which there is a substantial and presently irreconcilable difference between himself and his parent or guardian.

2. To avoid the problems existing in current welfare arrangements, an independent official to be known as the Youth Advocate should be appointed. His functions should include—

(a) the co-ordination of the work of welfare agencies in individual cases;
(b) the exploration of alternatives to court proceedings, including, where appropriate, mediation and reconciliation;
(c) the initiation, where necessary, of proceedings to have the child declared to be a child in need of care; and
(d) duties in relation to criminal proceedings against young offenders.

3. The Youth Advocate should be assisted by a small consultative committee comprised of representatives of the Welfare Branch of the Department of the Capital Territory, the Capital Territory Health Commission and, when appropriate, representatives of the Australian

Federal Police and of voluntary welfare agencies. Its functions should include—

(a) linking the welfare agencies and the Youth Advocate;
(b) advising the Youth Advocate as to matters of policy and the handling of individual cases; and
(e) the monitoring of individual cases.

4. A Youth Services Council should be established. It should be comprised of representatives of the Welfare Branch of the Department of the Capital Territory, the Capital Territory Health Commission, the A.C.T. Schools Authority, the Australian Federal Police, the Family Court Counselling Service and selected voluntary agencies. It should ensure—

(a) effective co-ordination of existing services;
(b) the making of recommendations for change in those services; and
(c) the formulation of policy affecting children and their needs.

Child abuse

5. There should be compulsory notification by medical practitioners and other professionals of suspected cases of child abuse. There should also be provision for voluntary notification by any person of suspected cases of child abuse. The law should make it clear that persons who make a notification in good faith do not incur legal liability. As the facts for the co-ordination of welfare services and the person responsible for initiating care proceedings, the Youth Advocate is a readily identifiable and appropriate recipient of notifications.

6. The police or an authorised officer may remove a child who is in immediate danger of abuse and detain him in a hospital or other place of safety for 48 hours provided that the Youth Advocate is notified as soon as possible and obtains a holding order as soon as possible from a magistrate.

7. In some cases it may not be in the interests of the child that criminal proceedings should be taken against the parent. Procedures (including consultation with the consultative committee) should be introduced to facilitate reconsideration of a decision to take such proceedings. Where, in view of the interests of the child, it is desirable to do so, it should be possible to have such proceedings withdrawn with the leave of the court.

Day care services

8. With the exception of those caring for children in private homes, all those offering day care services for children under seven should have a licence if a charge is made.

9. All those offering day care services—whether a charge is made or not, and whether operating in a private home or not—should have a licence if they care for more than four children under the age of seven.

10. Provisions relating to the licensing of day care services should apply to occasional care, part-time care and full day care.

11. Provision should be made for the granting of interim licences, and for all licences to be reviewed annually.

12. There is no need for legal controls over services provided for children over the age of seven.

13. The existing practice of granting single licences in respect of

designated premises is satisfactory, and there is therefore no need for separate licences for premises and operators.

14. The Court of Petty Sessions, and not the Children's Court, should exercise jurisdiction over proceedings involving alleged breaches of licensing provisions.

15. The Administrative Appeals Tribunal should have jurisdiction to review the granting and revocation of licences.

Human tissue transplants

Report No. 7: "Human Tissue Transplants", has been published by the Australian Law Reform Commission. Submitted with the Report is draft legislation for the Australian Capital Territory which reflects the Commission's recommendations. In the Commission's opinion a uniform approach to transplant legislation is desirable, particularly in view of the doubts which surround the constitutional power of the federal government to enact a national law on the subject.

A table lists relevant cases from Australia, Britain, New Zealand and the U.S.A. discussed in the text, and there is an extensive bibliography. Also included is a table of legislation from some 34 jurisdictions.

The following summarises some of the Commission's recommendations—

(i) adults should be able to give their tissue on independent medical advice, after signing a written consent, which could be revoked at any time;

(ii) minors (under 18) after receiving independent medical advice, and with the consent of a parent, should be able to donate regenerative tissue. As regards non-regenerative tissue, donations by minors should generally be prohibited unless all the following conditions are satisfied—
  (a) the donor and recipient belong to the same immediate family,
  (b) the recipient is in danger of dying,
  (c) medical advice is given to the donor regarding the nature and effect of the removal, and of the transplantation,
  (d) the donor must have sufficient mental capacity fully to appreciate the position, and must agree to the removal,
  (e) the parents must consent,
  (f) an ad hoc Committee (comprising a judge, a medical practitioner and a social worker or psychologist) must unanimously decide that the removal is desirable, is in the interests of the donor, and should be permitted;

(iii) persons lacking legal capacity for reasons other than minority, whether adult or not, should not be subjected to tissue removal;

(iv) there should be simplified procedures for donation by persons dying in hospital. It should be obligatory to obtain authorisation from close relatives, but by improved procedures;

(v) coroners should be empowered to give pre-death approval to tissue removal. Such consent may be oral, or by telephone, to be later confirmed. The person who can authorise tissue removal from a deceased should not be able to do so until the coroner has consented, and until the other prescribed inquiries have been conducted and the appropriate responses obtained;

(vi) the law should forbid payment of any kind to a person for any dead body or part of a dead body, or for human tissue removed in accordance with the recommendations of the Report from any living person or from any dead person, or removed for the purposes of transplantation or other therapy or for medical or scientific purposes;

(vii) the proposed legislation should provide clear protection to medical practitioners and other persons involved in activities permitted by the recommended legislation. Such persons should not be liable in any proceedings whether civil or criminal, for any act done in pursuance of a consent, agreement or authority given under the legislation when done without negligence and in good faith;

(viii) provision should be made for removal of tissues obtained during normal autopsies, for public therapy purposes;

(ix) the proposed legislation should contain a definition of death for all purposes in the following terms—

> "41. This Part applies in determining for the purposes of this Ordinance or for the purposes of any other Ordinance or continued State law, that a person has died.
>
> 42. A person has died when there has occurred—
>
> (a) irreversible cessation of all function of the brain of the person;
>
> (b) irreversible cessation of circulation of blood in the body of the person.";

(x) in the case of "brain death", where it is desired to remove tissue for transplantation, death should be declared by two registered medical practitioners one of whom should be a neurologist or neurosurgeon. Neither should participate in any transplant involving tissue of the deceased.

The Commission's Report draws attention to the "considerable future expansion in human tissue transplants", some of which are expected within the next few years. These include—

(a) transplantation of a human ovum,

(b) fertilisation of human ova in test tubes,

(c) transplantation of genital organs,

(d) use of fetal tissue.

The Report makes it clear that operations of this kind will shortly be

possible. The scientific breakthrough in immunology is predicted which will increase the success and number of transplant operations. The Report calls attention to the need to give urgent consideration to these matters and others such as genetic engineering, human experimentation, euthanasia and the medical treatment of minors.

Australia—A.C.T.

Child welfare

The Law Reform Commission of Australia has published Discussion Paper No. 9 under the title "Child Welfare: Children in Trouble". The Australian Attorney-General has given the Commission a Reference asking it to enquire into child welfare law and practice in the Australian Capital Territory. The Commission is to consider the rights and obligations of children, of parents and other persons with responsibility for children, and of the community. In particular the Commission is asked to examine:—

(a) the treatment of children in the criminal justice system,
(b) the position of children at risk of neglect or abuse,
(c) the roles of welfare, education and health authorities, police, courts and corrective services in relation to children, and
(d) the regulation of the employment of children.

The Paper begins by replacing the Reference in its context in relation to law reform activity in this area of the law and states that in view of the wide scope of the Reference and the time limit imposed, the Commission has decided that the initial Report will concentrate on the Australian Capital Territory's system for dealing with young offenders, as well as with neglected and uncontrollable children. The Paper is similarly confined to these three categories. By "the system" is meant the Children's Court, the police, child welfare services, educational and health authorities, correctional agencies and voluntary organisations. The aim of the Report will be to offer a blueprint for procedures for dealing with children in trouble in the Territory.

The Paper gives an historical account of, and describes, the existing system for dealing with children in trouble and concludes that the present system in the Australian Capital Territory is a confused and piecemeal adaptation of procedures employed for adults. Little consideration has been given to the appropriateness of these procedures for the young and at no stage has a coherent and comprehensive set of principles been developed on the basis of which a special tribunal for children can be built.

As a first step towards the integration of child welfare programmes in the Territory and the co-ordination of government-sponsored and community based initiatives to help children in trouble and in need, the Commission has already formed the tentative view that a co-ordinating body should be established. This could be an independent

statutory commission, a statutory council consisting largely of part-time personnel, or a unit in the Welfare Branch of the Department of the Capital Territory. The Commission feels it to be important that there should be a permanent advisory body with representatives of a number of different interest groups associated with child welfare and related areas to act as a stimulus for on-going reform, a monitor of the effectiveness of current laws and facilities and watchdog of children's rights in legislation and practices affecting them.

The following are the key issues identified in the Paper, upon which proposal and comment is invited—

Children in the Criminal Justice System

1. What is the age below which a child should not be criminally liable at all? At what age should a child pass beyond the jurisdiction of a special children's tribunal to the ordinary court system?
2. Should a clear distinction be made between offenders (i.e., children who have breached the criminal law) and non-offenders (i.e., neglected and uncontrollable children)? Should different tribunals, facilities and services be created to deal with each group?
3. If we want a distinctive system for dealing with young offenders why do we want such a system and what characteristics should mark it off from that employed for adult offenders? Should the same penalties apply to a child as to an adult for the same offences?
4. Should greater efforts be made to divert young offenders from the court or tribunal and, if so, how should this be achieved?
   - By Police/Welfare Branch consultation?
   - By the appointment of a reporter or similar official?
   - By the introduction of informal panels?
   - By other means?
5. To what types of services should offenders be diverted?
6. When formal intervention is required what type of tribunal should deal with young offenders?
   - A modified criminal court?
   - A panel?
   - The Family Court?
   - Other?
7. Should very serious offences by a child (e.g., murder) be dealt with in the adult system rather than in a special children's court or tribunal?
8. Should the court of tribunal exercise complete control over the nature and duration of the measures employed for young offenders (e.g., detention for a specified time) or should these measures be flexible, allowing those who administer them to exercise discretion (e.g., indefinite detention to be reviewed in the light of circumstances)?
9. Should new types of measures be available for young offenders?
   - Periodic detention?
   - Community service?
   - Intensive probation?
   - Intermediate treatment?
   - Other?
10. Should an institution for children who commit offences be built in the Australian Capital Territory to replace the present system of sending such children to New South Wales institutions?

Neglected and Uncontrollable Children

11. At what age should the state cease to assert the right to intervene coercively in the life of a neglected or uncontrollable child?
12. In what situations should the state intervene to protect children considered to be neglected or uncontrollable and should these situations be narrowly defined or should the legislative net be cast wide?
13. When formal intervention is required what type of tribunal should deal with neglected and uncontrollable children?
    - A Court of Petty Sessions?
    - The Family Court?
    - A community panel?
    - An expert panel?
    - Other?

The Supporting Services

14. Should greater emphasis be placed on the provision of informal services for children in trouble? If so, what types of services are lacking at present and how can they best be organised and provided?
15. Is fragmentation of services a problem and, if so, how can co-ordination be improved?
16. Should greater use be made of the work of non-governmental agencies?
17. Are there deficiencies in the welfare and psychiatric services available to the Children's Court? If so, what are these deficiencies and how can they be remedied?

Australia—New South Wales

Drug trafficking

The New South Wales Royal Commission on Drug Trafficking has presented its Report to the State Government. The Royal Commission, which was presided over by a Judge of the Supreme Court of New South Wales, was appointed in 1977 to inquire into and report on—

(a) the cultivation, production, manufacture, distribution, supply, possession and use of illegal drugs;
(b) the identity of the persons involved in that traffic; and
(c) whether, in the light of the findings of the Royal Commission, any amendments were desirable in the law relating to drugs.

Apart from recommending the prosecution of certain State police officers and Italian immigrants suspected of having been concerned in drug trafficking, the Royal Commission made 85 other recommendations.

These were—

Cannabis

General

1. The cultivation, possession, supply or use of cannabis should not be legalised.

2. Legislation which would permit the possession of small quantities of cannabis grown for one's own use should not be introduced.

3. The possession or use of cannabis should not be decriminalised.
4. The criminal records of those convicted of possession of marihuana for personal use, or of supplying marihuana by way of gift or without remuneration, should be destroyed at the end of two years, on the application of the person convicted, except in stipulated circumstances.

Access to such records should be restricted to members of law enforcement agencies, and to authorities having lawful access to police records for criminological research.

Psychomotor skills

5. The Government should support a substantial program of research into the effects of cannabis, and drugs generally, on driving performance, with a view to developing suitable practical tests which will enable detection and prosecution of the drug-intoxicated driver.
6. The Government should institute a program whereby the extend of employee drug-taking can be determined and an assessment made of its impact on individual performance, safety and other matters within the industrial setting.
7. The Government and the various authorities concerned, should adopt an increasing role in regulating drug use in industry, and institute a program for the purpose of disseminating, in a practical way, non-drug philosophies to members of the workforce, particularly apprentices and younger workers.
8. Police investigations following discovery of large cannabis crops should thoroughly explore the possibility that the owner, or those arrested on the property, may be no more than minor participants acting on behalf of a major producing or trafficking organisation, and that in such cases careful inquiry into, and analysis of, those and related cases, including those interstate, should be conducted with a view to producing evidence on which to base conspiracy charges against the principals.
9. Institute organised procedures for detecting cannabis plantations and, in particular, for the purpose of more effectively combating large-scale cannabis production—

(i) liase with the Department of Agriculture to explore the possibility of satellite monitoring;
(ii) enlist the assistance of officers of other departments engaged in field work or property inspection, with such officers being given instruction on what they should look for and the action they should take when they find anything suspicious;
(iii) encourage similar media publicity to alert local citizens in growing areas with, perhaps, the ancillary effect of discouraging potential producers;
(iv) publicise flights over "high-risk" districts during the growing season.

Narcotics

10. The Government must recognize that the economic conditions of the heroin market and the lack of internal structure at the present time lend themselves to the emergence of an organisationally monopolistic crime syndicate.

11. The Government should institute a program whereby the incidence of new use of narcotic drugs is closely monitored so that remedial policies can be quickly developed and implemented.
12. The Government should encourage and support studies with a view to monitoring the incidence of persons commencing to use heroin.
13. Priority should be given in the enforcement effort towards those drugs with the highest level of direct social cost. At the present time heroin falls within this category.

Other drugs
14. The Police Department and the various health authorities, Federal and State, should work jointly to carry out studies and surveys to monitor trends in the abuse of drugs such as amphetamines, cocaine and hallucinogens.
15. Monitoring work in relation to the incidence of use of heroin, amphetamines, cocaine and halluciogens should be based on systematic intelligence and assessments of variations in availability, use, quality and price.
16. A small unit should be established within the drug squad of the State Police Department, which can liase with both the State Health Commission of New South Wales and the State Drug and Alcohol Authority, to produce intelligence summaries at regular intervals for the information of Government, police and interested departments and institutions.
17. Specific steps should be taken against the importation, manufacture or use of phencyclidine and, for the purpose, an "early warning system" coupled with the monitoring of precursors should be instituted on a national basis.

Law enforcement
Policy
18. Endeavours by the United Nations and the United States of America to limit supply in major heroin-producing areas should be supported to the fullest practicable extent.
19. State and Federal Governments should offer some assistance to the Thai Government in the training of personnel and the supply of equipment.
20. There is a need for an increase in Australian law-enforcement personnel in major overseas drug supply centres.
21. There is a need in Bangkok for a small professional unit of Australian law-enforcement officers, with full clerical assistance and adequate transportation.
22. Efforts should be made to evolve an integrated drug enforcement program with other States and the Federal Government.
23. Priority should be given in the enforcement effort to the investigation of high-level and organizational trafficking.
24. The Police Department should divide its manpower resources so that at least 65 per cent of the drug law-enforcement effort is spent in attempting to intercept traffickers above the street level.
25. A specialised drug-enforcement agency should not be established, nor is anything in the nature of a crime commission, designed to combat

all forms of organized crime, recommended until the Police Department is given an opportunity to implement new procedures.

26. There should be an expansion in divisional units of police engaged in drug-related investigations in order to free, so far as is practicable, the drug squad for specialised work.

27. The various law-enforcement authorities must gear themselves to combat an almost inevitable emergence of more highly organized crime than has hitherto been present in the State.

28. There should be published annually a State administrative plan for containing the drug-abuse problem.

29. In fixing a realistic figure for bail in respect of alleged drug traffickers or importers, courts should take into account that—

(a) some importation organizations have access to vast sums of money, and bail money may represent to such persons a mere operational cost factor,

(b) reporting conditions on the surrender of passports often have little practical effect in limiting flight,

(c) an abnormally high proportion of foreign nationals charged with drug-importation offences abscond while on bail.

Intelligence

30. A single, joint, Federal-State intelligence system should be established.

31. There should be an approach on the part of law enforcement to a conspiracy-type investigation and a willingness to postpone action against individuals until evidence is available to involve the whole, or a singificant part, of an overall network.

32. The number of police officers trained in surveillance should be increased and the scope of such activities should be broadened.

33. Greater use should be made of undercover agents in the drug enforcement effort in order to apprehend upper-level traffickers.

34. The Government should be prepared to provide more money to the Police Department to aid undercover agents in their efforts against major traffickers.

35. Consideration should be given to the problem of increasing the flow of intelligence from all sources and the need to provide concessions to those who are willing to make information available, including convicted criminals serving prison sentences.

Co-operation

36. State and Federal Governments should commit themselves to close inter-agency co-operation.

37. The joint task force concept should be adopted on a permanent basis by State and Federal Governments.

Treatment and Diversion

Classification

38. Drug offenders coming before courts should be classified in the following manner:

(1) those charged with trafficking or with serious drug-related criminal offences;

(2) those charged with simple possession or use of marihuana;

(3) those charged with illegal use or simple possession of non-narcotic drugs other than marihuana; and
(4) those charged with possession or use of narcotics but who do not come within Class 1.

In relation to Class 1 offenders, the law should take its course and the offender be dealt with according to the nature and degree of the offence.

Class 2 offenders should be dealt with under the present law but neither diverted nor imprisoned.

Where a Class 3 offender is also a heroin user, he should be treated as if coming within Class 4; otherwise such offenders should be dealt with in the same manner as those coming within Class 2.

Class 4 offenders should be subject to procedures similar to those which the law has developed for dealing with the socially disadvantaged.

Courts should be provided with all relevant information and, in appropriate cases, offenders should be diverted into treatment, but only after being dealt with in relation to the charge.

Treatment

39. There should be a State plan for the organization and co-ordination of drug-treatment services. The plan should be for three years but should be revised and published annually for the ensuring three-year period.

It should direct its attentions to all aspects of the drug problem and contain strategies to be employed in treatment. It should also form the basis for future public expenditure.

The compilation of the plan should be the responsibility of the State Drug and Alcohol Authority, which should co-ordinate the recommendations of the various Government authorities concerned.

40. Drug treatment programs should have practically realisable objectives seeking optimum improvement in drug-oriented behaviour.

41. The financing of therapeutic communities should be continued and funds made available for the expansion of facilities to meet demands by those who are prepared to enter and remain in such programs.

Diversion

42. Diversion schemes, despite their lack of success in the State, should not be abandoned as a method of dealing with drug offenders, and any program proved to be effective should be fully supported by the Government.

43. The Government should make no further decisions as to the structure or funding of diversion schemes until the results of the new pilot scheme, which is soon to be put into operation, are known.

44. No recommendation with regard to the introduction and establishment of any particular diversion scheme could be made as there was insufficient evidence to make any valid determination.

Changes in the Law

Possession

45. Possession of illicit drugs for personal use should remain a criminal offence.

46. No amendment should be made to the Poisons Act 1962 to insert the word "knowingly" as an ingredient of possessory offences under that

Act or to superimpose an additional requirement that the prosecution establish mens rea in respect of such offences.

47. Section 4(1) of the Poisons Act should be amended by inserting a new definition of "possession" which accords with the judgments of the New South Wales Court of Criminal Appeal in *R.* v. *McGrath, R.* v. *Bush, R.* v. *Rawcliffe, R.* v. *Router* and *R.* v. *Kennedy.*

48. No amendment should be made of the Poisons Act to insert a statutory presumption as to possession by specified persons in situation where illicit drugs are found concealed in places to which no one person has exclusive access.

Paraphernalia

49. No amendment should be made to s. 21(1)(f) of the Poisons Act to remove the requirement to establish that a person intended to use illegally specified drug paraphernalia in his possession.

50. No amendment should be made to the Poisons Act to prohibit or regulate the sale or possession of hypodermic syringes and needles.

51. The Poisons Act should be amended to prohibit inciting or soliciting, whether by advertising or otherwise, persons to obtain or use instruments designed to facilitate the use of illegal drugs.

Analogues and precursors

52. The definition of "substance" in s. 4(1) of the Poisons Act should be amended to include—

(a) any preparation or admixture of all salts and derivatives of any substance; and

(b) anything represented or held out by or on behalf of the person selling or supplying it to be such substance.

53. No amendment should be made to the definition of "substance" in s. 4(1) of the Poisons Act to include "analogues" thereof, or to include "other closely related substances with a similar chemical composition producing broadly equivalent pharmacological effects", or to expand the definition by any similar means.

54. No amendment should be made to the definition of "substance" in s. 4(1) of the Poisons Act to include "immediate precursors" thereof.

55. Prominent precursors of commonly used illicit drugs should be included in the Poisons List, where not already included, and it should be an offence under the Poisons Act to possess any such precursors "with the intention of manufacturing, contrary to this Act, any prescribed restricted substance, drug of addiction or prohibited drug".

56. Regulations should not be introduced requiring drug companies and proprietors of businesses selling chemicals to report to the police full details of all suspicious purchases of specified chemicals which are known to be immediate precursors of various named illicit drugs.

Power to search

57. Search powers equivalent to those which officers of the Federal Narcotics Bureau now exercise by means of general warrants or writs of assistance under ss. 198, 199 and 200 of the Federal Customs Act 1901 should not be conferred on the New South Wales police officers.

58. The Poisons Act should be amended, as the Police Department proposes, to empower police officers investigating suspected drug trafficking to enter premises without warrant in exigent circumstances.

However, with a view to preventing abuse, the following statutory provisos should apply—

(a) Warrantless searches should not be undertaken by virtue of this amendment, where it is reasonably practicable to obtain a warrant before entry and unless the police officer effecting entry into the premises suspects or believes on reasonable grounds that:
  (i) a traffickable quantity (as defined in the Poisons Act) of illicit drugs is on the premises; and
  (ii) there is a substantial risk of imminent destruction or removal of those drugs before entry by warrant can be effected.

(b) In any case where such a warrantless search is carried out, the police officer conducting the search should, regardless of whether or not a traffickable quantity of illicit drugs is found, within 24 hours of entry into the premises, make a statutory declaration setting forth details of—
  (i) his reasons for not obtaining a warrant;
  (ii) the basis for his suspicion or belief that a traffickable quantity of illicit drugs was on the premises; and
  (iii) the basis for his suspicion or belief that there was a substantial risk of imminent destruction or removal of those drugs before entry with a warrant could be effected.

(c) Within seven days of such warrantless search being conducted, and regardless of whether or not an occupant of the premises makes a complaint, statutory declarations by the police officer conducting the search and any other police officers involved in the entry of the premises, together with a report by a superior office of the Police Department should, in all cases, be forwarded to the State's Ombudsman for examination and, if required by him, to the police internal affairs branch for investigation and any necessary disciplinary or other action.

