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NEVER TRY TO STARE DOWN A GRIEVING WIDOW: POSTHUMOUS USE OF GAMETES AND EMBRYOS IN AUSTRALIA

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NEVER TRY TO STARE DOWN A GRIEVING WIDOW: POSTHUMOUS USE OF GAMETES AND EMBRYOS IN AUSTRALIA

By STEPHEN PAGE[1]

INTRODUCTION

Posthumous use falls into one of two categories –

- Retrieval
- Use

A dear American colleague[2] has suggested that surrogacy lawyers have one of three roles:

- An architect- who plans the whole journey.
- A pilot- when the intended parents know where they want to go- and want to get there *fast*.
- A cleaner- cleaning up other people's messes.

These comments are apt about the role of a lawyer in posthumous cases, too. If it appears that death is on the horizon, engaging a lawyer early can make the posthumous use process for the grieving widow[3] quicker, simpler and cheaper.

Conversely, trying to retrieve sperm posthumously can lead to difficulties, which a lawyer is sought to clean up in the most trying of circumstances.

I am going to be discussing posthumous use in Australia – a country of 27 million, but with eight systems of law on this point.

HANDY POINTER

From the perspective of posthumous use, if you have a patient who has evident health complications to such a degree that death is not out of the question, and is contemplating having a family, then the sooner that the patient can provide and freeze their genetic material, the better.

The sooner that planning is in place for possible posthumous use later, then the reproductive journey for the widow later will be quicker, simpler and cheaper, and more likely to be effective.

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[2] Richard Vaughn.

[3] I say widow. While posthumous retrieval from women occurs, it is rare. Posthumous retrieval from men is much more common.

Example

Fred and Mary were married. Fred has been diagnosed with cancer. Doctors have told him that it is likely to be terminal cancer, but there is no certainty of life expectancy. Fred supplies a quantity of sperm to be frozen. He and Mary consult a fertility counsellor. Fred executes a Will as well as other documents directing that in the event of his death, Mary can use the sperm in order to become a mum.

Fred subsequently dies. Mary is then able to use the sperm in order to be able to reproduce. So far, the cases that I have seen involving posthumous use have been:

- Man dies from cancer and put his affairs in order – as Fred did, to enable his widow to use the sperm.
- Man dies from cancer, after being told that it was terminal. His widow leaves it too late to retrieve the sperm (example discussed below).
- Man dies unexpectedly – stroke, blunt force injury (fell over skateboarding without a helmet), surfboard accident, electrocuted at work, accidental drug overdose while partying.
- Man suicides.
- Woman dies of cancer after having had her eggs retrieved and wanting to make those eggs available for her brother for his surrogacy journey. The woman did not execute documents in time to allow the use of the eggs, meaning that they were therefore not able to be used and would need to be discarded.

Quite simply, if there is planning put in place, then it is clear that there can, within the parameters of legislation or the NHMRC *Ethical Guidelines*, the ability to use the gametes and embryos.

Too often there is instead an accidental or unexpected death and then a panic to try and retrieve the sperm with the intention of it being able to be used later.

Ricardo and Lucy

Posthumous retrieval necessitates that there is an IVF clinic nearby able to safely store the sperm or eggs, and that there is the relevant hospital official, fertility doctor and scientist on hand available to facilitate the retrieval.

Australia is a big place. There are many parts of Australia where there is not a local IVF clinic, let alone the people to enable the retrieval to occur.

Ricardo had cancer. Lucy had always intended to retrieve his sperm, but for some reason did not enable a retrieval of sperm from Ricardo before his death. Lucy believed that Ricardo would last another two weeks- but he died.

On this Friday morning, Lucy did not know where Ricardo's body was - whether it was at the hospital or morgue. The regional city in Queensland had two IVF clinics, but only one doctor able to undertake the retrieval - and the doctor was away. The next regional city, four

hours' drive away, had a doctor available. A myriad of phone calls established that. However, the scientist in that city was away. She had a weekend off.