59. To modernise the application procedures for search warrants, and to enable police investigating suspected drug trafficking or other offences to move swiftly in exigent situations, and to alleviate the need for warrantless searches, legislation should be enacted, as the Police Department proposes, to permit search warrants to be obtained by telephone or two-way radio.

However, to minimise the risk of abuse, this procedure should not be used unless a genuine emergency exists, it should not be used in complex cases, and the oral application should be recorded.

60. Legislation should not be introduced to permit warrantless entry into premises for the purposes of "impounding" them until a search warrant can be obtained.

61. The amendment of s. 43(2) of the Poisons Act, proposed by the Police Department, to remove the requirement that the complaint made for the purpose of obtaining a search warrant show on its face the grounds upon which the reasonable suspicion or belief exists, is not recommended.

62. Section 43(2) of the Poisons Act should be amended, as the Police Department proposes, to remove the requirement that a warrant shall, on its face, name the police officer who is to execute it.

63. Section 43(2) of the Poisons Act should be amended, as the Police Department proposes, to make it clear that execution of a search warrant under that Act can take place either by day or night.
64. Either the Poisons Act or the Crimes Act 1900 should be amended, as the Police Department proposes, to make it clear that any police officer of or above the rank of Sergeant or in charge of a police station or a police vessel has power to stop, search and detain any vehicle or vessel in which he reasonably suspects that there is any drug of addition, prohibited drug or prohibited plant.
65. Either the Poisons Act or the Crimes Act should be amended, as the Police Department proposes, to make it clear that any police officer has power to stop, search, and detain any persom whom he reasonably suspects of having or conveying any drug of addition, prohibited drug or prohibited plant.

Electronic interception
66. The Police Department should, without delay, commence to utilise fully its powers under the Listening Devices Act, 1969 (NSW) to intercept non-telephonic communications, especially in the area of illicit drug trafficking.
67. Federal legislation should be amended, as the Police Department proposes, to permit State police, in investigating drug trafficking, to intercept telephone communications and other telecommunications, upon approval being given by a Judge of the Supreme Court of New South Wales or Judges of the Federal Court of Australia, or the State Attorney-General.

Compulsory interrogation
68. Amendment of the law, as the Police Department proposes, to permit compulsory interrogation of suspected drug traffickers, in so far as this involves the privilege against self-incrimination being abolished or curtailed, is not recommended, but further consideration by the Government of this question is necessary.
69. Enactment, as the Police Department proposes, of a Special Crime Investigations Act, which would confer power of compulsory interrogation in relation to a vast range of criminal activities, including those of suspected major drug traffickers, is not recommended.
70. Enactment, as the Police Department proposes, of analogous provisions to Part VI A of the Companies Act 1961, for the purpose of compulsory interrogation of suspected major drug traffickers, is not recommended.

Bounty schemes and rewards
71. Drug bounty schemes, whether statutory or private, which promise rewards for information leading to conviction of drug traffickers, should not be introduced, promoted or encouraged.
72. No amendment should be made to the Poisons Act to establish a system of rewards for the supply of information leading to the conviction of drug traffickers.

Informers
73. Amendment of the Poisons Act, as the Police Department proposes, to render immune from examination by courts or the defence reports or

documents produced within the Police Department or received by it in any official capacity relative to any prosecution under that Act, is not recommended.

74. Amendment to the Poisons Act, as the Police Department proposes, to prohibit the disclosure of the names of informers in any circumstances in the course of prosecutions under that Act, is not recommended.

Compulsory disclosure of source

75. The Poisons Act, as the Police Department proposes, should be amended to make it an offence for a person found in illegal possession of drugs to refuse or fail to disclose the name and address, if known, of the person from whom be obtained the drugs, the place from which he obtained them, and such other details as would assist in the identification and location of that person.

Bail

76. No amendment should be made to the Bail Act 1979, to prohibit the granting of bail, or to create a presumption against bail, for persons charged with drug-trafficking offences.

Sentencing

77. No amendment should be made to the Poisons Act to increase the terms of imprisonment prescribed under that Act.

78. Penalties for simple possession or use of narcotic drugs should not be reduced.

79. Amendment of the Poisons Act to restructure penalties by creating greater specificity of punishment, whether in the form of mandatory minimum sentences or a rigid and graded tariff of penalties, is not recommended.

Forfeiture

80. Amendment of the Poisons Act, as the Police Department proposes, to provide for forfeiture of vehicles (including planes, boats and motor vehicles) used to assist in the commission of offences under that Act, is not recommended.

Fines

81. The maximum fine in respect of indictable offences under the Poisons Act should be increased from $A60,000 to $A200,000.

82. The introduction of legislation authorizing "means inquiries" to investigate the financial position and dealings of convicted major drug traffickers, with a view to making imposition and recovery of fines more effective, is not recommended.

Goods in Custody

83. Extension of the "goods in custody" provision in s. 527C of the Crimes Act 1900 to cover situations where the proceeds of drug trafficking have been placed in an account such as a bank, building society, credit union or solicitor's trust account, is not recommended.

84. The Poisons Act should be amended to empower a court, upon conviction of a person charged with an offence under that Act, in

addition to penalties of imprisonment and fine otherwise provided, to order execution against—

(a) property held by or on behalf of that person which has been obtained or paid for whether wholly or in part as the result of the commission of that offence;

(b) any account (e.g. bank, building society, credit union, solicitor's trust or other similar account) kept in that person's name or on his behalf where an amount has been credited to that account, as a result of the commission of that offence.

Confidentiality

85. Legislation should be introduced which, subject to specified exceptions—

(a) makes communications between a drug abuser and drug treatment facility staff confidential, and prohibits disclosure thereof; and

(b) protects from disclosure the records of that facility in respect of communications with, and testing, examination, diagnosis and treatment of drug abusers.

Australia—South Australia

"The Substantive Criminal Law"

The Criminal Law and Penal Methods Reform Committee of South Australia has published its Fourth Report on "The Substantive Criminal Law" [briefly noted at (1978) 4 C.L.B. 614].

The Report, which runs to 460 pages, includes tables of cases and statutes, and a bibliography. Earlier Reports of the Committee appeared in 1973 (First Report—Penal Methods), 1974 (Second Report—Criminal Investigation and Procedures), 1975 (Third Report—Court Procedure and Evidence), and 1976 (Special Report on Rape and Other Sexual Offences).

In introducing this Report, the Committee points out that amendments to the substantive law recommended in earlier Reports have not been reconsidered, although where practicable references are made to those earlier recommendations. For ease of reference, the Special Report on Rape and Other Sexual Offences has been reproduced as Chapter 4 of the Report in the form in which it was originally presented.

Below is a summary of the Committee's principal recommendations.

(xviii) the following should be the test of insanity as an answer to a criminal charge in substitution for the McNaghten Rules—

> A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission;

(xix) no special provision should be made for insane delusions, nor should the law relating to automatism be changed;

(xx) a defence of diminished responsibility in charges of murder should not be introduced;

(xxi) the term "intoxication" should not be limited to intoxication by the ingestion of alcohol but include the disordering of the faculties by any drug or poison;

(xxii) intoxication should be only a factor to be taken into account with the rest of the evidence in determining the defendant's actual state of mind at the relevant time. The question whether the defendant became drunk voluntarily should be irrelevant as a matter of law unless either the defendant is charged with an offence of which intoxication is by definition an element or there is evidence that he deliberately ingested intoxicants to nerve himself for the commission of the offence charged. In the latter case his state of mind immediately before he set about intoxicating himself should be the relevant one for the purpose of criminal responsibility;

(xxiii) the law of causation with respect to offences of which the causing of death is by definition an element should be that the defendant caused the death charged if his acts or omissions substantially contributed to the death having regard to the time at which and the manner in which it occurred: the year-and-a-day rule should be abolished;

(xxiv) the law relating to involuntary manslaughter should be abolished;

(xxv) the rule of law under which suicide or an attempted suicide is a crime should be abrogated;

(xxvi) legislation similar to that contained in s. 6B of the Crimes Act 1958 (Victoria) in relation to suicide pacts and inciting to commit suicide should be enacted;

(xxvii) an offence of mercy killing should not be introduced;

(xxviii) an inquiry as to the circumstances under which life support systems may lawfully be withdrawn should be conducted;

(xxix) there should be no statutory definition of death for the purposes of the criminal law.

(xii) the age of consent for the purposes of tatooing, or medical or surgical treatment should be 16 years;

(xiii) so far as the criminal law is concerned, no person should be required to undergo medical or surgical treatment if it is against his religious beliefs to do so, and the appropriate age of personal decision should be 16 years;

(xiv) an offence directed at penalising conduct which causes death or serious harm to persons by frightening them to such an extent that they bring these consequences upon themselves should be enacted;

(xv) in the law relating to abortion any belief on the part of the

defendant should be required only to be genuine but not necessarily objectively reasonable, in accordance with general recommendations as to belief on the part of the defendant in the criminal law.

(i) there should be no statutory definition of rape. In a charge of rape the Crown should continue to bear the onus of proving beyond reasonable doubt that the accused had unlawful sexual intercourse with a person without her consent, knowing that she is not consenting, or being recklessly indifferent as to whether she is consenting or not;

(ii) the statutory presumption that a boy under 14 years of age is incapable of committing rape should be abolished;

(iii) a husband should be indictable for rape upon his wife whenever the act alleged to constitute the rape was committed while the husband and wife were living apart and not under the same roof, notwithstanding that it was committed during the marriage;

(iv) there should be created a specific crime relating to *penetratio per os* where such act is performed upon a person who submits under force or by fear induced by threat, or who is asleep or rendered incapable of resistance through intoxication or otherwise;

(v) except as otherwise expressly provided the age at which a person shall, for the purposes of a criminal prosecution, be capable of consenting to sexual intercourse or to an act constituting an indecent assault, should be 16 years;

(vi) a person aged 14 years or over should be capable, for the purposes of a criminal prosecution, of consenting to sexual intercourse (or to an act constituting indecent assault) with a person who is not more than 5 years older than him or her;

(vii) a person under the age of 18 years should be incapable, for the purposes of a criminal prosecution, of consenting to sexual intercourse (or to an act constituting indecent assault) with his or her guardian, teacher, schoolmaster or schoolmistress, unless such guardian, teacher, schoolmaster or schoolmistress is not more than 5 years older than the ward or pupil and the ward or pupil is aged 14 years or over;

(viii) the existing law should be repealed and be replaced by a section making it an offence to have sexual intercourse with a person known to the offender to suffer from a mental defect or disease which renders him or her incapable of appraising the nature of his or her conduct and thus incapable of giving a true consent to sexual intercourse;

(ix) a person under the age of 18 years should be incapable, for the purposes of criminal prosecution, of consenting to sexual intercourse or an act constituting an indecent assault with his or her parent or brother or sister, but a person who has sexual

intercourse with, or commits an act constituting an indecent assault upon, his brother or sister of or above the age of 14 years should not be liable to prosecution if such person is not more than 5 years older than the brother or sister;

(x) specialist police officers who deal with alleged rape victims should undergo a course in practical psychology before appointment;

(xi) there should be established a panel of doctors (including women) one of whom should be selected to examine the alleged victim of a rape. The alleged victim should be examined by a woman doctor if she so elects;

Non-medical use of drugs

The South Australian Royal Commission on Non-Medical Drug Use of Drugs in South Australia has presented its Report to the South Australian Government [also see (1979) 5 C.L.B. 563].

The Royal Commission has recommended that people charged with possessing illegal drugs should appear initially before a three-member drug panel at a private, informal, hearing. It recommended that new drug assessment and aid panels be modelled on the aid panels before which juvenile offenders appear in South Australia.

The drug panels would determine whether criminal prosecution should proceed.

"If the panel decides that a prosecution should not proceed, it should consider what treatment or other action, if any, is required to assist the offender to overcome the problems associated with his use of drugs", the Report of the Royal Commission says.

The panels would have no power to force compliance with their decisions, but could require the offender to appear and give undertakings for up to six months. They would not try to establish guilt or innocence. Proceedings would be informal, with power to hear submissions from a person who has been treating or counselling the offender. Legal representation is not recommended.

In deciding what action should be taken, the panel would have to take into account the charged person's personal circumstances, his suitability and willingness to undergo treatment or other programme, and the need to protect the community.

"In some circumstances prosecution will be clearly warranted," the Report says, "This might be the case where the offender is charged with a number of offences of which possession is only one." A first offender who is an experimental user of drugs and clearly not in need of any formal treatment might be thought to warrant a caution or advice rather than the stigma of a conviction.

"We emphasise that not all offenders require treatment and part of the panel's function is to identify the offenders who might benefit from treatment," the Report says.

The Royal Commission also recommends the repeal of legislation authorising the compulsory committal of drug-dependant people to institutions.

Police searches: Special rules for investigation and arrest in drug-related matters should be changed in some cases, the Royal Commission stated.

Warrants for police to enter and search premises over drugs should be valid for a specified period, of up to 14 days, instead of only during a nominated day.

But warrants to enter and search premises, now in practice issued by police officers, should be issued only by a magistrate or a judge.

However, the Commission recommends also that in an emergency police should have the power to enter and search premises without a warrant. Such situations would include cases where entry is required to prevent destruction of evidence.

Although at common law a person is not required to submit to a search involving bodily cavities, the Commission said that "because of the techniques used to transport drugs illegally we are persuaded that there may be occasions when it is necessary to conduct a medical examination to ascertain if a suspect is carrying drugs."

Because severe infringement of personal dignity was involved in such searches, they should be carried out only after arrest and with the written consent of the person or after a police officer has satisfied a magistrate that there was reasonable cause for the examination.

Consolidation of existing controls over the availability and use of mood-altering drugs under the Controlled Substances Act (S.A.) is recommended.

In criminal offences, magistrates hearing charges of supplying illegal drugs should be able to impose a maximum fine of $A2,000, two years' imprisonment or both, and be able to refer the case to a higher court if a more severe penalty is warranted.

Drug education: A complete review of school and community drug education programs should be undertaken, the Royal Commission says.

Education in schools is often seen as the answer to curtailing the spread of non-medical drug use. But after evaluating drug-education programmes in Australia and overseas the Commission concludes that the normal education is much less effective in changing behaviour related to drug-taking than most people realise. "Consequently, the notion that drug-education programme can be used as a short-term measure to reduce markedly the number of young people engaging in illegal or harmful drug use is an over-simplification," it says.

"Indeed, there is evidence that certain kinds of drug education, particularly when outsiders are brought into schools for 'one-night stands', can actually encourage young people to experiment with drugs."

Drug education in schools should take place within a broad health-education program. This would place the problem in wider perspective.

Treatment: The Commission says that treatment for drugs use is a far more complex issue than is often thought.

"The special problems include the difficulty of defining what is to be treated, since the circumstances of persons requiring treatment for drug mis-use are very different and addiction itself is not an easily diagnosed condition".

"It is also difficult to formulate gaols for treatment programs and to measure where programs are successful".

Abstinence from drug use is often not possible for addicts. Even more modest objectives, such as improved social participation, may prove elusive.

In assessing the role of opiate-maintenance programs, the Commission says that there are dangers in prescribing methadone too freely as a substitute for heroin.

Drug sales: The Royal Commission recommends that compound analgesics, now sold over the counter, be available only on a doctor's prescription.

The Royal Commission said: "The evidence strongly suggests that compound analgesics containing caffeine are widely mis-used, the habituating effects of caffeine being a likely factor in this".

"There are adverse side effects on the kidney resulting from the use of compound analgesics. The single analgesics have their side effects too, but these are not as dangerous as with the compound analgesics".

It says most people can be expected to obtain as much pain relief by using a single as by using a compound analgesic.

The Commission says it has changed its tentative opinion on the need to give the retail pharmacist greater control over the distribution of single analgesic preparations.

It concludes now that the risks of present public use are not great enough to justify restricting their distribution to retail pharmacies.

Australia—Tasmania

Decriminalisation of drunkenness and vagrancy

The Law Reform Commission of Tasmania (Report No. 3 of 1977) has made the following recommendations—

(i) the offences of being drunk and disorderly and of being drunk while in charge of any vehicle or animal, or when in possession of any firearm and ammunition or of any other dangerous weapon, should remain punishable offences as at present;

(ii) there should be no punishable offence of being drunk and incapable of taking care of oneself. Instead, persons who are drunk and incapable should be dealt with as set out in recommendation (viii) below;

(iii) section 5 of the Police Offences Act should be amended to provide for two categories of persons—
  (a) Those who are destitute, and
  (b) Those who are living upon money or property dishonestly obtained;

(iv) being destitute should not be a punishable offence. Instead, such persons should be dealt with as set out in recommendation (viii) below;

(v) there should be a new offence of living upon money or property dishonestly obtained, based upon the reasonable belief of a police officer. The onus of showing that his money or property was obtained honestly should be upon the offender, and the court should take sworn evidence as a matter of course;

(vi) special 'institutions' should be established to provide temporary accommodation, treatment, diagnostic and therapeutic services, and other facilities for persons who are drunk and incapable of taking care of themselves or who are destitute;

(vii) unless and until such institutions are established at appropriate centres, 'places of safety' should be designated to which police officers can take drunk and destitute persons for protection. At such places of safety persons will receive, at the least, accommodation for the night. In addition, where such places are located in urban centres, they should be able to obtain treatment and counselling;

(viii) the machinery provisions for dealing with persons who are drunk and incapable or who are destitute should be as follows—
  (a) a police officer shall have power to arrest such a person and to convey him to 'an institution' or 'a place of safety' provided that the police officer reasonably believes that this course is necessary for the protection of such person,
  (b) such person may be lawfully detained at such institution or place of safety for a period not exceeding twenty-four hours,
  (c) such person shall be released after a maximum period of twenty-four hours' detention unless a police officer has reasonable grounds for believing *either* that such person is then incapable of taking care of himself *or* that he is alcohol or drug dependent *or* he has no suitable accommodation to which to proceed. In either of such cases, the police officer shall arrange for such person to be brought before the court without delay so that he can be heard and suitable arrangements made for any treatment and care,
  (d) no complaint or other form of documentation shall be necessary in order to bring such person before the court,
  (e) any person detained under the above provisions may, if he

so desires, apply to the court in a summary way for a determination of his case, notwithstanding that he has been released after a maximum period of twenty-four hours' detention,

(f) where such person appears before the court, under either (c) or (e) above, it shall, wherever practicable, be constituted by a magistrate sitting alone. No publicity shall be given to the proceedings before the court except at the express request of such person or any person appearing on his behalf;

(ix) leaving an institution or place of safety whilst under lawful detention should be made an offence punishable in the ordinary way.

Australia—Victoria

Prostitution—the alternatives

The Victorian Minister for Social Welfare has issued a paper advocating compulsory health checks for prostitutes, a brothel tax and special traffic controls in "red light" areas. The paper also canvasses the possibility of sanctioning soliciting in bars and restaurants, using ex-prostitutes in welfare work and asking customers to produce medical certificates.

The paper, "Prostitution—the Alternatives", discusses the options of prohibiting, suppressing, decriminalising and legalising prostitution, and coincides with the Victorian Government's plans to introduce higher penalties and tougher planning controls in legislation.

The discussion paper admits that existing legislation "does not come to grips" with many problems and "cannot be considered to provide an effective control of...prostitution and neither is it regarded as generally enforceable". It says that restrictive definitions made it difficult to prove offences and were often irrelevant. Further, it was difficult to prove prostitution was taking place and to trace "behind-the-scenes owners", and penalties did not deter illegal massage parlours.

The paper also cites inequities in existing laws, such as sexual discrimination against women and the fact that the prostitutes' customers are not prosecuted. There was also the question of the individual having the right to determine what to do with his/her own body. "Promiscuity in itself is not an offence" it says. "Should promiscuity with payment then be considered an offence?" It could also be said that prostitutes had a right to keep someone on their earnings if they wanted to.

The paper stated that Police estimated that there are 156 massage parlours, 122 escort services involving 300 prostitutes and 50 streetwalkers. It says there is no reliable information on the incidence of

"pimps or hoons" and payment of money for protection. It lists prostitution problems as public nuisances (such as offence advertising, traffic problems and gutter crawling), protection of prostitutes, and general public concern (such as organised crime, drugs and police corruption).

It says there are four major options open; prohibition, aimed at eliminating prostitution from Victoria; suppression, aimed at discouragement but recognising prostitution will not be wiped out; decriminalisation, a laissez-faire policy using only normal business controls; and decriminalisation with special controls.

The paper suggests various actions the Government could take, and the problems likely to be encountered. For example, prohibition would drive prostitution further underground and suppression would maintain prostitution "as part of the criminal subculture".

The longest discussion is on regulation or legalisation under which prostitution would be decriminalised in part or whole, with certain controls.

Organ transplants

The Victorian Government has been urged to amend the State's legislation on organ transplants from both living and dead donors [see also (1980) 6 C.L.B. 320].

In a Report prepared by a Committee headed by a former State Coroner, formed to examine recommendations by the Australian Law Reform Commission on human tissue transplants, the committee has called on the Government to adopt the Commission's suggested definition of death—viz: that a person was dead after irreversible cessation of all brain functions or irreversible cessation of blood circulation.

The Report says that the Government should integrate, in one piece of legislation, laws on human tissue transplants, post mortem examinations and the donation of vital organs, and that relatives should not be able to thwart a person's wish to donate his organs or tissue after he has died. Also, donation of children's non-regenerative tissue and organs, such as kidneys and lungs, should not be allowed.

The Report points out that four existing Acts in Victoria do not deal with problems created by recent medical developments and changing community attitudes, and that there is a gap in the legislation on the position of children as donors, the use of bodies for research, and the determination of death.

The State Minister for Health said the proposed legislation gave guidelines on consent for organ transplants, from both live and dead donors, and also sets out procedures for obtaining consent for post mortem examinations which take into consideration the wishes of the deceased person before death and the wishes of such a person's next-of-kin.

The Committee recommends the repeal of Victoria's Medical Act 1958 and the Sale of Human Blood Act 1962, and major amendments to the Medical Practitioners Act 1970.

The Committee's major recommendation was that, under the proposed legislation, a person's decision to donate an organ or organs should be respected after he or she died. Now, if a close relative objected to the organs being removed, the wishes of the deceased could be ignored and no organ transplant would take place.

The Committee also suggested a number of amendments to the Law Reform Commission's findings, including that the donation of non-regenerative tissue by children should be forbidden.

Australia – Western Australia

Exemption from jury service

The Law Reform Commission of Western Australia has published a Working Paper on "Exemption from Jury Service" (Project No. 71), which discusses the issues involved, sets out the Commissions's provisional views, and calls for comments.

The Working Paper explains that the State law relating to the qualifications of jurors, their mode of selection, and the right to obtain exemption from jury service is contained principally in the Juries Act 1957 – 76. The existing legislation replaced the Jury Act 1898 and introduced a number of important reforms in the law making the electoral roll the basis for general liability for jury service instead of a list compiled by the police from among those with certain property qualifications. It also abolished special juries, and gave women the right to serve as jurors, while giving a woman the special privilege of cancelling her liability to serve by sending notice the Sheriff.

The Working Paper reviews the law in other jurisdictions, and pays special attention to the law in England, New South Wales [see (1978) 4 C.L.B. 234] and Victoria. It notes that in these jurisdictions the notion of exemption from jury service has been replaced by those of ineligibility and right to be excused. Persons whose occupation involves them in the administration of law and justice are declared to be ineligible to serve, examples being members of the judiciary and police and prison officers. Those whose occupation is such that interruption of it for jury service could unduly inconvenience or harm the public are given the right to be excused, examples being members of emergency services and doctors.

The Commission considers it to be axiomatic that the obligation to serve as a juror should be spread as widely and fairly as practicable throughout the community. A person should not be freed from the responsibility of jury service, or denied the right to serve, except for good reason. No one should be freed from jury service simply for the purpose of avoiding what might be seen as a tiresome duty, or to avoid some minor inconvenience to the person concerned or the public. In the Commission's view, a person should be denied the right to serve on a jury, or freed from the responsibility of jury service, only if he or she –

(a) is not a fit person to serve as a juror,
(b) is involved in the administration of law and justice to such an extent as to make it inappropriate that he or she should serve as a juror,
(c) performs duties of such a nature that interruption to them for jury service would cause serious inconvenience or undue personal hardship to any other person,
(d) would suffer undue personal hardship if required to serve as a juror.

The Commission suggests that the law as to jury service should neither discriminate against women nor favour them. Accordingly, the present right of a woman to cancel her liability to serve should be abolished. In its place should be a provision entitling pregnant women and persons who are caring for children or for aged or sick persons to excusal as of right.

The Commission also considers that, since a coroner's jury could return a verdict upon which the coroner could found an order that a person be committed for trial, the classes of person who should be ineligible for jury service in respect of criminal and civil trials should also be ineligible in respect of coroners' juries. There also seemed to be no reason why the classes of person who should have the right of excusal in respect of criminal and civil trials should not also be entitled to be excused from service on a coroner's jury.

The Working Paper lists those whom it suggests should be ineligible for jury service, and those who should be entitled to be excused from such service, as follows –

Persons ineligible for jury service

Parliament
Members and officers of the Legislative Assembly
Members and officers of the Legislative Council
The Parliamentary Commissioner for Administrative Investigations

Law
Judges, Stipendiary Magistrates, Judges' Associates and ushers
Justices of the Peace
Sheriff's officers and court bailiffs
Legal practitioners, enrolled in the Roll of Practitioners pursuant to the Legal Practitioners Act 1893

Government
The Commissioner of Police and all persons under his direction and control
The Director of the Department of Corrections and all officers under his direction and control
Members of the Parole Board
Officers under the jurisidiction of the Attorney General (excluding officers of the Land Titles Office and Public Trust Office)
Officers of the Department for Community Welfare
Officers and temporary employees employed in the Road Traffic Authority

Incapacitated Persons
Persons incapacitated by reason of infirmity of mind or body from discharging the duties of jurors

Commonwealth Officers
Persons exempt under the Commonwealth Jury Exemption Act 1965

Persons with the right to be excused from jury service

Emergency Services
Persons actually engaged on Civil Emergency Services
Officers and members of permanent fire brigades

Health
Medical practitioners, dentists, veterinarians, psychologists, nurses and chiropractors registered as such according to law, if actually practising
Pharmaceutical chemists registered as such according to law, if actually engaged in business
Staff of the Derby Leprosarium
Staff of mental hospitals
General staff of hospitals and homes for aged persons

Commerce and Industry
Harbour and marine pilots
Masters, officers and members of crews of vessels actually trading
Inspectors of Mines
Mining managers and engine-drivers on mines in which not less than ten men are engaged in mining operations
Pilots, navigators and radio operators of commercial aircraft

Family
Pregnant women
Persons who have the full-time care of children under the age of 14 years or of persons who are aged or in ill-health

Religion
Ministers of religion

Barbados

Report of the National Commission on the Status of women in Barbados

The National Commission on the Status of Women in Barbados, appointed in 1976 with wide ranging term of reference, has now presented its most comprehensive Report. Its 1,461-page Report examines the historical background, traditional attitudes; women and the law; education; women and employment; health; the family; women and the church; and politics; and the media; the contribution of women, and abortion.

Included among its 212 recommendations, and of particular interest to lawyers, are—

(liii) that any proposal to change the existing abortion law in a more permissive direction should contain provisions not only for providing an abortion service but for mounting an anti-abortion education programme;

(liv) that before attempting to change the abortion law efforts should be made to ensure that the contemplated change represents the collective national desire and that the nation is made fully aware of the possible consequences of its choice;

(lv) that the service should permit abortion on the sole request of women up to the twelfth week of pregnancy;

(lvi) that beyond twelve weeks, abortion should be permissible under specified conditions;

(lvii) that in the case of those under 18 years, those over 40 years, and those with four or more children, indications for termination of pregnancies beyond twelve weeks should be liberally interpreted;

(lviii) that where medical termiantion of pregnancy beyond twelve weeks involved high medical risk, possibly death, to the mother, the consent of at least one parent of minors and the spouse/partner of older women should be obtained;

(lix) that abortions only be performed by a registered medical practitioner;

(lx) that a counselling mechanism should be included in the service for women who wish to be aborted beyond the twelfth week of pregnancy (This may be achieved by referral from the doctor to a special social service agency followed by a delay of not less than three and not more than seven days before the abortion is performed. This is to give the woman a chance to weigh the advantages and disadvantages of having an abortion before making a final decision);

(lxi) that consideration should be given to the devising of a system to ensure that abortions are not performed on pregnant women who had an induced abortion within the previous six months;

(lxii) that provision for adequate and up-to-date record keeping should be made;

(lxiii) that the service should be available in the following places—

(a) separate in and out-patient facilities at the Government Hospital,

(b) Government clinics operating out-patient facilities with in-patient cases referred to the facilities at (a),

(c) the Family Planning Association – on an out-patient basis with in-patient cases referred to at (a), and

(d) private sector;

(lxix) that medical practitioners and auxiliaries who object to abortions on the grounds of conscience, should not be required to work in any of the publicly provided facilities.

One of the Commission has entered a minority report (principally in disagreement with the recommendation that grounds for abortion be widened), and the Commission's Chairperson, Ms. Norma Monica Forde, has presented a separate statement which urges more wide-ranging reform of family and other laws. In particular she would see the abolition of all the old common law actions which were designed to protect the proprietory rights of the man and only in small measure and indirectly benefited the woman, such as breach of promise of marriage, jactitation of marriage, and loss of consortium.

The three volumes of the Report may be obtained from the Barbados Government Printing Office.

Canada

Committee on the operation of the abortion law

In 1969 the Criminal Code was amended to provide that an abortion could lawfully be performed by a qualified medical practitioner in an accredited or approved hospital if the therapeutic abortion committee of the hospital has issued a certificate stating that in its opinion the continuation of the pregnancy would or would be likely to endanger the woman's life or health. In the period that has elapsed since this change in the law concern was expressed over the way the law was working. In view of the limited amount of factual information available the Government of Canada appointed a sociologist, a physician and a lawyer to conduct a fact-finding study "to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada". This group, the Committee on the Operation of the Abortion Law, was under the chairmanship of Professor Robin F. Badgley of the University of Toronto. The Committee was not asked to consider the merits of the abortion law itself or to make recommendations. The terms of Reference, which were intended to assist the Committee in its task, stated that it was to "make findings on the operation of this law rather than recommendations on the underlying policy".

The Committee visited many hospitals, surveyed their operations and staff, conducted a survey of doctors to ascertain their views and the extent of their experience with abortion and surveyed as well nearly 5000 women who had obtained abortions. A Gallup poll was commissioned to establish the knowledge and experience of adults and teenagers with induced abortion, and statistics were obtained from abortion centres in the United States to ascertain the extent to which Canadian women were travelling abroad to obtain terminations.

The Committee made a number of findings on matters within and related to its terms of reference. Some of the major findings were –

(i) no consensus exists for major changes in the law – most Canadians were neither in favour of removing abortion from the Criminal Code nor of refusing therapeutic abortions under any circumstances. Their complaint was with the way the law was working;

(ii) the law is not operating equitably – the procedure provided in the abortion law for obtaining therapeutic abortions is not operating equitably across Canada. There are sharp disparities in the distribution and accessibility of therapeutic abortion services and unreasonable pressure on some physicians and hospitals. The burden of the inequitable operation of the abortion law tends to fall on women who are less well educated, who have lower incomes and who live in smaller centres or rural areas with no direct access to abortion services;

(iii) the abortion law itself is not inequitable – the 1969 amendment to the abortion law resulted in a sharp reduction in illegal abortions. In addition, there was a substantial reduction in deaths resulting from attempted self-induced or other illegal abortions. Provincial regulations and the practices of hospitals and the medical profession rather than the abortion law itself have led to the inequities in its operation. The law is specific in setting out the procedure to be followed to obtain a therapeutic abortion and its definition of guidelines is broad enough to accommodate the circumstances under which it might be considered necessary to obtain an induced abortion;

(iv) the abortion law limits the therapeutic abortion procedure to hospitals accredited by the Canadian Council on Hospital Accreditation or approved by provincial health authorities. While in some instances hospitals of eight beds were accredited, additional provincial requirements for the rated bed capacity of hospitals which are eligible to establish therapeutic abortion committees varied from an undesignated number to 50 and 100 beds. There were a number of other additional provincial requirements for eligibility. Taken together these requirements set by provincial health authorities were a major factor which made a sizeable number of general hospitals ineligible to establish therapeutic abortion committees. When these requirements were added to the established medical custom that the therapeutic abortions are usually done by obstetrician-gynaecologists, the number of hospitals eligible to do the abortion procedure was effectively reduced to two out of every five hospitals in the nation;

(v) in addition to the requirements set by provincial health authorities most hospitals where abortions are done have devel-

oped their own requirements to be met by patients prior to their applications being reviewed by therapeutic abortion committees. These requirements include one or more of: prior consultations with one, two or three physicians; a social service review; a residency requirement; tests for congenital deformities; contraceptive counselling; the consent of a spouse or partner; length of gestation; or interviews with patients by members of the therapeutic abortion committee. The use of these different requirements meant that some women seeking a therapeutic abortion had their applications speedily reviewed, while others in similar circumstances experienced considerable delay or had their applications rejected;

(vi) delay by physicians is increasing risk and stress – on an average, women took 2.8 weeks after they first suspected they had become pregnant to visit a physician. After this contact had been made there was an average interval of 8.0 weeks until the operation was done. This kind of delay results in higher cost of health services, increases the stress on patients, and puts off the abortion until later in the pregnancy with the increased risk this can entail;

(vii) there has been an absence of detailed reviews by provinces – the abortion law makes provision for review of the operation of the therapeutic abortion procedure by provincial health authorities. There have been no detailed reviews by the provinces of provincial regulations imposing conditions for the establishment of therapeutic abortion committees, the hospital requirements to be met by patients before their applications will be reviewed by a committee or the range of circumstances that may be seen to constitute danger to a woman's health. Despite nation-wide medical care insurance there is a financial deterrent for some women to obtaining a therapeutic abortion. One out of five women who had a therapeutic abortion paid extra medical fees and in some instances the performance of the operation was contingent upon payment of the extra fees. These charges were not evenly distributed among all abortion patients, but affected most of those women who were young, were less well educated, or were newcomers to Canada;

(viii) women are leaving the country to obtain abortions – for every five women who obtained an abortion in Canada, at least one woman left the country for this purpose. About 9600 Canadian women obtained induced abortions in 1975 in the United States. Relatively few Canadian women went to other countries for the operation. Seven out of eight women in a small group of Canadian women surveyed who had abortions in the United States would have preferred to have had an

abortion in Canada, if they had known or had been told this option was available. Over half of these women said that their doctors felt they had little chance of getting an abortion in Canada, were morally opposed to assisting them, or were unwilling to refer them to a hospital where this procedure was done in Canada;

(ix) special treatment centres are beneficial – there were fewer risks for patients at hospitals which had developed considerable specialization in doing therapeutic abortions. When this situation has occurred in the treatment of other health conditions in Canada it has on occasion resulted in the establishment of special treatment centres. This trend toward the specialization of abortion treatment has already partly evolved, although it has not been formally recognized by hospitals or provincial health authorities;

(x) family planning information is lacking – Canadians lack accurate information about contraception. In terms of the allocation of public effort and resources, family planning has been only modestly supported. More money is spent on paying for the treatment and care of women who have induced abortions than on ways of seeking a reduction in the number of abortions and in providing more effective programmes of family planning and sex education. Existing sex education courses in schools, the work of public health programs and the efforts of voluntary associations when considered together have had little impact on the population as a whole;

(xi) statistics concerning abortion are inadequate – the classification system for abortion requires extensive review in light of the different purposes for which information is compiled. There were almost as many abortions in Canadian hospitals which were classified under other headings as there were therapeutic abortions. These other abortions varied considerably in number among regions and different types of hospitals. Information is required about the use of contraceptive methods and the volume of induced abortions. Greater use could be made of much of the information collected which is neither fully analyzed nor made public. Fuller analysis of existing sources would provide more information for the public on the operation of the abortion law and the health consequences of abortion.

Sexual offences

The Law Reform Commission of Canada has published Working Paper No. 22 on "Sexual Offences". The Working Paper proposes a new formulation of sexual offences as an alternative to the present provisions in the Canadian Criminal Code. The Commission states

that the reformulation has two objectives: first, to simplify and organise sexual offences; second, to bring the law more in line with present values and attitudes towards sexual offences and towards the use of the criminal law.

The Commission's principal recommendations are summarised below—

(i) that the Criminal Code provisions relating to the offence of rape be reformulated to embody the notion of sexual assault as in the following—

(1) Every one who has sexual contact with a person without that person's consent is guilty of an offence of sexual assault.

(2) For the purposes of this section "sexual contact" includes any touching of the sexual organs of another or the touching of another with one's sexual organs that is not accidental and that is offensive to the sexual dignity of that person.

(3) In determining the sentence of a person convicted under this section, the judge shall consider all of the circumstances and consequences of the offence including whether there has been penetration or violence;

(ii) that if the provisions against rape as presently defined in the Criminal Code were to be maintained, the exception which stipulates that forced sexual intercourse between spouses is not rape should be abolished in regard to spouses who are not cohabiting;

(iii) that ss. 155 (buggery and bestiality) and 157 (gross indecency) of the Criminal Code be repealed. Instead forcible buggery and bestiality, as well as gross indecency would fall under the proposed sexual assault provisions, with the gravity of those acts determined on all the circumstances and more specifically on whether there has been penetration or violence;

(iv) that s. 158 be repealed from the Criminal Code: since the exemptions outlined in s. 158 relate to ss. 155 and 157 which are to be abolished in part and incorporated into the sexual assault provision in part, the section becomes superfluous;

(v) that the following reformulation or a similar reformulation be adopted regarding sexual relations with a young person under fourteen years of age—

(1) Every one who has sexual contact with a person under the age of fourteen years is guilty of an offence.

(2) For the purposes of this section "sexual contact" includes any touching of the sexual organs of another or the touching of another with one's sexual organs that is not accidental.

(3) In determining the sentence of a person convicted under this section the judge shall consider all of the circumstances and consequences of the offence including whether there has been penetration or violence.

(4) An accused is not guilty of an offence under this section because he or she has sexual contact with a young person under the age of fourteen years if, after the exercise of due diligence, proof of

which lies upon him or her, he or she believed the young person to be of the age of fourteen years or older;

(vi) that the following reformulation or a similar reformulation be adopted regarding sexual relations with a person between the ages of fourteen and eighteen—

(1) Every one who has sexual contact with a young person fourteen years or older but under eighteen years of age who is dependent upon him or her or under his or her authority but is not his or her spouse, is guilty of an offence where the sexual contact is caused by the exercise of such authority or dependency.

(2) For the purposes of this section "sexual contact" includes any touching of the sexual organs of another or the touching of another with one's sexual organs that is not accidental.

(3) In determining the sentence of a person convicted under this section the judge shall consider all of the circumstances and consequences of the offence including whether there has been penetration or violence.

(4) An accused is not guilty of an offence under this section if, after the exercise of due diligence, proof of which lies upon him or her, he or she believed the young person to be of the age of eighteen years or older;

(vii) that s. 146(2) of the Criminal Code be repealed. Instead, in the absence of force, fraud or exploitation, sexual intercourse on the part of adults with fourteen to sixteen year old persons should continue to be prohibited as contributing to juvenile delinquency or be prohibited elsewhere in the criminal law;

(viii) that s. 148 of the Criminal Code be repealed. Instead, sexual intercourse with a mentally handicapped person would be illegal only when that person was in fact incapable of giving valid consent. In such a case, a charge would be laid under the sexual assault provision on the basis of non-consent;

(ix) that ss. 151, 152, 153(1)(a) and (b), and s. 154 of the Criminal Code be repealed. Instead, the Commission's reformulation would provide for protection of young persons under the age of eighteen in dependency situations. For those whose employment opportunities are threatened by sexual exploitation, regulation should be left to labour legislation, with actions and referral to the appropriate Human Rights Commission;

(x) that those offences under the Criminal Code sub-heading "Offences Tending to Corrupt Morals" dealing with defilement, corruption and procuring of children would better be dealt with under the proposed federal legislation to replace the Juvenile Delinquents Act as well as under provincial child welfare legislation and the laws relating to prostitution;

(xi) that s. 142 be retained, but that the Criminal Code be amended so as to restrict publication or broadcast of material likely to lead members of the public to identify a rape victim, except with authorisation of the court, and maintain the

anonymity of the accused unless he or she is convicted or the court otherwise authorises;

(xii) that s. 147 of the Criminal Code be repealed. This exemption from criminal responsibility is unnecessary in the light of present laws, which provide that a person under fourteen cannot be tried in a criminal court;

(xiii) that s. 150 of the Criminal Code be repealed. Instead, incestuous behaviour would be prohibited under the reformulations suggested in this Paper dealing with sexual assault and sexual relations with young persons;

(xiv) that s. 169 of the Criminal Code (dealing with indecent acts calculated to offend others) be retained;

(xv) that s. 170 of the Criminal Code (dealing with nudity) be retained;

(xvi) that s. 171(1)(a), (c) and (d) (causing a disturbance, obstructing persons in a public place and disturbing the peace), s. 172 (obstructing clergy and disturbing a religious ceremony), and s. 174 (dangerous and volatile substances) be removed from the ambit of sexual offences and that the remaining sections in the Criminal Code under the subheading "Disorderly Conduct" be reformulated the better to reflect the organising principle of safeguarding public decency;

(xvii) that s. 171(1)(b) of the Criminal Code (which prohibits displaying indecent exhibits) should be retained to be modified in consonance only with changes, if any, in the law of obscenity;

(xviii) that s. 173 of the Criminal Code dealing with voyeurism remain substantively unchanged but undergo sentencing and procedural reform to recognise the sexually compulsive nature of the offence;

(xix) that s. 175(1)(e) of the Criminal Code be repealed subject to provisions allowing for a court to make an order so that a person convicted of a specific sexual offence can be restricted from access to certain specified public places. This order of restriction should be of limited duration;

(xx) that s. 195.1 of the Criminal Code (dealing with soliciting for the purposes of prostitution) apply equally to men and women;

(xxi) that should the Juvenile Delinquents Act be replaced by new legislation which does not prohibit contributing to juvenile delinquency, such a provision should be enacted in the Criminal Code.

Criteria for the determination of death

The Law Reform Commission of Canada has issued Working Paper No. 23 under the title "Protection of Life: Criteria for the Determination of Death". The Paper discusses death both as a medical and legal phenomenon, and reviews the experience of the U.S.A.,

Britain, France, Switzerland, Australia and the province of Manitoba, in this area.

The Paper includes extensive endnotes, a selected bibliography and selected definitions of death in other jurisdictions.

When discussing possible solutions, the Commission expresses the view that the problem is not purely theoretical; on the contrary, it is of real and practical importance, no less to the public and to society at large than to the lawyer and the medical and health professionals who frequently must confront it in their professional lives. Whatever solution is proposed ought to meet certain specific requirements. It should be flexible, allowing for adaptation to new developments in law and medicine, and it should try to reflect the consensus of a large segment of public and professional viewpoints, even though the prospect of a unanimously acceptable solution can be discounted as unlikely. Three types of approaches were possible—

(a) treating the time and criteria of death as a purely medical problem, and leaving their determination to the exclusive jurisdiction of the medical profession;
(b) leaving to the case law the task of gradually developing coherent criteria as to time and determination of death;
(c) proceeding directly by way of legislation to define the criteria of death, and apply them in the adjudication of individual cases.

The Commission notes that their comparative review of experience in other jurisdictions had revealed that the legislative or regulatory solution seemed to have met with approval even in jurisdictions like the U.S.A. and Australia, or Manitoba, where the common law tradition might have favoured a case-by-case approach. Moreover the opposition to legislative intervention, in most cases, had been directed not against the principle itself but against its particular formulations. In other words, the discussion had now centered more around the content of the legislation than around the question of whether or not legislation was required. The Commission's tentative view was that a carefully drafted legislative intervention, designed to meet specific and clearly-defined objectives, was probably the best alternative. Its psychological and legal effects would be to dissipate fears shared by doctors, other medical personnel and the public. It would also eliminate the tensions between the insights of tradition and the imperatives of contemporary medicine. However, it would be wrong to opt for just any type of legislative intervention with an unspecified content. The parameters of the solution must be carefully set out according to the objectives and the general philosophy of the reform.

The Working Paper sets out (with a detailed commentary) the following objectives of the legislation the Commission presently has in mind—

(i) the proposed legislation must avoid arbitrariness and give greater guidance to doctors, lawyers and the public, while

remaining flexible enough to adapt to medical changes;

(ii) the proposed legislation must not attempt to solve all the problems created by death, but only the problem of establishing criteria for its determination;

(iii) the one proposed piece of legislation must apply equally in all circumstances where a determination of death is at issue;

(iv) the proposed legislation must recognise only the standards and criteria of death: it must not define the medical procedure to be used, nor the instruments or procedures by which death is to be determined;

(v) the proposed legislation must recognise standards and criteria generally accepted by the Canadian public;

(vi) to remain faithful to the popular concept, the proposed legislation must recognise that death is the death of an individual person, not of an organ or cells;

(vii) the proposed legislation must not in practice lead to wrong or unacceptable situations;

(viii) the proposed legislation must not determine the criteria of death by reference only or mainly to the practice of organ transplantation.

The Commission sets out its provisional proposals for reform in the following terms—

> The contemporary and shared conception of death is not as far removed from medical reality as is sometimes believed. Death is considered to be both the permanent and irreversible cessation of conscious and relational life of which the medical term is "irreversible coma". Whole brain death is its sign. The difficulty in a certain number of cases stems from an apparent conflict between this state of fact and a visual perception of it. For instance, an irreversibly comatose patient, according to the Harvard test, can be considered dead even if still on a respirator and thus showing signs of respiration which under other circumstances would be tangible signs of human life. Yet these signs or movements are misleading for they indicate only an "appearance" of life.
>
> The cessation of conscious and relational life must be permanent and irreversible, corresponding from a medical point of view, to a loss of consciousness and the absolute inability to regain consciousness. A patient under anaesthetic or with the symptoms of mere cerebral death, for instance, would not fall into that category. In the former case the patient has the capacity to regain consciousness.
>
> In the latter case despite symptoms of apparant "brain death" such persons will continue to be capable of spontaneous cardio-respiratory functions until the centre controlling them (the brain stem), is or becomes irreversibly damaged. It would be wrong to consider them dead, even when it is certain that they will never regain consciousness. The ambiguity here comes from a misuse of terminology and of the terms "cerebral death" and "brain death". "Brain death" is not only the irreversible loss of conscious and relational abilities and functions, but also the permanent cessation of spontaneous breathing and heart beat.

However, the simple fact that residuary electrical activities are still maintained in the spinal cord has never been considered by medicine as an obstacle to the declaration of brain death. These spinal reflexes are not included, as medical science readily accepts, within the meaning of "brain death" as we understand that term in the recommendation below.