By last thing Friday, Lucy was told that while the doctor was in the other city, and a funeral director could get the body there, there was no scientist - so the retrieval could not happen there. While the doctor could travel to the body in the first regional city, by the time the doctor got there, the one scientist there will have left.

Three things defeated the ability to retrieve:

1. Queensland does not have the ability to have pre-mortem retrieval from those who are brain dead.
2. The tyranny of distance.
3. Lucy left the retrieval too late.

A COMMENT ABOUT LAWYERS – BY A LAWYER

I have not yet had to bring an application to court for retrieval or use. Sadly, there have been quite a few cases where lawyers have done so on behalf of their clients. I say, sadly, because looking as a lawyer at these cases, most of them did not need to be before a court. They could have been dealt with adequately *without* going to court. By taking the matter to court, enormous stresses have been placed on the widows and their family members, including costs. In some cases at least, it would appear the reason for going to court might have involved ignorance by the lawyer about what laws there are governing retrieval, and the instinctive reaction of going to court to try something.

When the clock is ticking, time is counted in hours, and the grieving widow is wondering whether she will ever become a mum, the temptation is to immediately file an urgent application in the Supreme Court. To do so is a mistake. Administrative processes fill the void. Courts have come to the conclusion that the Supreme Court of each State and Territory (which has the widest jurisdiction of any Australian court) does not have jurisdiction to enable it to make a retrieval order.

For a retrieval case, for example, I am aware in an uncontested case a client spent A$14,000. I am aware of another retrieval case that a widow, immediately after her husband's death, was told by another lawyer that the cost would be A$25,000 – and to put that money into trust before the application could be brought to the court; the retrieval having to be brought ordinarily within 24 hours of death. In those two case examples, neither needed to go to court. If the existing administrative processes had been adopted, they could easily have avoided going to court, saving a huge extra amount of stress and cost.

And another point. Just because use may not be allowed in the State or Territory in which the widow lives, retrieval is allowed *everywhere* in Australia. Therefore, many of the cases, both in practice and in reported cases, deal with retrieval occurring somewhere and then the desire to export the sperm somewhere else in Australia to where it can be used. Typically, the courts will allow the export to occur.

This desire to export to a more favourable place is normal and natural. It is the desire to take advantage of differences in the law between the States to effect an outcome- i.e. to become a

parent. Humans are not alone in using whatever tools they might available to them in order to be able to reproduce. In the words of Sir David Attenborough[4]:

> *"If you watch animals objectively for any length of time, you're driven to the conclusion that their main aim in life is to pass on their genes to the next generation. Most do so directly, by breeding. In the few examples that don't do so by design, they do it indirectly, by helping a relative with whom they share a great number of their genes. And in as much as the legacy that human beings pass on to the next generation is not only genetic but to a unique degree cultural, we do the same. So animals and ourselves, to continue the line, will endure all kinds of hardship, overcome all kinds of difficulties, and eventually the next generation appears."*

RETRIEVAL

Can Retrieval Occur Before Death?

This was an issue that I had to consider in 2021. The man had slipped into a coma. It was only a question of days before he would die. The medical advice was unequivocal – the quality of sperm will be much greater prior to death being declared, than retrieval occurring after death.

The view taken by both the lawyers for the hospital and myself was that retrieval was not possible prior to death. Quite simply, to retrieve the sperm from a still living man would be an assault, which would on its face be an offence, for example under the Criminal Code of Queensland[5] and an offence under the human tissue laws[6], as well as the civil wrong of trespass to the person.