The legislation must deal with concrete problems. The most frequent one is that of irreversibly comatose patients showing no signs of brain life or of spontaneous respiratory and cardiac functions but where the latter are assisted by modern technology. We believe that legislation should address itself to that specific problem. The case is one of whole brain death which cannot be ascertained by the usual method, that is, the cessation of cardiac and respiratory functions.

Finally, as we have already discussed before, the legislation should not contain the description of the medical procedures or techniques for determining death. At most, it can include reference to the norms generally accepted by contemporary medical practice.

Taking these factors into account, the Commission makes the following recommendations:

(1) *That the Parliament of Canada adopt the following text:*

A person is dead when an irreversible cessation of all that person's brain functions has occurred.

The cessation of brain functions can be determined by the prolonged absence of spontaneous cardiac and respiratory functions.

When the determination of the absence of cardiac and respiratory functions is made impossible by the use of artificial means of support, the cessation of the brain functions may be determined by any means recognized by the ordinary standards of current medical practice.

(2) *That the Government of Canada enter into agreements with the Provincial Governments to insure the adoption of this text or a similar one throughout the country for all legal purposes in order to achieve suitable uniformity.*

Sterilization and the mentally handicapped

The Law Reform Commission of Canada has published Working Paper No. 24 on "Sterilization; Implications for Mentally Retarded and Mentally Ill Persons" as part of its Protection of Life Series. [Working Paper No. 23 in this series—"Criteria for the Determination of Death" was summarised at (1979) 5 C.L.B. 806.] An introduction explains that in the Paper the Commission specifically deals with the sterilization of two groups of persons—those who are mentally ill and those who are mentally retarded. These two categories of persons were chosen as the focus of the Paper for a number of reasons. First, because of a legislative history which particularly selected out these groups as being exempt from otherwise mandatory consent requirements. Secondly, because of a general

attitude towards such persons as being excluded in one way or another from the rights and responsibilities of other members of society. And thirdly, because of increased public concern about lack of control of the reproduction of mentally handicapped persons consequent upon the adoption of policies of deinstitutionalisation.

The first section of the Paper examines the medical, social, and legal definitions of mental illness and mental retardation. In the second section the positions that have been taken concerning the sterilization of these groups are presented along with a detailed examination of the social, bio-medical, and moral arguments that have been advanced. The issues that are raised by non-consensual sterilization are outlined in the third section, followed by a discussion of whether there are conditions under which non-consensual sterilization can be justified from the point of view of the criminal law. In the final section of the Paper, legislative alternatives are analysed, and guidelines proposed.

Set out below, is the Commission's own summary of its provisional proposals—

1. That the legal basis for procedures for sterilization be based on the following classifications:
   (a) *Voluntary therapeutic sterilization:* this would be any procedure carried out for the purpose of ameliorating, remedying, or lessening the effect of disease, illness, disability, or disorder of the genito-urinary system, and with the fully-informed consent of the patient.
   (b) *Emergency therapeutic sterilization:* this would be the same procedure as in (a) (above) carried out in a medical emergency and where the patient or next-of-kin is unable to give consent.
   (c) *Voluntary non-therapeutic sterilization:* this would be a safe and effective procedure resulting in sterilization when there is no disease, illness, disability, or disorder requiring treatment but the surgery is performed, with the fully-informed consent of the patient, for:
      (i) the control of menstruation for hygienic purposes;
      (ii) the prevention of pregnancy in a female; and
      (iii) prevention of ability to impregnate by a male.
   (d) *Involuntary non-therapeutic sterilization:* this classification would be for the same procedures as in (c) (above) but where the person is not competent to give consent.
2. That therapeutic sterilizations fall within the broader provisions respecting medical treatment proposed in the Law Reform Commission's forthcoming Working Paper on treatment in the criminal law.
3. That, for the purpose of criminal law, mentally handicapped persons who understand the nature and consequences of the sterilization procedure and are under no coercion or duress should have the same options to consent to, or to refuse, sterilization as other persons.
4. That, for the purpose of criminal law, a judicial hearing be held to determine competence to consent to sterilization according to the

following criteria and procedures:

(a) a hearing be initiated to ascertain whether an individual has the capacity to consent if any one of the following circumstances prevail:
  (i) the presumption of an individual's capacity to consent is questioned;
  (ii) the request for sterilization has emanated or can be presumed to have emanated from a third party;
  (iii) there is any indication that the individual requesting his or her own sterilization is specially susceptible to coercion or undue influence to consent to such treatment.

(b) the hearing be held in the Unified Family Court; however, in the absence of such a court, it be held in a superior, county or district court;

(c) the finding of the capacity of the individual to consent be dependent on the individual's ability to understand the nature and consequences of the medical procedure of sterilization;

(d) the individual be represented at such hearings by a person who, the court is satisfied, will provide independent advocacy on behalf of the individual;

(e) a right of appeal to a superior appellate court be provided by law;

(f) if the court rules that an individual's decision to be sterilized or not to be sterilized is valid, the particular choice of the patient may be relied upon by the physician as discharging his or her responsibility to obtain and record the proper consent of the patient according to usual practice;

(g) if the court rules that an individual is incompetent, an advocate be appointed by the court to act on behalf of the individual for any sterilization authorization board hearing;

(g) all findings, judgments, and orders of the court in competence hearings pertaining to sterilization be filed with the sterilization authorization board.

5. That in any case where there is no valid consent and in the case of any person younger than sixteen years, no non-therapeutic sterilization be permitted except with legal authorization provided by a board established for that purpose and operating according to the following criteria and procedures:

(a) any person appearing before the board be represented by an independent advocate judicially appointed or acceptable to the board;

(b) the board be composed of a multidisciplinary team of persons qualified to evaluate the medical, social, and psychological benefits of sterilization to the individual and to determine if there is a compelling interest to justify the operation;

(c) appointments to the board be made by the provincial minister or ministers responsible for the mentally handicapped from a list prepared by the government authority responsible for persons who are minors or incompetents in the applicable province;

(d) appointments to the board include:
  (i) persons capable of assessing relevant medical and psychological evidence;

(ii) persons such as advocates capable of assessing social and ethical evidence, and lay persons with expertise in mental handicap or human rights;
(iii) a lawyer with the jurisdiction to determine questions of law arising in any proceeding.

(e) the board be required to ensure that the following minimum criteria are established before authorizing a sterilization procedure:
(i) the individual is probably fertile, and there is some evidence to that effect;
(ii) the individual is both of child-bearing age and sexually active and other forms of contraception have proved unworkable under the particular circumstances of each case or are inapplicable so that pregnancy is a likely consequence;
(iii) there is more compelling evidence than age or mental handicap alone that childbirth itself or childrearing itself will probably have a psychologically damaging effect on the individual;
(iv) the sterilization will not in itself cause physical or psychological damage which will be greater than the beneficial effects to the individual, based on a comprehensive medical, psychological and social evaluation;
(v) the views of the individual have been taken into account in the determination regarding whether or not to sterilize; and

(f) the board be required to maintain a transcript of the proceedings and submit reasons for its decision including the basis of its conclusions of fact and consideration of other alternatives,

(g) a right of appeal from the decision of the board be provided by law on matters of both fact and law,

(h) an independent, external evaluation of the sterilization authorization boards be carried out every two years and the evaluation procedures be placed within the jurisdiction of human rights commissions.

Medical treatment and criminal law

The Law Reform Commission of Canada has published Working Paper No. 26 in its Protection of Life Series under the title "Medical Treatment and Criminal Law". The Paper points out that a comprehensive study of potential criminal liability for the administration of treatment had not previously been undertaken. A preliminary examination had revealed an anomaly between a plain interpretation of the Canadian Criminal Code and contemporary medical practice particularly in the terminal treatment situation.

In the Commission's view the criminal law provides a basic system of fundamental values to guide human activity and is thus a likely instrument to reflect contemporary social thought on biomedical issues. Concern had been expressed that advancing technology, providing control over life and death, could be dictating the

prerequisites to treatment, rather than treatment being decided on the basis of individual rights within a context of social review.

The Paper undertakes a basic examination of the content and policy of the present criminal law as it relates to medical treatment. It then evaluates that policy in the light of modern thought and development. The Commission favours the drafting of a new offence for the wrongful administration of treatment, the substance of which would be based on the recommendations contained in the Paper.

The Commission thus summarises its provisional recommendations—

In this Working Paper, the Law Reform Commission has primarily sought to preserve societal interests in the preservation of life, health and personal integrity and in keeping dynamic and competent healing professions. Through an examination of the present law and of contemporary medical and ethical standards, it has been shown that the criminal law does not accurately reflect either the expectations that individuals have when they seek and receive treatment, or the assurances of immunity that professionals desire before undertaking treatment. A reconciliation of this differential can be achieved through changes in the present law according to the following principles.

The administration of treatment by qualified personnel in the pursuit of continuing life and health is to be differentiated from other intrusive acts upon the body of another. The value of treatment makes its administration special among offences against the person. However, there is still the need to assure that this everyday activity be performed according to precise and ascertainable criteria in the Criminal Code.

Individual rights to security of the person and privacy must be protected by the requirement of knowledgeable consent and recognition of the right to refuse treatment. If, through either legal or factual disability, an individual is unable to consent, his/her interests must be fairly and accurately represented and protected according to usual legal procedures. However, there are situations, such as an emergency, when assisting personnel should be able to act to preserve life and health despite the absence of consent.

The differentiation of treatment from other offences against the person is based primarily on the recognition of the competence and high ethical standards of our healing professions. At the same time, realistic expectations of standards of professional care must be implemented. This involves the adoption of a flexible standard based on reasonableness and on the particular circumstances of each case.

Because of the dependence of individuals upon health care services, the legislators have the obligation to ensure that essential needs will be met, especially if an individual is unable to secure the service himself. This obligation has developed to professionals who willingly undertake to provide treatment; but the role of legislators continues. Thus, the Criminal Code has traditionally required persons to provide treatment if they have undertaken to do so or if they are responsible for disabled persons. These obligations should be maintained and expanded, if necessary, to guarantee all Canadians a basic security of the person.

These broad principles may best be effectuated through implementation in the Criminal Code of the following recommendations:

(1) that the administration of treatment continue to be regulated by the Criminal Code but be distinguished from certain other acts of application of force which are considered to be criminal;
(2) that the concept of treatment be recognized for the purposes of the Criminal Code as a process oriented towards the therapeutic alteration of individual health conditions resulting from disease, illness, disability or disorder;
(3) that treatment and non therapeutic interventions be distinguished by the criminal law, the former being considered as prima facie legal;
(4) that the provisions of the Criminal Code apply to non-therapeutic interventions as for any other acts involving the application of force and wounding, but that a defence be available to prevent certain of them from constituting a criminal offence;
(5) that individual consent continue to be recognized as one of the essential conditions of the legality of the administration of treatment;
(6) that what constitutes a legally valid consent to treatment, for the purposes of the criminal law, be determined according to the standards evolved by case law;
(7) that treatment shall not be administered without the consent of the individual treated, unless there is or has already been a finding of incompetence or another specific exception recognized by law;
(8) that the judicial finding of incompetence be made by a Superior, a District or a County Court;
(9) that decisions regarding non-therapeutic interventions on incompetents, be made by a provincial board established for this purpose;
(10) that the right of a competent adult to refuse treatment be specifically recognized by the Criminal Code;
(11) that treatment shall not be administered against an individual's refusal unless there is a finding of incompetence or an exception recognized by law;
(12) that treatment can legally be administered to an individual without the necessity of obtaining his consent, in a situation of emergency, where that individual is incapable to express his consent;
(13) that the right of a competent individual to refuse treatment in a situation of emergency be recognized;
(14) that the acceptable minimum standard required from a qualified person in the administration of treatment be the knowledge, skill and care of a competent similarly qualified person performing the same act in similar circumstances;
(15) that the standard of reasonable knowledge, care and skill recommended above apply also in emergency situations, taking into consideration the particular circumstances of the case;
(16) that the acceptable minimum standard for the unqualified person in the administration of treatment be that of the reasonable, ordinary person and not that of the qualified person;
(17) that where a person holds himself out as having certain qualifications and where the public or the individual treated rely on these qualifications, that person be judged according to the standard of the qualified person he represented himself to be;
(18) that the substance of the present provisions of the Criminal Code concerning duties tending toward the preservation of life be retained;

(19) that these provisions be extended to apply also where there is a danger of permanent injury to a person's health;
(20) that the Criminal Code make separate provisions for the general duty of reasonable knowledge, care and skill in the performance of dangerous acts and for the duty of reasonable knowledge, care and skill, in the administration of treatment by qualified professionals;
(21) that the duty of reasonable knowledge, care and skill apply upon the undertaking of the administration of treatment;
(22) that an exception to the duty to undertake or to continue a treatment be recognized when necessary resources are not available;
(23) that the Criminal Code recognize the general duty to render assistance to an individual in danger, where the life or health of that person is seriously threatened and the circumstances are such that the person is aware of the emergency and can provide immediate assistance without undue hardship to himself.

Consent to medical care

The Law Reform Commission of Canada has published a Study Paper in its Protection of Life Series under the title "Consent to Medical Care". Chapters in the Study deal with the doctrine of informed consent; how are consent in the medical relationship and the underlying principles of autonomy, inviolability and privacy affected by "disability" of the patient or research subject; and criminal law aspects of consent to medical interventions.

The major specific recommendations made in the Paper are thus summarised by the author—

A. *At a conceptual level*

1. That both criminal and civil law controls and remedies be retained in the area of consent to medical care.

2. That the rights to autonomy and inviolability be distinguished from each other and recognized.

3. That for the purposes of legal analysis and precedent, a distinction be made between the traditional doctrine of consent and the new doctrine of "informed" consent. The latter being wider will encompass the former, though the opposite proposition is not true.

4. That a distinction be made between the patient's consent to the medical contract and his consent to medical care.

B. *At a practical level*

1. That the general rule should be that the patient's "informed" consent to all medical procedures must be obtained. This means that information about the nature of the proposed procedure and its attendant risks which a reasonable man in the patient's position would want to know, or which the doctor knows the particular patient would want to know, must be explained to the patient. In general the less necessary the procedure and the greater the risks, the more stringent is the content of the duty of disclosure. The doctor may reply on the patient's consent as being valid if there is apparent, subjective understanding of this information by the patient.

2. That the above general rule may be cut down in its operation by application of the doctrine of "therapeutic privilege". This means that in a particular case telling the patient some, or all, of the information required to be given under the general rule, would, *in itself,* harm him physically or mentally. It is not sufficient for operation of the privilege that the required disclosure would affect the patient's decision-making. Further, the privilege being an exception is to be construed narrowly, and being a justification the burden of proof of its applicability is on the person relying on it, namely the doctor.

3. That information be disclosed and consent obtained in as non-coercive a manner, language and situation as is possible. Except in very rare circumstances, deception is unacceptable. Further, there must be a constant concern to protect and be sensitive to the rights of privacy of the patient.

4. That both the necessity to inform the patient and to obtain his consent be seen as continuing requirements.

5. That it should be emphasized that the purpose of the doctrine of "informed" consent is protection of the patient.

6. That in life threatening situations when the patient refuses treatment, it is a policy decision as to whether the requirement for consent should be dispensed with by the law. In emergency situations where it is impossible to obtain consent a defence of necessity should apply.

7. That consent be regarded as a necessary, but not sufficient, justification for a medical intervention.

8. That consent to any significant medical intervention be obtained before a third party witness and be evidenced in writing.

9. That the coercion naturally present in the doctor-patient relationship, and especially the doctor-dying-patient relationship, be recognized.

10. That with respect to consent to medical interventions on children:

(a) the "mature-minor" rule should be clearly established;

(b) the term "proxy consent" should be abandoned and replaced by either parental authorization or permission;

(c) the parent may consent to therapy on the child not yet within the scope of the "mature-minor" rule. The child should have a right of objection or veto, but this may be overridden by the parent with justification;

(d) except in extremely rare circumstances a parent may not consent to non-therapeutic, or more than minimal risk personally non-beneficial interventions on the child;

(e) special protection must be given to institutionalized children with respect to consent to medical interventions on them.

11. That with respect to consent to medical interventions on foetuses:

(a) where therapy is involved the same rules apply as for non-discerning children;

(b) where the intervention is non-therapeutic for the foetus but directed at therapy for the mother the mother's consent is adequate;

(c) in all other cases any rules on consent should recognize the mother's, and possibiy a medical research physician's, conflict of interest.

12. That with respect to consent to medical interventions on mental incompetents:

(a) their consent should be sought to the extent that they are capable of giving it;
(b) in cases where the mental incompetent is factually incapable of consenting the same rules should apply as suggested for non-discerning children, including institutionalized children.

13. That with respect to medical interventions on prisoners;
(a) the prisoners' "informed" consent to all medical treatment must be sought. The only exception to treating a prisoner without consent is where he has a disease state threatening the health or well-being of other prisoners;
(b) a very high degree of care must be taken to counteract the coercive effects on consent, of the institutionalization and deprivation suffered by prisoners.

Sanctity of life

The Law Reform Commission of Canada has published a Study Paper as part of a research project it has undertaken on protection of life issues in the biomedical context. The Paper, under the title "Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law", has been prepared by Edward Keyserlingk, the co-ordinator of the project.

The author explains that although the Paper is written in the context of a law reform project, it is not primarily a legal analysis, nor does it make, at least in legal language, specific law reform proposals. Its purpose is that of a background paper, and its perspective is largely ethical (philosophical and religious). It seeks to do four things. First of all, to describe and evaluate from that ethical perspective some of the major views and trends today on those related and somewhat elusive subjects of "sanctity of life" and "quality of life" in the medical context. Secondly, to make some reasoned choices and proposals. Thirdly, to indicate some of the implications and priorities of the ethical and value analyses and proposals for law and law reform. Fourthly, to indicate and encourage the interaction of law and morals, yet draw attention as well to the differences in perspectives and priorities.

Detailed conclusions are contained in the body of the 224 page study. Part IV of the Paper entitled "Conclusions: Some Priorities for Public Policy and Law" is set out below—

Preamble

(1) On the one hand law is entitled to address itself to the issues dealt with in this paper. There are important individual and societal values to be underlined, rights and duties to be protected, public debate to be invited and formal decision-making and conflict-resolution processes to be used and evolved. All of these, in part at least, are the proper tasks of

the legislative forum (Parliament and Provincial Assemblies) and of legal justice (laws and courts). The former to focus public debate and formulate public policy, the latter to dramatize and articulate the ideals of legal justice—impartiality, objectivity, consistency, fairness and equality.

(2) But on the other hand (as noted in the Introduction), the mere presence of endangered values and rights or of immorality does not necessarily mean in every instance that law should be brought more directly and frequently into play. In some instances it may be too blunt, too insensitive to better the situation. More law and legal process may in some instances only further bureaucratize and depersonalize a medical system which, by general consensus, has already gone too far in that direction.

Wherever possible there should be room for both an ethic of rights and an ethic of responsibility in any law reform proposal. The general maxim that law should play a limited, "last resort" role is applicable to our issues. In many instances there may be people, processes and socializing agencies at more fundamental, more immediate levels better able to encourage responsibility and protect the rights in question. About any particular medically oriented issue there is therefore some onus on legislators and law reformers to establish not only that this or that particular law is better than another, but that law itself belongs here, is likely to do a better job than another and perhaps less intrusive means or at least likely to play a useful supplementary role.

(3) When it comes to the formulation or re-formulation of particular public policies, laws or law reforms in this area, an essential and primary consideration is the determination of just where the real problem is, which particular issue should be regulated or legislated to best cope with a perceived problem and endangered rights, and which issues if directly regulated or legislated in might actually finish by only further depriving these or other patients of the very rights one seeks to better protect.

(4) Legislation or any other form of social policy enacted or reformed in any of the areas discussed in this paper, should not seek to provide for physicians a form of "no fault" immunity from prosecution or civil suits. Even if such legislation were feasible, it would not likely promote the high standard of care encouraged by continuing to allow all such medical decision-making to be reviewable by courts, and by continuing to allow physicians (and others involved in these decisions) to be responsible for their decisions and actions. Rather than seeking full legal immunity, physicians should continue to accept the responsibility of sometimes allowing a patient to die by ceasing or not beginning useless or burdensome-to-patient treatment, and at other times accept the responsibility of not neglecting patients who are treatable and able to be cared for, even though their quality of life is minimal. In any clarification of responsibility and liability in these matters, it should be stated or assumed that the sanctity of life principle imposes a greater burden of proof on those who would allow to die than on those who would continue to treat.

(5) In view of the fact that this paper was not intended to be an in-depth analysis and evaluation of existing law, the specifics which follow are not necessarily meant to be proposals for law reform. In some instances at least, the law may already adequately reflect the (moral)

concerns expressed in these specifics. That is for others to determine. They are offered only as a summary and selection of some of the moral considerations dealt with in this paper, those which ought to be central concerns in public policy, law and law reform as regards the protection of both the sanctity of life and the quality of life.

Specifics

(1) Public policy and law should (continue to) affirm and protect the absolute value, equality and "sanctity" of human life, and continue to prohibit (active) euthanasia for any reasons. But at the same time, it should make explicit that what it is affirming and protecting is the absolute value of human personal life, of persons.

(2) Public policy and law should acknowledge that sometimes death of the person may and will have to be established by a quality of life criterion, namely that of irreversible brain death (either of the whole brain or of the cerebral centres). And this even though human biological life in the form of circulatory and respiratory function continue, either spontaneously (in the case of cerebral death only) or artificially (in the case of whole brain death). It should be explicitly affirmed that physicians have no legal liability for not initiating or for ceasing "life" saving or "life" supporting treatment in such cases of biological human life alone, assuming of course that all the necessary tests have been carefully made.

(3) Public policy and law should acknowledge that even in the presence of human personal life there can exist good quality of life reasons for not initiating or for ceasing medical treatment. Applied to both competent and incompetent patients the determinative criterion is the patient's perspective, the patient's benefit. In the case of competent patients, they should be free to interpret and determine what is to their benefit by themselves, refusing treatment on any grounds they wish. Decisions by others for incompetent or incoherent patients should be made according to the "reasonable person" test, determining both whether the treatment is useful and whether it would occasion serious patient-centered objections or burdens. Physicians who cease or do not initiate life saving or life supporting treatment either because the treatment is not useful, or would occasion a serious patient-centered objection, or both, should not incur legal liability.

(4) But if quality of life criteria are to be given any normative value in public policy and law for purposes of determining whether a particular medical treatment is (or was) useful as well as not excessively burdensome to the patient, then two serious dangers must be protected against. It is by no means certain that adequate protection can in fact be included in such laws and public policies.

The first danger would be to leave the term "quality of life" too vague and general, simply allowing "reasonable medical judgment" to determine the meaning and normative weight to be given to quality of life factors in given cases. Unless relevant public policy and law can articulate and defend some substantive quality of life criteria, the mere recognition of such criteria in general without any further specificity would probably be at best unhelpful, and at worst dangerously vague.

In other though related matters laws have usually been formulated in somewhat general terms, leaving it to the particular profession to deter-

mine and add the specifics to general (legal) standards such as "reasonable care and skill". But in the matter of quality of life standards in the medical context, this (traditional) manner of formulating relevant law would probably be inadequate. "Quality of life" as a norm for life and death medical decision-making is too elastic a term, and too much in need of public review and control to be "legalized" without carefully drawn definitions and parameters. Whether laws can in fact be moved in this direction in this matter is for others to decide.

The second danger in such a recognition would be to articulate quality of life criteria which have not been purged of any connotation of social utility, relative worth or merely subjective considerations. Such criteria would expose incompetent and non-competent patients to more risks than benefits. Therefore the criteria should not only be substantive, but as objective and patient-oriented as possible.

The two criteria suggested in this paper merit consideration. The first considers the patient's capacity to experience and relate. The second considers the intensity and the susceptibility to control of the patient's pain and suffering. If, even with treatment and loving care, a reliable diagnosis and prognosis indicates that there is not now and apparently never will be even a minimal potential capacity to experience and relate, or that the level of pain and suffering will be prolonged, excruciating and intractable, then and only then would a decision to cease or not initiate life supporting or life saving treatment for an incompetent or non-competent patient be beneficial and acceptable.

(5) It should be clear and explicit in public policy and law that all patients have the right to refuse treatment by withholding consent, even if death will inevitably result. This applies to both competent and incompetent patients. The competent should make such decisions for themselves, and for the incompetent or incoherent, a previously chosen agent, family member, or court appointed guardian (and in that order of authority) would exercise that right for them. The mere refusal of a "dying-prolonging" treatment by a competent patient should not be used as grounds for declaring a person incompetent.

(6) In the case of presently incompetent or incoherent (but formerly competent and coherent) patients, it should be clearly recognized in public policy and law that their wishes regarding initiation, continuation or cessation of treatment which were clearly and knowledgeably expressed when competent and coherent, are to be now respected.

(7) Since, as this paper has argued, medical (curative) treatment may be stopped under certain circumstances, though care or comfort continue to be morally obligatory, the law should recognize and define as clearly as possible the distinction between what I have called "(curative) treatment" and "(palliative) care". Clarity in this regard would make it possible to establish with (more) accuracy in what sorts of circumstances it is the physician's duty to treat as well as care, and when no such duty to treat exists, but only one of caring.

(8) Knowledgeable and informed medical decisions by patients or proxies to initiate, continue or cease treatment on the basis of quality of life considerations are impossible without full information and understanding as to the diagnosis, prognosis, risks and benefits involved. Such information and understanding is obviously all the more crucial in decisions involving life supporting or life saving treatment. Therefore

any relevant public policies and legislation concerning medical decision-making of this nature should be clear and unambiguous as to the patient's right not only to withhold consent, but also to be fully and clearly informed, and the physician's duty to so inform. When necessary of course, both the patient's right to be fully informed and the patient's right to withhold consent, will be exercised by a proxy (or proxies) for that patient.

Canada – Manitoba

Transexuals and birth certificates

The Manitoba Law Reform Commission has recommended that transexuals born in the province and certifiable in their sex changes be granted amended birth certificates showing their preferred sex. The two-year study had been initiated at the request of transexuals fearful that if convicted of a crime they might be sent to a correctional institute for inmates of an inappropriate sex.

The Commission has suggested the establishment of an ad hoc committee of specialists to prove the gender of an applicant.

Limitation of actions by children and disabled persons

The Law Reform Commmission of Manitoba has published a Working Paper on "Limitation of Actions by Children and Disabled Persons". The Working Paper deals with the following four inadequacies in the province's Limitation of Actions Act (C.C.S.M. Cap.L150) highlighted in part by the decision of the Manitoba Court of Appeal in *Mumford* v. *Children's Hospital of Winnipeg et al* [1977] 1 W.W.R. 666 (Man. C.A.) –

(a) the immunity of the medical profession and certain other professions and interest groups from the special protection given to children and disabled persons,
(b) the uncertain duration of the extension permitted by those special provisions,
(c) the peculiar difficulties of applying the special provisions in the case of disabled persons,
(d) the uncertainty of some of the provisions relating to discretionary time extensions under Part II of the Limitation of Actions Act.

The Commission's provisional recommendations are summarised below –

(i) the special time extension provision for children and disabled persons contained in s. 9 of the Limitation of Actions Act should be extended to apply to all sections for personal injury, whether covered by s. 3(1) of the Act or by the various statutes referred to in s. 6 of the Act, and to actions under the Fatal Accidents Act;

(ii) the special time extension provisions for children and disabled persons contained in ss. 9 and 58(1) of the Limitation of Actions Act should be re-worded to ensure that an action may be commenced at any time during the period of infancy or disability;

(iii) although some members of the Commission would prefer that the special time extension provision for children and disabled persons should be discretionary, the majority are presently of the view that it should remain an absolute right;

(iv) there would be little to be gained from permitting potential defendants to demand the commencement of actions during the period of infancy or disability;

(v) the special time extension provision for children and disabled persons should not be restricted to cases where the plaintiff is not in the custody of a parent, guardian, committee or trustee;

(vi) the special time extension provision for disabled persons under s. 9 of the Limitation of Actions Act should be available for disabilities occuring during the normal limitation period as well as for those in existence when the cause of action arose;

(vii) the definition of "disability" should be expanded to cover all forms of mental or physical impairment which render persons incapable or substantially impeded in the management of their affairs;

(viii) the discretionary time extension provisions in Part II of the Limitation of Actions Act should be clarified to ensure that a subjective standard is applied by the courts in determining, in accordance with s. 21(7), whether material facts were within the knowledge of the plaintiff;

(ix) although some members of the Commission believe that failure to understand one's legal rights should be treated as a "material fact" for the purpose of an application for a discretionary time extension under Part II of the Limitation of Actions Act, the majority are presently of the opinion that it should not.

Mental health legislation

The Law Reform Commission of Manitoba has published Report No. 29 under the title "Emergency Apprehension, Admissions and Rights of Patients under 'The Mental Health Act'". The Commission concludes that law of Manitoba in this area, contained in the Mental Health Act (C.C.S.M., Cap.M.110) has many shortcomings. The Report makes reference to the limited role of the police in the administration of this legislation and, in general, the unsatisfactory emergency apprehension procedures it now provides. It touches on the rather extensive and far-reaching power of the Director of Psychiatric Services; the limited responsibility in tort of hospital

personnel; the lack of attention to the civil rights of the individual; the possibility of indefinite committal which this legislation contains, and its general inattention to the principles of natural justice.

The Report acknowledges and considers the views of the medical profession as they have thus far been expressed to the Commission. The Report compares Manitoba's Mental Health Act with the legislation in Ontario and Alberta, as well as with that in the other Canadian provinces and some American jurisdictions.

The Report states that on the whole, the Commission was impressed by the Ontario and Alberta statutes and the solutions in them to the problem of reconciling the interests of society in preserving safety and health and safeguarding the liberty of the individual. The Commission believed that with some modification such provisions would be appropriate for enactment in Manitoba. The Act should provide some periodic or easily accessible review procedure, similar to that provided in Ontario. The criteria for committal should be made more precise; and strict time limits should be set on the period of confinement. The proposals are intended to provide a comprehensive scheme for (1) the admission of persons to mental institutions, (2) the periodic review of these patients, and (3) their release, the basis of which is a fair balance of the interests of the mentally ill with those of the public at large.

The following is the Commission's summary of their Report's recommendations—

1. A person should be admitted to a psychiatric facility for compulsory observation and assessment, only upon:
   (a) the medical certificate (called a "Medical Order for Psychiatric Assessment") of a single medical practitioner or psychiatric nurse duly qualified or registered to practise in the province; or
   (b) the order (called a "Judicial Order for Psychiatric Assessment") of a provincial court judge; or
   (c) the emergency apprehension and conveyance to the hospital by a peace officer designated under the Criminal Code (called an "Emergency Police Apprehension for Psychiatric Assessment").

The procedure for voluntary admission to a psychiatric facility for observation and assessment should be handled by the facility like any other voluntary admission.

2. (a) A "Medical Order for Psychiatric Assessment" should be signed and dated by the practitioner or psychiatric nurse who personally examined the person named in it, no later than within seven days of the examination and the medical order should cease to have any force and effect unless it is presented to the hospital in question within seven days of the time of the signature of the practitioner or psychiatric nurse.
   (b) The practitioner or psychiatric nurse who signs a "Medical Order for Psychiatric Assessment" should be required to state his or her belief based on reasonable grounds that the

person in respect of whom the order is made

(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(ii) has behaved, or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has shown or is showing a lack of competence to care for himself,

and in addition, that the person is apparently suffering from mental disorder of a nature or quality that is likely to result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person.

(c) The practitioner or psychiatric nurse who signs a "Medical Order for Psychiatric Assessment" should be required to state the facts upon which he/she bases his/her belief as above, that the person is apparently suffering from mental disorder. The practitioner or psychiatric nurse should also be required to distinguish as between those facts observed and those communicated to him/her.

3. (a) A valid and subsisting "Medical Order for Psychiatric Assessment" should be sufficient authority for anyone to take the person who is the subject of the order into custody and to convey the person to a psychiatric facility forthwith.

(b) Upon receipt by a peace officer of a valid and subsisting "Medical Order for Psychiatric Assessment", the officer should be required to do all things necessary to take the person who is the subject of the order to a psychiatric facility forthwith.

4. (a) When information upon oath is brought before a provincial court judge or magistrate that a person

(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has shown or is showing a lack of competence to care for himself,

and in addition, based upon information before him the judge or magistrate has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person,

the provincial court judge or magistrate should be empowered to issue a "Judicial Order for Psychiatric Assessment" of the person.

5. Where a peace officer has reasonable cause to believe that a person

(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has shown or is showing a lack of competence to care for himself,

and in addition the officer is of the opinion that the person is apparently suffering from mental disorder of a nature that likely will result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person,

and that it would be dangerous to proceed for a "Judicial Order for Psychiatric Assessment", he should be enabled to make an "Emergency Police Apprehension for Psychiatric Assessment" of the person.

6. (a) A peace officer who takes a person into custody either pursuant to a medical order, judicial order, or emergency police apprehension for psychiatric assessment should be required to convey the person forthwith to a psychiatric facility for observation and examination.

(b) A patient who arrives at a psychiatric facility pursuant to a medical order, judicial order, or emergency police apprehension for psychiatric assessment should be accepted by the facility for psychiatric observation and assessment.

(c) A peace officer who takes a person in custody to a psychiatric facility should be required to remain at the facility and retain custody of the person until the facility accepts him for observation and assessment.

7. (a) A person who arrives at a psychiatric facility pursuant to a medical order, judicial order or emergency police apprehension for psychiatric assessment should be examined forthwith upon his arrival at the facility, but in any event not later than within 48 hours, by a psychiatrist duly qualified to practise in the province.

(b) Although medical officers on staff at psychiatric facilities should be empowered to detain, restrain and observe a person once he or she is admitted for assessment, no general power should be invested in the medical personnel to treat a person during the 48 hour period in which he/she is detained, except to the extent that it is necessary for the purpose of relieving immediate danger to the admitted person or to others, or to the extent that it is necessary to permit the required psychiatric assessment to be made.

(c) A person who, following psychiatric assessment, is not certified for admission to the facility either as a voluntary or as a compulsory patient is to be released forthwith, but in any event within 48 hours of his arrival.

8. (a) As soon as possible after his arrival at a facility for psychiatric assessment, a person is to be advised, in simple language, of

his rights under the legislation, in particular the reasons and period of his detention, his right of release and his right to apply to the provincial Mental Health Review Board for a review. Efforts to contact next-of-kin should be required to be made at this time.

(b) An interpreter should be provided where there is language difficulty.

9. (a) A person may be admitted to a psychiatric facility as a voluntary patient where the psychiatrists conducting the examination for assessment are of the opinion that he suffers from a mental disorder of such a nature that he is in need of the treatment provided in the facility and that he is suitable for admission as a voluntary patient. The method by which the patient arrives at the psychiatric hospital should not determine his status.

(b) A voluntary patient should have the right to be discharged within a reasonable period of time following his request for discharge unless there are already in existence at that time two admission certificates duly completed for his compulsory committal. Eight hours would be a reasonable period of time in these circumstances.

(c) Every member of the staff of a psychiatric facility should have the responsibility to bring to the attention of the Superintendent of the facility or other medical officer in charge of the psychiatric facility in question every request for discharge which he or she receives from a voluntary patient.

10. A person should only be admitted to a psychiatric facility as a compulsory patient, or alternatively his admission should be extended only where, following separate psychiatric assessments by them, two psychiatrists duly qualified to practise in the province, independently issue their certificates of admission or renewal, as the case may be. Psychiatrists should be required to certify that in their opinion the person is suffering from mental disorder of a nature that likely will result in serious bodily harm to the person; serious bodily harm to another person; or imminent and serious physical impairment to the person unless that person remains in the custody of the hospital and that the person is not suitable for admission or continuation as a voluntary patient.

11. Every admission and renewal certificate should be dated and signed by the psychiatrist who issues it. In addition, each should show the date and time that the personal examination was made and the facts upon which the psychiatrist formed his opinion as to the nature of the disorder, distinguishing the facts observed by him from the facts communicated to him by others.

12. (a) Two certificates of admission should be sufficient authority to detain a person at a psychiatric facility for a period of no more than one month.

(b) Certificates of renewal to extend the compulsory confinement beyond one month should be invalid unless they are issued within specified periods of time. These periods should be—

(i) within one month from the date of the person's admission as a compulsory patient, that is, within one month from the issuance of the two certificates of admission;

(ii) within two months from the date of the first renewal certificates;

(iii) within three months from the date of the second renewal of the certificates and every renewal thereafter.

13. A compulsory patient whose authorized period of detention, either on admission or renewal, has expired, should thereupon become a voluntary patient. The patient and his/her nearest relatives should thereupon be advised of the changes in his/her status, and the patient's right to discharge upon eight hours' notice.

14. A compulsory patient whose authorized period of detention either on admission or renewal has not expired, should nevertheless be continued a a voluntary patient where, in the opinion of the attending psychiatrist, it would be appropriate. In his case, the certificates of admission and renewal should be deemed to be cancelled and the patient and his/her nearest relative should be so advised.

15. Upon his admission and later upon his continuation as a compulsory patient and upon every subsequent extension of his detention, a patient should have the right, on request, to have an independent assessment of himself by a psychiatrist of his own choice.

16. (a) Upon his admission or continuation as a voluntary or as a compulsory patient, both the patient and his nearest relative should be informed in simple language of the reason for his detention. He should also be given a written statement of the authority for his detention, the period thereof, of his right to communicate with counsel and the Ombudsman, and other appropriate parties, and in the case of a compulsory patient his right to an independent psychiatric assessment by his own psychiatrist or by a psychiatrist he selects; in the case of a voluntary patient his right to request discharge. The existence of the office of the "Patients' Advocate" should also be made known to all patients at this time.

(b) A statement made to a compulsory patient should also include information concerning the existence and function of the Review Board(s), the name and address of the Chairman of the appropriate board, and the patient's right to apply to the Board at specified intervals for cancellation of the admission or renewal certificates then in force.

(c) The information concerning the patient's rights which is contained in a written statement given to him should be supplemented by posters on display in all psychiatric facilities in the province. The posters should also advertise the existence and availability of Legal Aid, the Ombudsman and the office of the Patients' Advocate.

17. (a) A Patients' Advocate should be available in all psychiatric facilities to intercede in matters concerning the rights of

mental health patients, such advocates could possibly be established through the office of the Public Trustee.

(b) Where a person is admitted or continued as a voluntary patient or admitted or continued as a compulsory patient in a psychiatric facility the medical director or other officer in charge should be required to forward a notice in writing of that fact to the office of the Patients' Advocate.

(c) Where there is a conflict of opinion as between the psychiatrist at a hospital and a psychiatrist selected by a patient to conduct an independent psychiatric assessment of him, the medical director or other officer in charge of the facility should forward a notice to that effect to the office of the Patients' Advocate.

(d) A notice to the office of the Patients' Advocate should contain information advising the advocate of the presence of the patient at the facility, the date of his arrival, the date of his admission, his status in the facility, as well as other information needed to facilitate the bringing by the patient, or the advocate on his behalf, of an application for review, a notice for discharge and a request for independent psychiatric assessment.

18. (a) The province should establish a Mental Health Review Board for the purpose of hearing and considering applications from compulsory patients for the cancellation of admission or renewal certificates.

(b) In addition the Mental Health Review Board should automatically, at least once a year, review the case of every compulsory and every voluntary patient who has been in a psychiatric facility for a year or more.

(c) The Mental Health Review Board should consist of one or more three member panels, the members of which should be appointed by the Minister of Health and Social Development for the province and should include at least one psychiatrist and at least one barrister or solicitor.

19. The Commission is unable to present a majority recommendation on the issue of membership on review panels. We therefore suggest one of the following be adopted—

19A. (a) No person who is serving as a member of the staff of a facility should be eligible to sit as a member or alternate member of the review panel when the panel is considering the case of a patient of that facility.

(b) No member of the Review Board should sit on a panel when the panel is considering the review of a patient or former patient, client or former client or relative of a member of the review panel in question.

OR:

19B. (a) No person who is actively serving as a member of the staff of a facility should be eligible to sit as a member or alternate member of a review panel when the panel is considering the case of a patient of that facility.

(b) No member of the Review Board should sit on a panel when

the panel is considering the review of a patient or former patient, client or former client or relative of a member of the review panel in question.

(c) Members of a barrister and solicitor or a psychiatrist's family should also be excluded from sitting on a panel when the panel is considering the review of a patient or former patient, client or former client of the barrister and solicitor or psychiatrist in question.

OR:

19C. (a) No person should be eligible to sit as a member or alternate member of a review panel when the panel is considering the review of a patient with whom he or she is acquainted.

20. (a) A compulsory patient or a person on his behalf should have the right to apply to the chairman of the Mental Health Review Board for cancellation of the admission or renewal certificates under which authority he is detained, but he should be permitted to make no more than one application with respect to the initial admission and to each subsequent renewal.

(b) Within 28 days of the receipt of an application by the chairman or such longer period as the Minister allows, the review panel appointed to hear the review should hear and consider the application.

(c) The panel which hears the review should be required to reach its decision within 14 days after completing the hearing.

(d) Within seven days of the date of its decision, copies of the decision of the review panel, including in the case of an adverse ruling, a notice regarding the right to appeal the decision, should be sent to the applicant, his nearest relative, and the office of the Patients' Advocate as well as to any other person interested in or present at the hearing.

(e) A decision of the Mental Health Review Board should be binding upon the board of the facility.

(f) An appeal *de novo* from the decision of the Mental Health Review Board should be to the County Court as of right. Notice of appeal should be given within 28 days of the decision and may be given by the patient or someone on his behalf or by the medical superintendent or director of the facility.

21. (a) The hearings of the Mental Health Review Board should be in camera.

(b) The patient and/or his counsel or someone on his behalf, his family, and a representative of the facility should however have the right to be personally present at the hearing.

(c) Any other person should be admitted to the hearing only with the prior consent of the panel.

22. (a) The patient or his representative should receive a summary of the contents of the medical records and of the reasons for his continued detention within a reasonable time in advance of the hearing of a review panel.

(b) In addition to the provision of a summary, a patient's legal

counsel or other representative should have access within a reasonable time in advance of the hearing, to all of the patient's medical history and records at the facility.

(c) All the patient's medical history and records relating to his admission and detention at the facility should be provided to the Mental Health Review Board within a reasonable time in advance of the hearing.

23. Notice of the date of a hearing should be given to the patient, his nearest relative, counsel and the Patients' Advocate within a reasonable time in advance of a hearing.

24. A patient should have reasonable opportunity to present evidence at the hearing.

25. The Commission is unable to present a majority recommendation on the issue of free communication. We therefore suggest one of the following alternatives be adopted—

25A. A patient in a psychiatric facility should have an unrestricted right to communicate in writing and no communication which is written by a patient or sent to a patient should be opened, examined, withheld or delayed.

OR:

25B. (a) Communications written by or to a patient in a psychiatric facility by or to—

(i) a barrister or solicitor;
(ii) a member of the Mental Health Review Board;
(iii) a member of the Legislative Assembly;
(iv) a member of the Parliament of Canada;
(v) the Ombudsman;
(vi) the Patients' Advocate;
(vii) the Public Trustee; or
(viii) a psychiatrist duly qualified to practise in Manitoba,

should not be opened, examined, censored, withheld or delayed.

(b) Any other communication written by or to a patient should be subject to be opened, examined, censored, withheld or delayed only where the officer in charge of a psychiatric facility or other person acting on his instructions has reasonable grounds to believe that the contents would

(i) be unreasonably harmful or offensive to the addressee;
(ii) prejudice the best interests of the patient;
(iii) interfere with the treatment of the patient; or
(iv) cause the patient unnecessary distress.

(c) Where the officer in charge of a psychiatric facility censors or withholds the delivery of a communication either from the patient or to the addressee, a copy of the original communication should thereupon immediately be delivered to the office of the Patients' Advocate whose responsibility it should be to determine the question of delivery.

(d) Where a communication is not released to the patient or forwarded to the addressee as a result of the order of the Patients' Advocate, it should be returned to the sender.

26. (a) A patient who is in a psychiatric facility on a voluntary basis

should be permitted to vote in provincial and municipal elections.

(b) A patient who is in a psychiatric facility on a compulsory basis should not be permitted to vote in provincial and municipal elections.

27. All controversial, experimental or surgical psychiatric procedures should be subject to independent review before they are permitted whether or not the patient is voluntary or compulsory and whether or not he appears to give his consent.

28. The Commission is unable to present a majority recommendation on what form independent review should take. We therefore suggest one of the following alternatives be adopted—

28A. Any treatment of a controversial, experimental or surgical nature should be subject to review by a court before it may be performed.

OR:

28B. Any treatment of a controversial, experimental or surgical nature should be subject to review by the Mental Health Review Board before it may be performed.

29. (a) Where a compulsory patient objects to drastic treatment other than treatment of a controversial, experimental or surgical nature, the treatment in question should not be performed unless it is recommended following independent assessment by a psychiatrist selected or approved by the patient or his representative.

(b) Where the psychiatrist who conducts the independent assessment does not recommend the treatment, the attending psychiatrist who proposed the treatment should forward a notice of these facts to the Mental Health Review Board for a hearing.

30. A person who is a voluntary patient in a psychiatric facility should have the absolute right to consent or refuse to consent to treatment of any kind.

Canada – Saskatchewan

Health care and the consent of minors

The Law Reform Commission of Saskatchewan has published a paper entitled "Tentative Proposals for a Consent of Minors to Health Care Act". The proposals were prepared by the research staff of the Commission and have been tentatively adopted by the Commissioners. Comment and criticism is invited.

The paper discusses the present law in the Province and reviews relevant legislation in England, British Columbia, Ontario and Québec. It also comments upon proposals for reform made by the Alberta Institute of Law Reform and Research, and upon the Medical Consent of Minors Act adopted and recommended by the Uniform Law Conference of Canada. It is noted that a statute in that form has been enacted, with one minor departure, only in New Brunswick.

A draft Bill, which would reflect the Commission's tentative proposals is included in the paper. The Commission explains its approach in the following manner –

(i) teenagers today have adopted a lifestyle involving travel, living away from home and generally enjoying more freedom than their counterparts of earlier generations might have wished for or could have imagined. At the same time, the notion of parental authority has been undergoing change;

(ii) the age of 16 is not without legislative foundation in the Province. The Family Services Act 1973 sets 16 years as the age limit for neglected children. As well, 16 year olds can legally leave school, validly drive an automobile, and receive social assistance as an adult. It would, therefore, appear reasonable that teenagers 16 years of age and older should be capable at law of consenting to their own health care;

(iii) while it is hoped that physicians, if asked to provide health care for a patient under the age of 16, would seek the patient's permission to consult with his or her parents, it must be recognised that there will be situations where patients below the age of 16 years will be unwilling, or unable, to obtain parental consent. In such cases, the continuing health and well-being of the patient under the age of 16 should be paramount. If the physician in consultation with another physician is of the opinion that the under 16 year old is mature enough to understand the nature and consequences of the health care to be provided, then parental consent should not be necessary, unless a court decrees otherwise. In those cases where the under 16 year old is not sufficiently mature, then parental consent must be sought or a court order obtained dispensing with such consent;

(iv) in recommending the enactment of the Consent of Minors to Health Care Act in the form proposed, an attempt has been made to provide legislation that clarifies the law, recognises that all minor children have a right to adequate health care and guarantees older minors a right of privacy.