The relevant human tissue law provides:

> *"(1) A person shall not—*
>
> *(a) remove tissue (other than blood) from the body of a living person for use for any of the purposes referred to in section 10 or 11 except in pursuance of a consent or an authority that is, under part 2 , division 3 , sufficient authority for the person to remove the tissue or as authorised under part 2 , division 6; or*
>
> *(b) remove blood from the body of a living person for any of the purposes referred to in section 17 except in pursuance of a consent that is, under part 2 , division 4 , sufficient authority for the removal of the blood; or*
>
> *(c) remove tissue from the body of a deceased person for any of the purposes referred to in section 22 (1) or 23 (1) —*
>
> *(i) except in pursuance of an authority that is, under part 3 , sufficient authority for the person to remove the tissue; and*
>
> *(ii) if the deceased person is one in relation to whom section 45 (1) (b) is relevant—except where a certificate given in relation to that person in accordance with section 45 (2) is in existence; ...*

[4] *Trials of Life* (1990).
[5] S. 246. It is not a surgical operation for the benefit of that person: cf. s.282.
[6] *Transplantation and Anatomy Act 1979* (Qld), s. 48.

except in pursuance of an authority that is, under part 5, sufficient authority for the removal, retention or use of the body;

...

Penalty—

Maximum penalty—100 penalty units or 1 year's imprisonment.

(2) A person who—

(a) gives an authority under this Act without having made the inquiries that the person is required by this Act to make; or

(b) makes a false statement in a certificate given for the purposes of this Act; or

(c) contravenes or fails to comply with a provision of part 2, division 5;

is guilty of an offence against this Act.

Penalty—

Maximum penalty—100 penalty units or 1 year's imprisonment.

(3) Nothing in subsection (1) or (2) applies to or in relation to—

(a) anything done in pursuance of an order by a coroner under the Coroners Act 1958 or the Coroners Act 2003 ; or

(b) any other act authorised by law."

In the words of a NSW Supreme Court judge[7] about that State's *Human Tissue Act*:

"The Act...was not originally drafted with extraction of gametes in mind."

Who could authorise that assault?

In the absence of such legislation, there must be some person who lawfully authorises the retrieval. In theory, it could be someone like an adult guardian – but the problem is that the retrieval is not for the benefit of the man who is dying, but for his widow and members of her family. This issue was identified in NSW where under the *Guardianship Act "necessary medical treatment"* can be authorised. However[8]:

"*Necessity could only pertain to treatment directed towards relieving the patient's symptoms, improving his comfort, rectifying a disorder of fighting a disease. Within the sense of this object, treatment could not be necessary unless directed to one or more of these ends. It could not be necessary if it could make no difference to the patient's affliction or injury.*

Throughout the expanded definitions of major and minor treatment in s 33 there is no indication that the legislature intended to broaden the concept of treatment for which

[7] *Chapman v South Eastern Sydney Local Health District* [2018] NSWSC 1231 at [19].
[8] At [43]-[44].

consent may be given under s 36, so as to embrace medical interventions which do not have the purpose of promoting the patient's health or well-being."

Similarly, there is the ability under the common law jurisdiction of every Supreme Court in the country, what is called the *parens patriae* jurisdiction, to make orders. Supreme Courts from time to time make orders authorising medical treatment relying on this jurisdiction.

A recent helpful description of the *parens patriae* jurisdiction was by Justice Atkinson in the Queensland Supreme Court in 2018[9], where her Honour said:

> *"[13] The Supreme Court has a parens patriae jurisdiction which is exercised to protect the person and property of people, especially children, who are unable to look after their own interests.*
>
> *[14] Lord Esher MR described the jurisdiction in these terms in R v Gyngall:*
>
> > *"The Court is placed in a position by reason of the prerogative of the Crown to act as supreme parent of children, and must exercise that jurisdiction in the manner in which a wise, affectionate, and careful parent would act for the welfare of the child."*
>
> *[15] However, the Court's powers when exercising the parens patriae jurisdiction are much broader than that of a natural parent, as explained by the High Court in Marion's case:*
>
> > *"The more contemporary descriptions of the parens patriae jurisdiction over infants invariably accept that in theory there is no limitation upon the jurisdiction. No doubt the jurisdiction over infants is for the most part supervisory in the sense that the courts are supervising the exercise of care and control of infants by parents and guardians. However, to say this is not to assert that the jurisdiction is essentially supervisory or that the courts are merely supervising or reviewing parental or guardian care and control. As already explained, the parens patriae jurisdiction springs from the direct responsibility of the Crown for those who cannot look after themselves; it includes infants as well as those of unsound mind. So the courts can exercise jurisdiction in cases where parents have no power to consent to an operation, as well as cases in which they have the power."*
>
> *[16] In the exercise of this jurisdiction, the Court may override the wishes of a child's parents The overriding consideration for the Court is the 'best interests of the child'."*