Consent of minors to health care

The Law Reform Commission of Saskatchewan has published a Report under the title "Proposals for a Consent of Minors to Health Care Act". The Commission's 1978 working paper on the subject was noted at (1979) 5 C.L.B. 466.

The Commission explains that their original intention in proposing a statute was to fix the age 16 years as the age at which persons could consent to their own health care. After further consideration and taking into account the public response to their tentative proposals, the Commission decided against recommending either a fixed age for

a minor's consent or the necessity of a second opinion as to a minor's capacity. Instead the Commission has, in redrafting the proposed statute, condified existing common law. However, since the Commission remained of the opinion that in matters of a minor's health care the paramount consideration is the welfare of the minor, the Report proposes a procedure for the judicial determination of a minor's capacity to consent to health care. The Commission points out that the recommendation for widening the ambit of ex parte orders for the purpose of the Act to allow a mature minor to consent to his or her own health care without parental notification may be an extension of the present law.

Under the Commission's draft Act it is declared that—

(i) a minor who has the capacity to understand and appreciate the nature and consequences of health care proposed to be provided to him or her may consent to that health care;

(ii) any minor who is capable of consenting to his or her own health care is capable of consenting to health care for any minor child in his or her custody;

(iii) no consent is required for health care for any minor where it is necessary in an emergency to meet an imminent risk to the minor's life or health.

There would be provision for ex parte applications to the court (with no right of appeal against the decisions given) by "a person with sufficient interest" for any of the following orders—

(a) to declare that a minor has the capacity to understand and appreciate the nature and consequences of health care proposed to be provided to him or her; or

(b) dispensing with the required consent; or

(c) prohibiting the health care where that person has reasonable grounds to believe that the minor lacks the capacity to understand and appreciate the nature and consequences of that health care.

The draft Act also sets out the matters to which the judge shall have regard in considering an application.

Definition of death

The Law Reform Commission of Saskatchewan has published a report entitled "Tentative Proposals for a Definition of Death Act". The essential question addressed in the Report is whether the law should adhere to the traditional approach and focus entirely on cardiac and respiratory functions as the only acceptable evidence of death, or whether it should focus more attention on the brain in determining what constitutes death.

It is postulated in the preface that if the traditional approach is retained, a person whose heart and lungs are kept operating through

artificial means would be deemed to be alive, even though his brain function has ceased, whereas if the test of death focuses on the brain itself, then the fact that heart and lung functions are artificially maintained is irrelevant if other reliable evidence is available which establishes that the brain has ceased to function. The Commission acknowledges that the underlying issue has philosophical, moral, religious, medical and social ramifications, all of which it did not feel competent to explore.

The Commission nevertheless considers the state of the law and some of the many interesting questions raised by the need to determine the time of death, for example, how the time of death affects the question of availability of organs for transplantation.

The Commission notes that until recently death was defined in traditional common law terms of a total stoppage of such vital functions as respiration and circulation of the blood, a definition which has been rendered unsuitable by modern medical technology and so recognised in a number of recent decisions. There have been cases involving what has been described as "corpse ventilation" or "brain death" concept. The brain death concept was considered recently in *R* v. *Kitching and Adams* [1976] 6 W.W.R. 697 in which the accused were convicted for the manslaughter of a person kept alive by the help of a respirator. There was no dispute that the accused had caused the severe and irreversible brain injury that resulted in the "death of the brain" of the deceased.

The Report cites a number of decided cases to illustrate the uncertain state of the common law as regards death and suggests that there should be a statutory definition, which is still wanting. It notes that although "death" has been defined by legislation in a number of jurisdictions in the U.S.A. and in Manitoba, such was not the case in Saskatchewan. Although there are numerous examples of Acts in which the question arises as to the time of death, in none of these is the definition of death given. The Report notes that "Problems could easily arise where a person who has given the necessary consent has suffered brain death but is being mechanically ventilated by means of a respirator. Can the doctors remove the needed organs on the basis of brain death definition, or must they wait until cardiac arrest has occurred, at which point the organs will begin to deteriorate"?

The Report also considers the state of medicine, in which it notes that there seems to be general acceptance of the concept of brain death among the medical community, although there are disagreements as to the criteria to be employed in determining whether such death has occurred. However, it states four criteria for the definition of death, proposed by the Canadian Medical Association which the Association adapted from the Harvard criteria for the definition of brain death first proposed in 1968 by the Ad Hoc Committee of the Harvard Medical School,—

(a) unreceptivity and unresponsivity of the patient: total unawareness of externally applied stimuli and inner need and complete unresponsiveness;
(b) no movements or breathing: physicians must observe the patient for at least one hour to satisfy criteria of no spontaneous muscular movements or spontaneous respiration or response to stimuli such as pain, touch, sound or light: "When the patient is on a mechanical respirator, the total absence of spontaneous breathing may be established by turning off the respirator for three minutes and observing whether there is any effort on the part of the subject to breathe spontaneously";
(c) no reflexes: pupil fixed and dilated: will not respond to a direct source of bright light. Ocular movement and blinking are absent. No evidence of postular activity. Swallowing, yawning, and vocalisation are absent. Corneal and pharyngeal reflexes are absent;
(d) electro-cerebral silence: flat EEG of great confirmatory value.

The Association further states that—

> If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with the performance of the transplantation.

The Report notes that in the United Kingdom criteria for the definition of brain death had been considered by the Conference of Royal Colleges and Faculties of the United Kingdom with similar results. However, this Anglo-American approach to the definition of brain death is not subscribed to by the Austro-German School who criticise it as being inadequate on the ground that "death is not a certainty until the impossibility of brain function has been proved."

Disagreement is also recorded between those who support the definition of death as death of the neocortex alone, i.e., death of that part of the brain which controls the higher brain functions of thought, and whole brain death.

It was, the Report notes, this general lack of agreement in the medical community concerning the criteria for the determination of brain death that prompted the question whether, if a definition of death were to be legislated, the criteria should also be set by the legislature whether it should be left to the medical community. It notes that the Law Reform Commission of Canada was in favour of leaving the criteria to be determined by the medical community, and was also in favour of a definition of brain death which requires the cessation of spontaneous heartbeat but that the majority opinion which the Commission considered to be a more rational approach was in favour of a definition which did not require cessation of heartbeat.

The Report examines a select number of alternative definitions of

death some of which, e.g. the Manitoba definition, have been enacted. These definitions are set out in an Appendix to the Report as follows—

Australia—

(1) A person has died when there has occurred:
  (a) irreversible cessation to all functions of the brain of the person; or
  (b) irreversible cessation of circulation of blood in the body of the person.

(2) (a) Where the respiration and the circulation of the blood of a person are being maintained by artificial means, tissue shall not be removed from the body of the person for the purpose of the transplantation of the tissue to the body of a living person or for use for other therapeutic purposes or for medical or scientific purposes unless two registered medical practitioners (each of whom has carried out a clinical examination of the person, each of whom has been, for a period of not less than five years, a registered medical practitioner and one of whom is a specialist neurologist or neurosurgeon or has such other qualifications as are prescribed) have declared that irreversible cessation of all function of the brain of the person has occurred.

  (b) For the purposes of sub-section (a), any period during which a person who is a medical practitioner practised as a medical practitioner, however described, under the law in force in a country outside Australia shall be taken into account in calculating the period of five years referred to in that sub-section.

(Australian Law Reform Commission — "Report on Human Tissue Transplants.")

California—

7180 A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function. There shall be independent confirmation of the death by another physician.

Nothing in this chapter shall prohibit a physician from using other usual and customary procedures for determining death as the exclusive basis for pronouncing a person dead.

7181 When a part of the donor is used for direct transplantation pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 commencing with Section 7150) and the death of the donor is determined by determining that the person has suffered a total and irreversible cessation of brain function, there shall be independent confirmation of the death by another physician.

Neither the physician making the determination of death under Section 7155.5 nor the physician making the independent confirmation shall participate in the procedures for removing or transplanting a part.

(California Health and Safety Code 7180–81 (West Supp. 1975)).

Capron and Kass—

A person will be considered dead if in the announced opinion of a

physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

(Capron and Kass, "A Statutory Definition of the Standards for Determining Human Death", 121 U. PA. L. Rev. 87 (1972) (a)).

Kansas—

(1) A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these function to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

(2) A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory functions are terminated and before any vital organ is removed for purposes of transplantation.

(Kan. Stat. Ann. 77 – 202 (Supp. 1974)).

Law Reform Commission of Canada proposal—

A person is dead when an irreversible cessation of all that person's brain functions has occurred.

The cessation of brain functions can be determined by the prolonged absence of spontaneous cardiac and respiratory functions.

When the determination of the absence of cardiac and respiratory functions is made impossible by the use of artificial means of support, the cessation of the brain functions may be determined by any means recognized by the ordinary standards of current medical practice.

(Working Paper No. 23, 1979, Criteria for the Definition of Death.)

Manitoba—

2.1 For all purposes within the legislative competence of the Legislature of Manitoba the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs.

(The Vital Statistics Act, R.S.M. 1970, c. V60, as amended by S.M. 1975, c. 5, s. 1).

The Report acknowledges that opinion is divided as to whether there is need to legislate a definition of death but favours such

legislation for three main reasons—

(i) it will resolve the legal and moral dilemma in which the medical profession could easily find itself;

(ii) it will simplify the question of the time of death;

(iii) it will enable organ transplantation to proceed unhampered by concerns as to possible liability of the physicians concerned.

The Commission made its own proposals for an enactment in the following terms—

An Act respecting the Definition of Death

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows:

Short title 1. This Act may be cited as The Definition of Death Act, 19.

Definition 2. Death is the total and irreversible cessation of brain function.

Determination of Death 3. (1) Death may be determined by the irreversible cessation of spontaneous circulation and respiration or by any other means recognized by the ordinary standards of current medical practice.

(2) Where mechanical support or respiration and/or circulation is being used, the determination of death by the attending physician shall be independently confirmed by another physician.

NOTE: In the event this legislation is enacted, the words "in accordance with accepted medical practice" where they appear in Section 8(1) of The Human Tissue Gift Act, R.S.S. 1978, c. H – 15 would have to be deleted.

New Zealand

Administrative Tribunals

The Public and Administrative Law Reform Committee has presented its Ninth Report (1977) to the Minister of Justice.

The following is a summary of some of the recommendations made in the Report—

(i) that arrangements should be made for a complaint made to a disciplinary body of a profession or occupation and rejected as trivial, misconceived, or otherwise lacking in merit to be examined by a lay representative; and that the public should be represented on the disciplinary tribunal to which an investigative body makes its report;

(ii) that those who serve on the investigative body should be disqualified from serving on the disciplinary tribunal;

(iii) that the procedure of the investigative body should be such as to ensure that a fair hearing is given to both the complainant

and the person whose conduct is being investigated; and that, in general, the principles of natural justice should be observed;

(iv) that the grounds on which registration or membership of a profession or occupation may be cancelled or suspended, or another penalty imposed, must be seen to be appropriate to the profession or occupation;

(v) that there should be adequate appeal rights available to both parties from decisions of disciplinary bodies.

Bodily examination of suspects

The Criminal Law Reform Committee of New Zealand has published a Report under the title "Bodily Examination and Samples as a Means of Identification". The Committee explains that during discussions on visual identification which led to the Committee's Report on Identification [noted at (1979) 5 C.L.B. 155] members had been drawn to the view that in some cases the unreliability inherent in eyewitnesses evidence might be avoided if the identification of the offender were effected by the use of forensic methods. An offender, in the course of committing his crime, sometimes left physical evidence of his bodily characteristics at the scene, e.g. a fingerprint, or strands of hair.

Alternatively, evidence might be left on the body of the offender which indicated his participation in the crime, e.g. scratch marks inflicted by his victim, or matter adhering beneath his fingernails. In both situations, however, there was the problem of obtaining the requisite samples from the offender for comparison or of examining his body. At common law and under present New Zealand statutory law no Court had power to compel this.

The Report examines and discusses the state of the law and proposals for reform in several Commonwealth jurisdictions, and in the U.S.A. and, by a majority, felt that there should be established a statutory procedure for compulsory bodily examination or taking of samples of the means of identification. Two members of the Committee dissented from the recommendations of the majority, and minority reports are annexed. Of these, one was completely opposed to the statutory procedure proposed, while the other supported it in relation to a suspect after, but not before, arrest.

The Committee recognised that the proposals involved a nice balancing of interests, particularly if the procedure were to apply to a person who has not actually been arrested and charged with an offence. As a general principle, however, it was felt that the rights of the individual were no more absolute than society's need for effective law enforcement.

The following is a summary of the Committee's recommendations—

(i) there should be enacted a statutory procedure to enable a member of the Police of or above the rank of Sergeant to apply to a Magistrate for an order authorising the external examination of a suspect's body, or the obtaining from a suspect of a sample of his blood, saliva, hair, or nail clippings and scrapings, or his finger, palm or footprints, or his dental impressions.

(ii) such a procedure should be available where there are reasonable grounds to believe that the suspect has committed a specific offence punishable by 12 months' imprisonment or more, and that relevant material or evidence will result from the examination or taking of the sample which will assist in determining the guilt or innocence of the person suspected of having committed that offence.

(iii) the procedure should be available both before and after the arrest of the suspect;

(iv) the procedure should also be available where suspicion falls on an identifiable group of people of whom one must have committed the offence;

(v) application for an order should be made ex parte, but the suspect should have a right to object to the order on genuine medical or religious grounds, or to seek a variation of a particular term of the order, before the order is executed;

(vi) the person executing the order should be permitted to use such reasonable force as may be necessary to overcome any physical resistance by the examinee during the examination or taking of the sample;

(vii) there should be a further emergency procedure whereby a member of the Police of or above the rank of Sergeant may authorise the immediate taking of nail clippings or scrapings by a doctor where there is a danger that the sample may otherwise be destroyed;

(viii) an order should remain in force for a specified duration only. In ordinary circumstances it should not remain in force for more than a week. Some discretion should be left to the Magistrate in appropriate cases to specify that the order is to be executed within some lesser time;

(ix) there should also be provision that, where the time specified in the order has expired and the order has not yet been executed, a Magistrate may renew the order if satisfied that there are special reasons for his doing so;

(x) as a general principle whenever a body examination involves the removal of the examinee's clothing to the extent that it may impinge upon his or her modesty and dignity, then, unless the examination is to be carried out by a doctor, the examinee should have the right, where practicable, to be examined by

someone of the same sex. Every other officer assisting the examiner should also be of the same sex as the person being examined;

(xi) the examinee should be able to have his own lawyer, doctor, dentist or friend present during the examination if he wishes. In some cases, depending on the nature of the examination, he may wish to have more than one of such persons present, e.g. both his lawyer and a doctor. For practical reasons however some limit on numbers has to be set, and to allow the examinee a total of three persons of his choice would be fair;

(xii) all possible effort should be made fully to advise the suspect of his right to remain silent. Not only should the Police be required to explain this orally to the suspect before any examination commences (or upon the suspect's being taken and detained for the purpose of examination following his non-appearance), but the right to remain silent should be clearly spelled out on the face of the order itself.

Inquiry into Chiropractic

The Commission of Inquiry into Chiropractic (viz. manipulation of the spinal column as a method of curing disease) has presented its report to Government. Chiropractic has been a subject of controversy within the New Zealand medical profession for a number of years. The three-person Commission had been established with terms of reference which directed it to have regard to and consider—

(a) the practice and philosophy of chiropractic, its scientific and education basis, and whether it constitutes a separate and distinct healing art;

(b) the contribution chiropractic could make to the health services of New Zealand;

(c) any other matters the Commission may think relevant to the general objects of the inquiry.

In the course of its deliberations the Commission received a total of 136 formal submissions, 37 of these being from organisations and 99 from private individuals; the majority of the submissions were presented in person by the individuals or representatives of organisations concerned. People presenting submissions orally were subjected to cross examination, as were some representatives of the principal parties in respect of evidence given to the Commission.

The Commission sat in public for a total of 78 days and in closed or restricted session for 15 days. It visited two medical universities and two schools of physiotherapy, and also attended some technical demonstrations by chiropractors and physiotherapists. In addition, it travelled overseas spending 17 days meeting officers of various organisations and looking at several chiropractic colleges where New Zealand chiropractors are trained.

The report of the Commission is being considered by Government. It is an extensive document covering complex issues which have serious

implications for the future pattern of health services in New Zealand. Its formal recommendations are lengthy but, in view of the Commission's own caution that they should be considered in the context of its general conclusion and in relation to the section of the report to which each recommendation refers, no attempt has been made to summarise them. They are set out below—

Chiropractors and the general health care team
Recommendation 1
That appropriate steps be taken to ensure that chiropractors are included as partners in the general health care team, in particular—
(a) By overhauling and strengthening the statutory provisions relating to discipline within the chiropractic profession (see recommendations 2-7, below);
(b) By reconstituting the Chiropractic Board (see recommendations 8-9, below);
(c) By transferring the administration of the Chiropractors Act 1960 from the Department of Justice to the Department of Health (see recommendation 10, below);
(d) By abolishing by statute the rules of medical ethics prohibiting medical practitioners from referring patients to registered chiropractors or from collaborating with chiropractors concerning patients (see recommendation 11, below);
(e) By enabling registered chiropractors to have access to hospitals to treat their own patients (subject to appropriate safeguards) (see recommendation 12 (1), below), and to take part in hospital programmes of physical medicine services (see recommendation 12 (2) below);
(f) By providing health and accident compensation benefits for the patients of registered chiropractors (see recommendations 13, 14, below).

Chiropractic professional discipline
Recommendation 2
That the present system of discipline within the chiropractic profession be overhauled, and that in particular:
(a) All disciplinary powers and disciplinary action within the chiropractic profession be regulated by the Chiropractors Act 1960, amended in accordance with these recommendations;
(b) The New Zealand Chiropractors' Association be reincorporated as a statutory body under the Chiropractors Act 1960, that its membership, objects, and powers be defined by the Act, that it should no longer act as a disciplinary body, and that membership of it be made compulsory for all chiropractors holding a practising certificate;
(c) The range of disciplinary offences be enlarged by statute and the penalties revised (see further, recommendations 3-6 below).

Recommended new disciplinary structure
(1) New Complaints Committee
Recommendation 3
(a) That the present Chiropractic Disciplinary Committee (Chiropractors Act 1960, section 7) be abolished and substituted by a statutory Complaints Committee.
(b) That the membership of the new Complaints Committee be the association's president and vice-president *ex officio,* two other persons being chiropractors holding current practising certificates, and one further member being a senior officer of the Department of Health to be nominated by the Director-General of Health.
(c) That the quorum of the new Complaints Committee be not less than three

members, one of whom shall be the nominee of the Director-General of Health.

(d) That the secretary of the new Complaints Committee be the secretary for the time being of the Chiropractic Board.

(e) That the functions of the new Complaints Committee be—

(i) To make a preliminary investigation of any complaint against a chiropractor and to determine whether the chiropractor should be charged with a disciplinary offence before the Chiropractic Board; and

(ii) In relatively minor cases, to hear and determine the complaint itself.

(f) That the new Complaints Committee, if it hears and determines the case itself, have power to impose the following penalties or make the following orders:

(i) The imposition of a fine not exceeding a total of $500 in respect of all charges;

(ii) Suspension for not longer than three months;

(iii) Censure;

(iv) An order that the chiropractor concerned pay the costs, or part of the costs, of the investigation and hearing.

Where the penalty is suspension, the chiropractor concerned should have the right to apply to the Chiropractic Board for rescission of the suspension. In all cases the chiropractor should have a right to appeal to the board.

(g) That in addition to the above powers, the new Complaints Committee be specifically empowered to require a chiropractor against whom a complaint has been made to furnish the committee, within a reasonable time of not less than seven days, with a written explanation; and that failure to supply such an explanation within the time required should be declared to be professional misconduct and punishable as such.

(2) Disciplinary Powers of Chiropractic Board

Recommendation 4

That the Chiropractic Board, as reconstituted (see recommendation 8, below), should have enlarged disciplinary powers, the existing statutory grounds for disciplinary action being inadequate.

Recommendation 5

That the existing statutory grounds for disciplinary action be enlarged so that the full list would read as follows:

(a) Gross negligence or malpractice in respect of his calling;

(b) Conviction of an indictable offence punishable by two or more years' imprisonment;

(c) Grave impropriety or misconduct, whether in respect of his calling or not;

(d) Use of the title "doctor" on any notice or sign or in any publicity material other than in the form of the letters "D.C." following his name;

(e) Conduct unbecoming a member of the chiropractic profession.

As to the recommended new ground (e), it is recommended that it be spelled out by statute what "conduct unbecoming" can include. The following formula is recommended:

Without limiting the meaning of the expression "conduct unbecoming a member of the chiropractic profession", the following conduct shall be deemed to be included in that expression:

(a) By words or conduct inducing any person to believe that a chiropractor should be consulted in the first instance in preference to a registered medical practitioner, in respect of any disease or disorder; or

(b) By words or conduct inducing any person to believe that chiropractic treatment will necessarily cure or alleviate any organic or visceral disease or disorder; or

(c) When consulted by a patient who he knows or ought to know is suffering from a disorder requiring medical care, failing to take reasonable steps to advise the patient to consult, or to continue consulting, a registered medical practitioner; or
(d) Exhibits or publishes to the public any circular designed for general publication which has not been approved by the association.

Recommendation 6
That the penalties which may be imposed by the Chiropractic Board as reconstituted (see recommendation 8, below) be reframed as follows:
(a) Removal from the register;
(b) Suspension for such period as the board thinks fit;
(c) A fine of not more than $5,000 in respect of each charge;
(d) Censure;
(e) An order that the chiropractor concerned pay the whole or part of the costs of the investigation and hearing.

Recommendation 7
That the present right of appeal from the Chiropractic Board to the Magistrate's Court (with assessors) be abolished, and that a right of appeal from the Chiropractic Board to the Supreme Court (without assessors) be substituted.

Restructuring the Chiropractic Board
Recommendation 8
That the Chiropractic Board be reconstituted as follows:
(a) The chairman should be a barrister of not less than seven years' standing.
(b) There should be six other members; four to be registered chiropractors of not less than seven years' standing to be nominated by the association, one to be the Director-General of Health or his nominee, being a senior officer of his department, and one to be a registered medical practitioner nominated by the New Zealand Medical Council (or, failing nomination by the New Zealand Medical Council, the Director-General of Health) (see chapter 14).

Recommendation 9
That the quorum of the reconstituted Chiropractic Board be four members, not three as at present (Chiropractors Act 1960, section 4(2)), at least one of whom, aside from the chairman, should be a non-chiropractic member (see generally chapter 43).

Administration of Chiropractors Act
Recommendation 10
That the Chiropractors Act 1960 be brought under the administration of the Minister of Health and the Department of Health (see chapter 14).

Abolition of Rules of Medical Ethics Relating to Chiropractors
Recommendation 11
That the rules of medical ethics prohibiting medical practitioners in New Zealand from referring patients to registered chiropractors or from collaborating with chiropractors concerning patients be abolished, and accordingly that the Medical Practitioners Act 1968 be amended by inserting the following provision:

"Notwithstanding any rule to the contrary, it shall be lawful and ethical for any medical practitioner—(a) to refer a patient to a registered chiropractor for treatment provided the medical practitioner retains overall responsibility for the patient and first personally satisfies himself that the chiropractor concerned is capable of safely carrying out such treatment; and—(b) to collaborate and associate with a registered chiropractor concerning the diagnosis or management of a patient's disorder."

Access to Hospitals by Chiropractors
Recommendation 12
(1)—
(a) That hospital authorities allow chiropractors to have access to their hospitals to give chiropractic treatment to patients who request it unless the supervising physician or surgeon withholds his approval on the ground that there are precise and specific contra-indications.
(b) That, if necessary, the Hospitals Act 1957 be amended to put the above recommendation into effect.
(2) That the participation by chiropractors in hospital physical medicine services should be positively encouraged in the public interest.

Health and Accident Compensation Benefits for Chiropractic Treatment
Recommendation 13
That, subject to the following limitations, *and subject to recommendation 14 below*, there be benefits payable under the Social Security Act 1964, and payments under the Accident Compensation Act, for chiropractic services:

(1) Chiropractic Benefits under the Social Security Act
(a) Subject to the limitations stated below, the chiropractic benefits should be equivalent to the general medical services benefits.
(b) (i) No benefit should be paid for any chiropractic treatment administered after 21 days from the date of the first consultation unless treatment for a period of more than 21 days is shown to be justified.
(ii) In no case should the total amount of chiropractic benefit (excluding a radiological benefit: see para. (c) below) paid in respect of any one patient in any one period of 12 months exceed the amounts stated in the table below, unless treatment involving payment in excess of any such amount is shown to be justified.

	Maximum $
Ordinary patients	25
Special group patients (including children and young persons)	80

The above maxima are inclusive of the benefit payment of $0.75 payable for each 15 minutes in excess of 30 minutes, but exclusive of the radiology benefit.
(c) Subject to recommendation 14(3), below, a radiological benefit should be paid in respect of chiropractic X-rays in addition to the general chiropractic benefit. The radiological benefit should however be confined strictly to the diagnostic process on initial consultation and should be limited to three plates at $5 per plate, thus providing for a maximum radiology benefit of $15 per patient.
(d) Part II of the Social Security Act should be amended accordingly.

(2) Payment for Chiropractic Treatment under the Accident Compensation Act
(a) That accident compensation benefits be made available for the cost of treatment by a registered chiropractor (subject to the limitations stated below) without medical referral.
(b) That the Accident Compensation Act 1972 be amended accordingly, and that in particular section 111 be amended as follows:
(i) In subjection (1), by inserting in line 5 after the word "medical" the words "or chiropractor's"
(ii) In subsection (2), by inserting after subparagraph (c) the following subparagraph: "(ca) Treatment of the person by a registered chiropractor".
(iii) In subsection (5), by inserting in line 3, after the words "medical practitioner", the words "or a registered chiropractor".

(iv) In subsection (8), by inserting in line 13, after the word "radiological", the word "chiropractic".

(c) That total payments in any one year in respect of a patient's chiropractic treatment (including X-ray costs, but subject to recommendation 14(3), below) should be limited to $200.

(d) That the total period of chiropractic treatment in respect of which benefits are payable should be limited to 21 days from the date of the first consultation.

(e) The limits stated in subclauses (c) and (d) should be waived in any case where chiropractic treatment beyond the financial or time limits is shown to be justified.

(f) (i) That chiropractors be expressly included as part of the Accident Compensation Commission's rehabilitation programme (Accident Compensation Act 1972, sections 48-53).

(ii) That the Act be amended accordingly by—

(i) Deleting in section 49(1)(a), the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic"; and

(ii) Deleting, in section 52, the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic".

Recommendation 14

(1) Limitations on Chiropractic Treatment Under Both Acts

(a) That the cost of treatment by a registered chiropractor or a chiropractic benefit, unless the treatment has been administered on referral from a registered medical practitioner, shall be payable only in respect of treatment aimed at the relief of specific musculo-skeletal symptoms, such as back pain, which are generally accepted as having their origin in biomechanical dysfunction of the vertebral column, pelvis, and the extremities, and their associated soft tissues. Without limiting the symptoms so described, such symptoms shall include migraine (both common and classical), other forms of headache, and all cases of referred pain which can reasonably be attributed to biomechanical dysfunction, but shall not include symptoms indicating organic or visceral disorder. Payment under either Act should not be made unless the treatment in respect of which payment is claimed is justified by—

(i) Specific identification of the symptoms at the relief of which the treatment is aimed; and

(ii) Specific identification of the biomechanical dysfunction diagnosed as giving rise to the symptoms;

and unless the chiropractor has certified his assessment of how many treatments are likely to be required and over what period of time.

(b) Payment under either Act may be made in any case not coming within the terms of para. (1)(a) of this recommendation where the treatment is given on medical referral.

(2) Collection of Benefits

Chiropractic benefits under either Act should be claimed and collected by the chiropractor direct from the Department of Health or the Accident Compensation Commission. Where a benefit or payment is claimed, the chiropractor should be entitled to recover from his patient only the amount of his fee not covered by those benefits.

(3) Conditions for Payment of Radiology Benefits (Medical and Chiropractic)

(a) That radiology fees or the radiology benefit be paid direct to the medical practitioner or chiropractor concerned.

(b) That the patient is to be liable only for that part of the radiologist's or chiropractor's fee not recoverable under the Social Security or Accident Compensation Acts.

(c) That before being eligible to receive payment of a radiology fee or benefit under either Act each medical practitioner and chiropractor should be required to undertake in writing to the Department of Health or the Accident Compensation Commission that he will, if called upon to do so, furnish a patient's radiographs to that patient's chiropractor or medical practitioner (as the case may be) for examination.

Chiropractic and Physiotherapy

Recommendation 15

(1) Use by Chiropractors of Physiotherapy Aids

That chiropractors should not be encouraged to use physiotherapy aids such as heat, light, water, etc., but should instead be encouraged to refer patients requiring such aids to a registered physiotherapist; but a chiropractor properly trained in the use of physiotherapy aids should not be prevented from using them. In particular the Physiotherapy Amendment Act 1953, section 3 (relating to the use of ultra-sound equipment) should be amended so as to include chiropractors who are able to provide satisfactory evidence of training in the use of ultra-sound equipment.

(2) Training of Physiotherapists in Spinal Manual Therapy

That the responsibility for spinal manual therapy training, because of its specialised nature, should in the future lie with the chiropractic profession; that part-time or vacation training for other health professionals in spinal manual therapy with a view to such other health professionals practising spinal manual therapy should not be encouraged; but that closer general co-operation between chiropractors and physiotherapists be encouraged.

(3) That any proposed Government funding for spinal manual therapy education and training be allocated, not to weekend or vacation courses for health professionals other than chiropractors, but to bursary assistance to enable prospective chiropractors and other health professionals to attend the Preston Institute in Melbourne (and see recommendation 16, below).

Chiropractic Education and Research

(1) Education

Recommendation 16

(1) That the New Zealand Chiropractic Board encourage New Zealand students to obtain their chiropractic education at the International College of Chiropractic at the Preston Institute of Technology, Melbourne.

(2) In recognition of the fact that no Government subsidised training is available in New Zealand, that a system of bursaries should be established, to be administered by the Department of Health or the Department of Education, to provide support for New Zealand chiropractic students at the Preston Institute. (The analogy is with the former veterinary bursary scheme operated at a time when veterinary training was not offered in New Zealand.) Such chiropractic bursaries should be tenable only at the Preston Institute. (This recommendation is conditional upon full accreditation of the proposed B.App.Sc. (Chiropractic) degree by the Victorian Institute of Colleges and subsequently by the Australian Tertiary Education Commission.)

(2) Research in New Zealand

Recommendation 17

(1) That the New Zealand Chiropractors' Association formulate a proposal for a clinical trial or trials on some aspect of chiropractic treatment to be conducted in co-operation with one of the clinical medical schools in

New Zealand. This proposal should be submitted to the Medical Research Council. If the Council is not prepared to support such a trial, our recommendation is that a special grant of $200,000 over a four-year period be made by the Department of health for this purpose.

(2) That the New Zealand Chiropractors' Association sponsor a post-doctoral research fellow to work in a New Zealand university on a topic related to fundamental chiropractic theory. The staff of the Otago University Medical School should be consulted in the formulation of such a topic. The funds required would be approximately $15,000 per annum.

Limitation on the use by Chiropractors of the title "Doctor"

Recommendation 18

That chiropractors who are not registered medical practitioners be restricted in their use of the title "Doctor", and that some usages of the title by them be made illegal as well as providing grounds for disciplinary action (as to disciplinary action, see above, recommendation 5); and that the Chiropractors Act 1960 be amended accordingly by inserting the following provision:

> "Any chiropractor who displays or causes to be displayed, or produces or causes to be produced for display or circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material which contains, in relation to any chiropractor who is not a registered medical practitioner any of the terms "Dr", "Doctor", or "Doctor of Chiropractic", commits an offence: Provided however that nothing in this section shall be read as prohibiting a chiropractor from displaying in his professional rooms any diploma or certificate relating to himself or to any other chiropractor with whose practice he is associated, or from using after his name letters denoting an academic or professional qualification."

Alternative Recommendation

(The Commission makes the following alternative recommendation on the ground that it might be thought unjust to single chiropractors out when others in the health field, not being registered medical practitioners, use the title "Doctor": see chapter 42, para. 21.)

That the Medical Practitioners Act 1969 be amended so as to make it an offence for any person who is not a registered medical practitioner to display or cause to be displayed, or produce or cause to be produced for display or circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material, in which the terms "Dr" or "Doctor" are used in such a way as to lead members of the public to believe that such person is a registered medical practitioner.

Miscellaneous

(1) Amendment to Chiropractors Act: scope of practice

Recommendation 19

That the Chiropractors Act 1960, section 2, be amended by deleting the definition of "chiropractic" and substituting the following definition—

> " 'Chiropractic' means the examination and treatment by hand of the joints of the human spinal column, pelvis, and extremities, including associated soft tissues".

(2) Amendments to the Social Security Act 1964

Recommendation 20

(1) Invalids' Benefits

That section 44 be amended by adding after the words "medical practitioner" the words "or, in respect of any condition within the ambit of his profession, a registered chiropractor".

(2) Sickness Benefits
That section 56 be amended by adding after the words "registered dentist", the words "or a registered chiropractor".

(3) Amendments to War Pensions Regulations (S.R. 1956/7)
Recommendation 21
That regulation 34 be amended so that an ex-serviceman may apply for free medical, surgical, or chiropractic treatment; and that regulation 35 be amended by deleting the words "any medical practitioner to whom the service patient has applied for medical treatment" and substituting "any medical practitioner or registered chiropractor to whom the service patient has applied for medical or chiropractic treatment as the case may be".

Papua New Guinea

Sorcery

The Law Reform Commission of Papua New Guinea has published Occasional Paper No. 4, "Sorcery". The Commission had been invited to examine the types of sorcery practised in the country, determine how wide was its practice and put forward proposals for the improvement of the existing law on the subject.

In the Paper, the Commission recognises that the practice of sorcery, in different forms and under different names, is a world-wide phenomenon. The widespread practice of sorcery in Papua New Guinea caused much fear, fighting, quarrels and killings. Apart from the statutory and customary law applicable to sorcery, a form of "peoples law" had developed. The traditional legal system provided agreed compensation as the main remedy for injury or death caused by sorcery but occasionally more drastic measures might be taken against an alleged sorcerer resulting in his being unlawfully killed.

The Paper discusses the existing statutory provisions and points out that the Sorcery Act 1971 (applied by the Local, District and National Courts) follows customary law by making a distinction between "good or innocent" and "bad or evil" sorcery. Offences and maximum penalties are listed. Other offences, triable by the Village courts, are created by part of the Village Courts Regulations made under the Village Courts Act 1973. These Courts also have jurisdiction to hear and adjudicate upon claims for compensation arising out of acts of sorcery.

The Commission indicates that it intends to visit different places to consult the public, and the Paper contains a number of questions to which answers are invited. The questions fall under the following headings: the nature of sorcery; reasons for sorcery; social effects of sorcery; ways of stopping sorcery; sorcery law and sorcery and healing.

Summary trial of indictable offences

The Law Reform Commission of Papua New Guinea has published Report No. 8 on "Indictable Offences Triable Summarily." The Commission notes the concern expressed for some time that the National Court is burdened by less serious criminal offences which could well be dealt with by senior magistrates resulting in the reduction of delays.

The Commission recommends that a number of offences now triable only on indictment should be brought within the jurisdiction of the District Court when presided over by senior magistrates. The Report includes a draft Bill which would give effect to the Commission's recommendations, the principal features of which are summarised below—

(i) although the National Court would retain a concurrent jurisdiction, the procedures were so arranged that the indictable offences triable summarily would be heard by the District Court except in cases where a lesser offence is joined with a more serious offence triable on indictment in the National Court. In these cases both charges would be heard in the National Court;

(ii) the present power of the National Court to stay proceedings in the District Court and have them transferred to the National Court would be retained but the District Court would not be able to transfer criminal proceedings for hearing in the National Court;

(iii) the specific offences in the Criminal Code which would be triable summarily in the District Court are itemised in the Schedule to the draft Bill, and divide into the following categories—
  (a) offences relating to letters, telegrams etc.
  (b) indecent dealings and assaults on women and girls
  (c) pornography and gambling offences
  (d) assaults up to and including assaults occasioning bodily harm
  (e) stealing money or other things
  (f) breaking and entering offences
  (g) lesser forms of arson
  (h) health and quarantine offences
  (i) miscellaneous offences such as unlawful assembly, unlawfully using a motor vehicle and dangerous driving causing death
  (j) attempts, and conspiracy to commit, those offences, and accessories in respect of such offences.

The Commission notes that the Papua New Guinea Criminal Code is based on the Queensland Criminal Code which, although considerably amended, is basically the same as when it was first enacted in 1899. With the passage of time, changes in social attitudes and the difference in life style and cultural development, what may have been

relevant in Queensland at the turn of the century may be inappropriate in Papua New Guinea today. The Commission believes that there is a need for an overall review of the Criminal Code having regard to the needs of the country and the orderly conduct of society, and this is being undertaken by the Commission. However, because the Criminal Code is the present law, the selection of offences to be heard summarily might reveal some anomalies. Some of the offences selected might appear very serious, or conversely, of so little importance as not to merit consideration. But the structure of the Criminal Code itself posed some limitations and until the review of the Criminal Code was completed, difficulties would remain.

Sorcery

The Law Reform Commission of Papua New Guinea has published Occasional Paper No. 10 "Sorcery Among the East Sepiks", prepared by the former Chairman of the Commission, Mr. Bernard Narokobi. The study covers an administrative unit comprising many villages. The author points out that sorcery, like many mystical beliefs, consists of an inner source of power and influence, which a sorcerer then uses to do good or evil either for his own benefit or for the benefit of others; in the latter case performing it for a fee. The dynamics of sorcery are complex, simply because they begin from a realm of mystery and end in mystery.

The Paper contains the following recommendations for law reform—

(i) all forms of evil sorcery should continue to be outlawed;
(ii) a minimum penalty of 5 years' imprisonment with hard labour should be introduced for proven sorcery cases;
(iii) Village Courts should continue to have the power to determine the guilt or innocence of suspected sorcerers;
(iv) wherever the Local, District or National Courts sit on sorcery cases, Village Court Magistrates should sit as assessors. Their determination on facts should not be disturbed by the courts;
(v) banishment from the village should be available as an alternative to imprisonment upon conviction. Banishment could be for a specified period or for life. That decision should be taken by the village or community through a secret ballot conducted by a representative of the provincial or national government;
(vi) those who kill known sorcerers should have available to them the defence of provocation as under the present Sorcery Act. But provocation should be redefined to be wider than the common law definition of provocation;

(vii) those practising good sorcery should be certificated to practise herbal and traditional healing. A registry of herbal medicines and good sorcery should be established in the Health Department;

(viii) courts should undertake inquisitions to prove evidence, subject to certain safeguards. Detection through divination should be available, but no person should be convicted on this evidence alone, without corroboration;

(ix) a period of amnesty and possibly reward should be offered to those who wish to give up sorcery—after that period, any proven sorcerer should be dealt with according to the full rigour of the law;

(x) protection should be offered to those who report sorcery—their identity should be kept secret;

(xi) severe penalties should be imposed on persons to teach other evil sorcery, or transmit evil sorcery in any way or form.

United Kingdom

Proposals for amendment of the law on mentally ill

A consultative document has been published, prepared by an inter-departmental Committee which is expected to lead to amending legislation. The Committee had before it a number of suggestions for amendment of the Mental Health Act 1959 which have been made in the recent years by various professional and other bodies, and by individuals. These include the outcome of comprehensive reviews carried out by the Royal College of Psychiatrists and the National Association for Mental Health. The document also deals with the Butler Committee's specific recommendations for change (made in the Report of the Committee on Mentally Abnormal offenders; noted at (1975) 2 CLB 60). The document takes as its basis the need to balance the rights of the patient and the needs of the public. The Committee finds that the central parts of the Act concerning the use of compulsory powers, the rights of detained patients and the safeguards for patients and staff, are all in need of review. Among the features of the consultative document are —

(i) a discussion of definitions of mental disorder and its sub-categories;

(ii) the suggestion that compulsory detention should be based not on the interests of "health, safety or the protection of others" but replaced by a more narrow criterion is discussed;

(iii) the use of ss. 25 and 29 of the Act is examined in the light of criticisms as to the extent of the use of emergency powers and

of the wide variation of their use in different parts of the country;

(iv) it is not thought that a requirement should be introduced for a second opinion to be sought when renewing authority to detain a patient, but it is suggested that after an initial period of treatment a tighter criterion for continued detention be introduced and that renewals of detention orders be monitored;

(v) it is suggested that, if annual reports are to be made to the Home Secretary on all "restricted" patients, the present intervals at which the Home Secretary may refer cases to Tribunals may not require to be changed. However, an automatic review for such patients after, say, four or five years might be introduced;

(vi) tribunals are at present unduly restricted by being able to choose only between ordering the discharge of a patient and leaving him subject to detention. A number of proposals for widening their powers are discussed;

(vii) The use of forensic psychiatrists as medical members of tribunals and the addition of a social worker as a member of a tribunal might be useful;

(viii) the issue of consent to treatment requires to be clarified. The Butler suggestion that only treatment intended to prevent violence, save life, or prevent deterioration, should be carried out without consent, is thought to be acceptable, as is the suggestion that a second opinion should be sought when a form of treatment is proposed which is irreversible or hazardous;

(ix) it is suggested that, in any proposal to give irreversible or hazardous treatment to a voluntary patient, the proposed panel might be asked to give a second opinion, even if the patient were able to give and had given an informed consent;

(x) the possibility of extending the Butler Committee's recommendation that there be statutory provision for the appointment of patients' friends to all patients is discussed and reference is made to the difficulties of doing so;

(xi) it is suggested that, if there is a need for such additional protection for the mentally disordered, patients' advisers might be appointed to advise the mentally disordered of their rights and of the formal complaint procedures. Such advisers might be employed on behalf of Community Health Councils, or voluntary organisations might be given Government assistance to enable them to provide this service;

(xii) the Butler recommendations on remands to hospitals are discussed and are thought to be generally acceptable, although some require to be examined in the context of criminal procedures generally.

Offences against the person

The Criminal Law Revision Committee has published its Fourteenth Report on "Offences against the Person" (Cmnd. 7844: £4.50). The Committee's 1976 Working Paper on the same subject was noted at (1977) 3 C.L.B. 126.

An introduction explains that the law relating to offences against the person is to be found partly in the common law, and partly in statutes, particularly the Offences against the Person Act 1861. For the most part the Act had consolidated sections from previous statutes of varying dates, repeating in many instances their antiquated language and unnecessary distinctions. No one who had worked with the Act of 1861 would doubt that it was overdue for replacement. In place of the present catalogue of offences in the Act of 1861 the Committee had tried to group criminal acts according to a small number of important common characteristics so that the issue would be whether the acts proved fell within the mischief against which the criminal law was aimed rather than whether they related to one of a series of special relationships or circumstances. Thus, if X were charged with assaulting Y, it would not matter, as it did under the present law, whether Y was a clergyman performing divine service or a magistrate preserving a wreck. The special relationship and the circumstances were generally relevant to sentencing and not to the definition of the substantive offence.

The Committee had not attempted to produce a code of the law relating to offences against the person, but had tried to lay a foundation of law which at some later date could either be brought into a code or used to make a code. If at some future time a code were drawn up it might become necessary to produce statutory definitions for every kind of criminal act for which the law provided penalties. In the meantime, however, the majority of the Committee were of the opinion that it was unnecessary to define in detail common law offences and defences if they were readily identifiable and judges had no difficulty in explaining them to juries, and clerks to their magistrates. An example was provided by the offence of assault.

The Committee, in this Report, had made recommendations on maximum penalties on the same basis as it had done since 1959, namely the sentences which would be appropriate for the worst cases reasonably likely to occur. In respect of each proposed maximum the Committee had asked itself this question: is it really necessary to have a maximum as high as that? This question was particularly important in relation to the less serious offences which were of common occurrence. It might be in the public interest to keep locked up for so many years a man who used firearms to accomplish his ends; but it surely was neither necessary nor wise to sentence to five years' imprisonment, as the present law allowed, a man who had caused minor injury by lashing out with his fists.

The following (with references to relevant paragraphs of the Report omitted) is the Committee's summary of its recommendations—

Murder

1. It should be murder:

(a) if a person, with intent to kill, causes death and

(b) if a person causes death by an unlawful act intended to cause serious injury and known to him to involve a risk of causing death.

In addition, if Parliament favours a provision of the type referred to in paragraphs 27 and 30, it should be on the following lines: that it should be murder if a person causes death by an unlawful act intended to cause fear (of death or serious injury) and known to the defendant to involve a risk of causing death.

2. For killing to constitute murder (or manslaughter or infanticide) the victim should have been born and have an existence independent of the mother.

3. There should be a special provision to secure that, if a jury are sure that either destruction or murder (or manslaughter or infanticide) has been committed or attempted, but are not sure which, they should convict of the lesser offence. The offence of concealing birth, contrary to section 60 of the Act of 1861, should be retained pending its examination by the appropriate departments.

4. There should not be a statutory definition of death for the purposes of offences against the person.

5. A killing should not amount to murder (or any other offence of homicide) unless death follows before the expiration of a year after the day on which the injury was inflicted. Time should run from the infliction of injury as opposed to the act which causes death.

The penalty for murder

6. We are divided on this matter. In view of the importance of the subject and the division of opinion amongst us the arguments for and against retaining the mandatory life penalty for murder have been set out in full. In the circumstances we are not in a position to recommend that there should be any change on this matter. In our consideration of other aspects of offences against the person we have assumed (unless otherwise stated) that the mandatory penalty for murder will remain.

Judicial recommendations under section 1(2) of the murder (Abolition of Death Penalty) Act 1965

7. The scheme of minimum recommendations introduced in 1965 should continue.

8. If the scheme is retained, the exercise of the power to make recommendations should continue to be discretionary. We do not agree with the Emslie Committee recommendations as far as England and Wales is concerned that judges should be required to make recommendations in every case except in exceptional circumstances. However the following changes should be made:

(a) an offender should be able to appeal against a minimum recommendation in the same way as against a determinate sentence;

(b) when making a minimum recommendation the trial judge should

state publicly the factors on which he is basing his recommendation;

(c) as a matter of practice, when minded to make a minimum recommendation the trial judge should invite the defence to make any representations they consider desirable.

Special defences to murder charges—provocation and diminished responsibility

9. Defences of provocation and diminished responsibility should be retained but with some changes.

10. The test of provocation should be reformulated so that provocation is a defence to a charge of murder if, on the facts as they appeared to the defendant, it can reasonably be regarded as a sufficient ground for the loss of self-control leading the defendant to react against the victim with a murderous intent.

11. The defendant should be judged with due regard to all the circumstances, including any disability, physical or mental, from which he suffered; the provocation need not be by the victim of the defendant's attack; and the defence of provocation should not depend upon the particular mode by which the victim was injured or killed. To this extent the "reasonable relationship" test should go.

12. The judge's discretion to decide whether there is any evidence on which the defence of provocation can properly be left to the jury should be restored.

13. A person who kills under provocation or while suffering from diminished responsibility should continue to be guilty of manslaughter and the offence should be punishable with a maximum penalty of life imprisonment.

14. The definition of diminished responsibility should be reworded. Some possible forms of rewording are suggested in paragraphs 92-93.

15. The burden on the defendant in respect of both provocation and diminished responsibility should only go to adducing sufficient evidence to raise an issue.

16. Provision should be made enabling a magistrates' court, if the defendant consents, to commit for manslaughter by reason of diminished responsibility or, if he has been committed for trial on a charge of murder, allowing a defendant, with his consent, to be indicted for manslaughter by reason of diminished responsibility.

17. There should be an offence of attempted manslaughter by reason of provocation or diminished responsibility.

Infanticide

18. An offence of infanticide should be retained.

19. The definition should include the following:

(a) the woman's act or omission causes the death of her child being a child under the age of 12 months;

(b) the act or omission is such as would otherwise amount to murder or manslaughter;

(c) at the time of the act or omission the balance of the woman's mind was disturbed by reason of the effect of giving birth or circumstances consequent upon that birth.

20. If the defendant is charged with murder, attempted murder,

manslaughter, or attempted manslaughter, it should be possible for her to plead to, or the jury to convict of, infanticide or attempted infanticide.

21. The burden resting upon the defendant to prove infanticide should only go to adducing sufficient evidence to raise an issue.

22. The offence should be triable on indictment only and punishable with a maximum penalty of 5 years' imprisonment.

23. There should be no specific restrictions on reporting trials of infanticide.

24. There should be an offence of attempted infanticide.

Mercy killing

25. There should not be an offence of mercy killing; nor should any special sentencing discretion be given to judges in such cases.

Involuntary manslaughter

26. It should be manslaughter (punishable with a maximum penalty of life imprisonment) if a person causes death with intent to cause serious injury or being reckless whether death or serious injury be caused. All other forms of the existing offence of involuntary manslaughter, for example manslaughter by gross negligence, should be abolished.

Terrorism

27. Crimes committed either directly or indirectly for political purposes, which have come to be referred to as terrorist crimes, should not be put into a special category of crime.

Killing by consent and suicide

28. Killing by consent should continue to be treated as murder.

29. The offence now in section 4 of the Homicide Act 1957 should be restated as an offence of killing in pursuance of a suicide pact punishable with a maximum penalty of 7 years' imprisonment. It should no longer be manslaughter.

30. On an indictment charging murder, if it is established that the killing was in pursuance of a suicide pact a jury should be empowered to return that verdict. Similarly, if attempted murder is charged attempted killing in pursuance of a suicide pact should be returnable as an alternative verdict.

31. The burden resting on the defendant of proving the existence of a suicide pact should only go to adducing sufficient evidence to raise an issue.

32. Aiding, abetting, counselling or procuring suicide should continue to be an offence but should be subject to a maximum penalty of 7 years' imprisonment.

33. The consent of the Director of Public Prosecutions to the institution of proceedings for aiding, abetting, counselling or procuring suicide and killing in pursuance of a suicide pact should be necessary.

34. On an indictment charging killing in pursuance of a suicide pact a jury should be empowered to return a verdict of aiding, abetting, counselling or procuring suicide if the facts establish that offence and vice versa.

Causing death by reckless driving and causing bodily harm by wanton or furious driving

35. The offence of causing death by reckless driving should be abolished.

36. There should be a provision empowering verdicts of reckless driving and careless driving to be returned on a charge of causing death recklessly.

37. The offence of causing bodily harm by wanton or furious driving should be abolished.

38. Consideration might be given to replacing the offence of reckless driving by a driving offence involving complete disregard for the life or safety of other persons.

Grievous bodily harm, unlawful wounding and actual bodily harm

39. The existing offences under sections 18, 20 and 47 of the Act of 1861 should be repalced by the three following offences:

(1) causing serious injury with intent to cause serious injury punishable with a maximum penalty of life imprisonment and triable on indictment only;

(2) causing serious injury recklessly punishable with a maximum penalty of 5 years' imprisonment, and triable either way;

(3) causing injury recklessly or with intent to cause injury punishable with a maximum penalty of 3 years' imprisonment and triable either way but made an arrestable offence.

40. We do not propose that there should be a definition or injury or serious injury except a provision that injury includes unconsciousness.

41. A magistrates' court should be empowered to convict without separate information being laid, of causing injury recklessly or with intent on a charge of causing serious injury recklessly.

Assault (including assault on a constable and sections 36-40 of the Act of 1861)

42. Assault should remain an offence and the definition should continue to be left to the common law.

43. No new offences of threatening assault or unlawful force should be created.

44. Assault should be triable summarily only and should be punishable with a maximum penalty of 6 months' imprisonment or a fine of £1,000 or both. There should be a provision empowering a jury to convict of assault on a charge of causing injury recklessly or with intent to cause injury, causing serious injury recklessly or causing serious injury with intent to cause serious injury. Similarly, a magistrates' court should be empowered to convict of assault, without separate information being laid, on a charge of causing serious injury recklessly or causing injury recklessly or with intent to cause injury.

45. Sections 42-47 of the Act of 1861 should be repealed without replacement.

46. There should continue to be an offence of asaulting a constable in the execution of his duty or a person assisting a constable in the execution of his duty.

47. In addition to having to prove that the constable assaulted was acting in the execution of his duty, the prosecution should be required to prove that the defendant knew or was reckless as to whether he was a constable.

48. The offence should remain triable summarily only with a maximum penalty of 6 months' imprisonment or a fine of £1,000 or both.

49. There should be a provision empowering magistrates' courts to convict, without separate information having to be laid, of the offence of assault on a charge of assaulting a constable or a person assisting a constable.

50. Sections 36, 37, 39 and 40 of the Act of 1861 should be repealed without replacement.

51. It should continue to be an offence for a person to assault another with intent to resist or prevent the lawful arrest of himself or any other person. The offence should be punishable with a maximum penalty of 2 years' imprisonment and triable either way.

52. There should also be a provision empowering a jury to convict of assault on a charge of assault with intent to resist or prevent a lawful arrest and similarly a magistrates' court should be empowered to convict of assault, without separate information being laid, on a charge of assault with intent to resist or prevent a lawful arrest.

Administration of poison and other noxious substances

53. Section 23 of the Act of 1861 should be repealed without replacement.

54. Section 24 of the Act of 1861 should be replaced by a provision along the following lines. It should be an offence for a person to administer to another without his consent and without lawful excuse any substance which in the circumstances is capable, and which that person knows may be capable of interfering substantially with the other's bodily functions.

55. The offence should be punishable with 3 years' imprisonment and triable either way.

Other offences under the Act of 1861 involving danger to life or bodily harm (railway offences, offences against children and sections 17, 21, 22, 26 and 31)

56. There should be a new offence on the lines of sections 32 and 33 of the Act of 1861 but extended to apply not only to railways but also to road and air traffic; the *actus reus* of the offence should be restricted in a similar way to that of sections 32 and 33, that is, to specific acts, as for example throwing obstructions onto motorways or interfering with airport safety equipment; and the offence should be committed if the defendant acts intentionally and is negligent as to causing personal injury or damage to property.

57. The offence should be punishable with a maximum penalty of 7 years' imprisonment and triable either way.

58. Section 34 of the Act of 1861 (which makes it an offence to do or omit or neglect anything so as to endanger railway passengers) should be left unrepealed.

59. Section 27 of the Act of 1861 (which relates to the abandonment of a child) should be repealed.

60. Sections 17, 21 and 22 of the Act of 1861 should be repealed without replacement.

61. The responsible government departments should give consideration to the repeal of section 26 of the Act of 1861 and section 6 of the Conspiracy and Protection of Property Act 1875.

62. Consideration should be given to modernising section 31 of the Act of 1861 and re-examining its substance. (Section 31 makes it an offence to set spring guns etc. with intent to inflict grievous bodily harm, or allow the same to remain. The provisos however allow traps to be set to destroy vermin and spring guns etc. to be set at night for the protection of dwelling-houses). What types of devices should be prohibited raises questions of public policy on which wide consultation will be necessary. Further consideration should therefore be given to these matters by the appropriate government departments.

Threats to murder or cause serious injury

63. The existing offence of threatening to murder should be extended to include threats to cause serious injury. It should remain triable either way and punishable with a maximum penalty of 10 years' imprisonment.

Solicitation to murder

64. Section 4 of the Act of 1861 should be repealed, leaving incitement to murder to be penalised at common law and punishable as it is now with a maximum penalty of life imprisonment.

False imprisonment, kidnapping and child stealing

65. The offences of false imprisonment, kidnapping, child stealing and abduction of an unmarried girl under 16 should be replaced by the following four offences;

(a) Unlawful detention whereby it will be an offence for a person
  (i) without lawful excuse
  (ii) intentionally or recklessly
  (iii) by act or omission
  (iv) to detain another, cause him to remain where he is or cause him to accompany another person
  (v) without the consent of the person detained (or where the consent is obtained by duress or by a deception which induces him to believe that he is under a legal compulsion).

  The offence should be triable either way and punishable with a maximum penalty of 5 years' imprisonment.

  The special defences available upon a charge of unlawful detention should be that the child was under the age of 14, or the defendant believed him to be under that age, and
  (i) the defendant had or believed he had lawful control over the child; or
  (ii) the defendant had or believed he had the consent of a person who had lawful control over the child or who the defendant believed had lawful control over the child.

  The burden on the defendant of establishing a special defence should only go to adducing sufficient evidence to raise an issue and the defence of belief should be honest belief, not belief on reasonable grounds.

(b) Kidnapping whereby it will be an offence for a person unlawfully to detain, etc, another as set out in (a) above, with one of the following intents:
  (i) the intention to hold the victim to ransom or as a hostage;

(ii) the intention to cause the victim to be sent out of the realm;
(iii) the intention to commit an arrestable offence.

The offence should be triable on indictment only and punishable with a maximum penalty of life imprisonment.

There should be no special defences to the offence of kidnapping.

(c) Abduction whereby it will be an offence for a person
(i) without lawful excuse
(ii) intentionally or recklessly
(iii) to detain or cause to remain or cause to accompany another
(iv) a child under 14
(v) so that the child is kept out of the lawful control of his parent, guardian or other person having lawful control of him without their consent.

The offence should be triable either way and be punishable with a maximum penalty of 3 years' imprisonment.

It should be made an arrestable offence.

The defences available on a charge of abduction should be:
(i) that the defendant was the mother or father of the child (except where the intention was to cause the child to be taken out of the realm);
(ii) that the defendant had a right, or believed he had a right, to the control of the child;
(iii) that the person taking the child believed that the parent, guardian or any other person having lawful control of the child had consented or would have consented had he known all the circumstances;
(iv) that the defendant believed the child to be aged 14 or over;
(v) that the defendant believed the child not to be in the lawful control of a parent, guardian or any other person.

(d) aggravated abduction whereby it will be an offence for a person to abduct a child under 14 as in (c) above together with one of the intents required for kidnapping in (b) above.

The offence of aggravated abduction should be triable on indictment only and punishable with life imprisonment.

There should be a special defence to the offence of aggravated abduction where the abduction is with the intention of causing the child to be taken out of the realm. In such a case it should be a defence that the defendant was the mother or father of the child abducted but he or she will remain liable to conviction for abduction.

The consent of the Director of Public Prosecutions to the institution of proceedings for any of the four recommended offences should be necessary.

Omissions

67. Save where liability for an omission is expressly imposed by statute,

(a) liability for omissions should be restricted to the offences of murder, manslaughter, causing serious injury with intent, unlawful detention, kidnapping, abduction and aggravated abduction; and
(b) such liability for omissions should arise only where the omission amounts to a breach of duty to act which is recognised at common law. The common law duties should not be codified.

Voluntary intoxication

68. The common law rules relating to voluntary intoxication due to drink or drugs or both should be replaced by a statutory provision on the following lines:

(a) that evidence of voluntary intoxication should be capable of negativing the mental element in murder and the intention required for the commission of any other offence: and

(b) in offences in which recklessness constitutes an element of the offence, if the defendant owing to voluntary intoxication had no appreciation of a risk which he would have appreciated had he been sober, such a lack of appreciation is immaterial.

69. Voluntary intoxication should be defined on the lines recommended by the Butler Committee.

70. In murder or in any other offence in which intention is required for the commission of the offence a mistaken belief arising from voluntary intoxication should be a defence to the charge if such a mistaken belief held by a sober man would be a defence. However in offences in which recklessness does constitute an element of the offence, if the defendant, because of a mistake, due to voluntary intoxication, holds a belief which, if he had been sober, would be a defence to the charge, but which he would not have held had he been sober, the mistaken belief is immaterial.

71. Our recommendations on voluntary intoxication should be applicable to criminal offences generally.

Defences

Self-defence

72.

(a) The common law defence of self-defence should be replaced by a statutory defence providing that a person may use such force as is reasonable in the circumstances as he believes them to be in the defence of himself or any other person, or in the defence of his property or that of any other person.

(b) The defence should be confined to cases where the defendant feared an imminent attack.

(c) There should be no specific provision relating to the retreat rule or the refusal to comply with an unlawful demand.

(d) Section 3 of the Criminal Law Act 1967 should be amended so that, as regards criminal proceedings only, whether the defendant believed that force was necessary in the prevention of crime or in effecting or assisting in a lawful arrest should be decided on the facts as the defendant believed them to be, but whether the force used was reasonable should be governed by an objective test.

(e) There should be a provision that, in considering whether the defendant believed he or another or his property or that of another was under attack, the presence or absence of reasonable grounds for such a belief is a matter to which the court or jury is to have regard in conjunction with any other relevant matters

(f) The burden on the defendant of establishing that he acted in self-defence should only go to adducing sufficient evidence to raise an issue.

73. Where a person kills in a situation in which it is reasonable for some force to be used in self-defence or in the prevention of crime but the defendant uses excessive force, he should be liable to be convicted of manslaughter not murder if, at the time of the act, he honestly believed that the force he used was reasonable in the circumstances.

Consent

74. The common law defence of consent should be continued for the pesent in the circumstances in which it is now available.

Discipline

75. The common law defence of lawful correction should be continued for the present in the circumstances in which it is now available.

Extra-territorial jurisdiction

76. The courts in England and Wales should have jurisdiction over murder and manslaughter where:
(a) the defendant's act or
(b) the infliction of the injury
occurs in England or Wales. They should also have jurisdiction in murder and manslaughter over a citizen of the United Kingdom and Colonies who kills a person anywhere outside the United Kingdom, whether on land or not but such jurisdiction should not extend to attempts to commit those offences.

77. Section 10 of the Act should be repealed without replacement.

78. Our courts should have jurisdiction over an alien whose act here causes death abroad.

79. On a charge of murder or manslaughter a defendant should not be able to plead that his act was not an offence in the country where it was done or that he had a partial defence under the law of that country.

80. It should be an offence to incite, conspire or attempt in this country to commit an act abroad which, if committed here, would amount to murder, manslaughter, causing an explosion likely to endanger life or property (contrary to section 2 of the Explosive Substances Act 1883), causing serious injury with intent to cause serious injury or kidnapping.

81. It should be an offence to incite, conspire or attempt abroad to commit in this country any of the offences at 80 above.

Confidential information

In its 278-page Memorandum No. 40 on "Confidential information", the Scottish Law Commission makes a number of suggestions and poses a series of questions for comment, criticism and consideration.

The report examines the position in contract and in tort, and considers other remedies such as copyright, patents and designs, restitution and recompense.

The provisional proposals and questions to which comment is invited are –

(i) whatever decisions may be taken on the creation of new rights and obligations, any rights and obligations which exist under the present law of contract and in tort should not be abolished;

(ii) in the creation of new rights and obligations, it is preferable to resort to general principles of law wherever practicable, rather than to detailed rules;

(iii) it should be made clear by statute that in an action for breach of contract involving the use or disclosure of information, damages should include, where appropriate, reparation for injury to feelings;

(iv) there is a case for making it clear by statute that a contractual obligation is enforceable against a third party who knows, or ought reasonably to know, that information has been received by him in breach of contract and that to use it would constitute a breach of that contract;

(v) the law regarding the circumstances in which obligations of confidence can be implied is not fully developed, and comment is invited whether difficulty has been experienced in practice for this reason. If so, one possibility is to provide by legislation guidelines on the circumstances in which a restriction would be implied on the disclosure or use of information by a person to whom it was communicated, for example in the following relationships: employer/employee, doctor/patient, clergyman/parishioner, lawyer/client, student/teacher;

(vi) it may be advisable to provide that, where information communicated for the purpose of being stored in a computer, the person to whom the information is communicated and the person responsible for the maintenance of the computer system should both be under an obligation that the information shall neither be disclosed nor used without the consent of the communicator except for the purposes for which it is communicated; and that both the person to whom the information is communicated and the person responsible for the management of the computer system should be held liable for any unauthorised use or disclosure of the information unless they can show that such use or disclosure occurred without fault on their part;

(vii) should a person, in particular a doctor employed in the National Health Service, who has acquired information under an agreement of confidence, be obliged to disclose it in connection with proceedings in a court of law?

(viii) are there any guidelines which could usefully be laid down to determine the extent to which disclosure should be allowed in the public interest? In particular, should disclosure be permitted if the information relates to a state of affairs which the public interest requires should not be allowed to continue?

(ix) it would be desirable, for the avoidance of doubt, to enact a

declaratory provision to the effect that an action based upon the tort of injuria should be competent, where it is claimed that injury to the feelings has been sustained through the disclosure of information about the pursuer, or through the means whereby information about him has been obtained, where these amount to an unwarranted aggression upon the pursuer's person, dignity or reputation;

(x) if it were thought undesirable to resort to the principles of the actio injuriarum, a statutory tort should be introduced, consisting of the use or disclosure of information amounting to a substantial and unreasonable infringement of a right of privacy, accompanied by the same heads of damage, defences, rules of evidence and law of prescription which apply to other branches of the law of tort;

(xi) if such a statutory tort is introduced, the court might be empowered to order the defender to destroy all articles or documents which had come into his possession by reason of or in consequence of the infringement;

(xii) if such a statutory tort is introduced, a person should be entitled to be protected from substantial and unreasonable intrusion upon his family. The definition of "family" should not be as extensive as the category of relatives entitled to claim patrimonial loss in terms of the Damages (Scotland) Act 1976, and should exclude in particular uncles, aunts and their issue, and former spouses;

(xiii) if it were thought undesirable to resort to the principles of the actio injuriarum, it would also be possible to introduce a statutory tort, actionable at the instance of any person who has suffered damage thereby, to disclose or otherwise use information which, at the time of the disclosure or use, the discloser or user knew, or in all the circumstances ought to have known, was obtained by unlawful means;

(xiv) the same principles should, so far as possible, apply to this tort as would apply to the tort described in proposal (x);

(xv) there should be a special procedure, similar to that which already exists in relation to financial information in petitions for variation of trust, to prevent the proceedings themselves causing further disclosure of the information. This could be achieved by using statements lodged in process, but not printed in the pleadings, to describe the confidential information;

(xvi) criminal sanctions should be introduced by statute against the following activities –

(a) it should be a statutory offence to enter upon premises without the occupier's consent, and without lawful authority, for the purpose of obtaining confidential infor-

mation or information which is of value, whether or not the information is actually obtained,

(b) it should be a statutory offence to search or examine the property owned or lawfully possessed by another person without that person's consent, or without lawful authority, with a view to obtaining confidential information or information which is of value. The term "property" should be sufficiently comprehensive to include vehicles, vessels, personal effects and tapes,

(c) the use of certain technical surveillance devices should be made a criminal offence. The category of device should include any electronic or optical devices which permit a man of normal sight or hearing to receive visual or aural signals in circumstances in which he would otherwise be unable to do so, or which permit a record of such signals to be made;

(xvii) the criminal law should not be extended by statute beyond the three categories set out in proposal (xvi).

Incest

The Scottish Law Commission has published Memorandum No. 44 on "The Law of Incest in Scotland". An introduction explains that the prohibition of incest in Scotland still derived from an Act of 1567 founding on the ancient Mosaic law as expressed in Leviticus Chapter xviii. When, in 1969, a committee under the chairmanship of Lord Kilbrandon had considered certain aspects of the marriage law of Scotland, sharp criticism had been expressed of the existing law on the forbidden degrees, both for marriage and incest. While the Marriage (Scotland) Act 1977 (c. 15) had remedied the situation in respect of marriage by providing a clear and comprehensible list of the relations who may not marry, the Act did not directly affect the law of incest. The need for reform of the law of incest in Scotland had long been recognised.

The Memorandum gives the general and historical background to the reference, reviews the present law and discusses the genetic and psychological effects of incest. It goes on to give an account of the law in England and Wales, New Zealand, Canada, Australia, the U.S.A., France, Belgium, Germany and Norway.

In explaining the Commission's approach to the matters in issue, the Memorandum points out that historically, the law of incest in Scotland derives from the dominant religious views in Scotland in the immediate post-Reformation period. However, this society now included persons of various religious beliefs and of no religious belief. Punishment in these circumstances must be justified in terms of society's present ends. The Commission would place high among

those ends the strengthening of the fabric of the family and the protection of its members, especially children, from injury and molestation. Although it had been suggested that incest was merely an offence against a particular moral creed, the Commission could not accept this. The examination of the subject persuaded them that there were good reasons for retaining the crime of incest, though the Commission proposed to narrow the scope of its application to cases where the need for its specific sanctions was most apparent.

In the Commission's view, the reasons why the offence should be retained included the following—

(a) the reduction of the risk of the birth of children with defects of a genetic origin;
(b) the prevention of psychological harm to children;
(c) the maintenance of solidarity within the family; and
(d) the recognition of the opposition of significant numbers of the community to the idea of sexual intercourse between blood-relatives.

But these considerations applied with full force only within the nuclear family. They did not apply to relationships by affinity and did not apply to all relationships based on consanguinity.

Set out below is the Memorandum's summary of the Commission's tentative proposals, upon which comment is invited—

(i) incest should be retained as a separate crime;
(ii) the crime of incest should not be constituted by intercourse between a person and the relatives of his spouse;
(iii) the prohibition against incest should extend only to the following relationships based on consanguinity—
  (a) parents and children,
  (b) brothers and sister,
  (c) grandparents and grandchildren,
  (d) uncles and nieces, aunts and nephews, and
  (e) half-brothers and half-sisters;
(iv) the illegitimate child should be placed with regard to incest in the same position as the legitimate child;
(v) sexual intercourse between relations by adoption only should not be characterised as incest;
(vi) should the protection available under the provisions of the law directed against sexual offences other than incest be extended beyond the age of 16 in the case of female adopted child or step-child?;
(vii) should increased penalties be available under such provisions in the case of the adopted child or step-child and, if so, should this be by way of removing or increasing statutory maxima?;
(viii) the present penalty for incest should be retained;
(ix) incest should not be triable only in the High Court but should also be triable on indictment in the Sheriff Court;
(x) the present definition of incest, requiring penetration, should be retained and should not be extended to other forms of sexual misconduct presently covered by other offences;

(xi) as an alternative to prosecution and punishment, provision should be made within the criminal process to secure help and treatment for the victim of incest and the other members of the victim's family.