The key element is that the treatment that must be authorised must be in the best interests of the person concerned. In the words of the Supreme Court of Canada[10]:

> *"Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised ... . The discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, caution that must be redoubled as the seriousness of the matter increases. This is particularly so in cases where a court might be tempted to act because*

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[9] *Children's Health Queensland Hospital and Health Service v AT* [2018] QSC 147.

[10] *E v Eve*, 1986 CanLII 36 (SCC), [1986] 2 SCR 388.

failure to do so would risk imposing an obviously heavy burden on some other individual."

The clear problem that for a court to authorise the retrieval is not in the best interests of the person lying comatose. It is in the best interests of their widow or widower.

The result? Retrieval was not able to be undertaken. Retrieval was authorised after the man was declared dead, but, not surprisingly, the sperm was of too poor a quality that it was not able to be used.

Legislative reform that would enable retrieval before death, subject to careful safeguards, would be welcome. In the words of Justice Fagan in the NSW Supreme Court[11]:

"55. Orders facilitating sperm extraction, either from unconscious patients or deceased persons, have now been made by single judges of this Court on several occasions, always under the adverse conditions of decision-making to which I have referred. Such orders have also been made by single judges of the Supreme Courts of other States, where legislation having some features in common with the New South Wales statutes is in force. Judges in the other States have also repeatedly adverted to the difficulty of identifying the applicable principles of law and the pressure of time under which this has to be done in such applications. See for example AB v Attorney-General of Victoria [2005] VSC 180 at [106]; Re H, AE at [8]-[11]; Re Cresswell [2018] QSC 142 at [3].

56. *Hospital, medical and legal staff could not fairly be expected to find and consider the possibly relevant statutes and the judicial decisions upon them in order to work out for themselves whether the law permits sperm retrieval, or whether the spouse of an unconscious man can give effective consent or whether a Court order can be made and should be sought. When next of kin request such a procedure neither the hospital staff with their professional responsibilities nor the spouse or relatives in the emotional distress of the situation should be put in the position of having to apply to the Court to obtain an answer. The present state of affairs calls for legislative intervention to enact a clear rule as an amendment to a statute where it may readily be found, such as the Assisted Reproductive Technology Act.*

57. *If Parliament should resolve to enact such a rule without altering the current law as I have sought to explain it, the rule would be to the effect that removal of sperm from an unconscious patient who had not given his own consent prior to losing consciousness is not permitted and cannot be effectively consented to by any other person nor approved by the Court. To avoid factual disputes about consent, it should be made clear that only consent in writing would suffice. If it is the judgment of Parliament, weighing up moral and social considerations which are its province, that the law should be changed to permit sperm extraction from an unconscious patient irrespective of his consent, then there should be prescribed precise conditions as to who may require the extraction and in what circumstances or under what conditions, leaving no element of evaluation or judgment for resolution by any tribunal or decision-maker. The circumstances in which an extraction is sought to be carried out on an unconscious and terminal patient do not permit of any degree of complexity or delay in the decision-making process."*

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[11] *Chapman* at [55]-[57].

Only one Australian State, Victoria, allows pre-mortem retrieval. A current review in Queensland is considering whether pre-mortem retrieval should be allowed there. Among the safeguards in Victoria for pre-mortem retrieval are these[12]:

> *"A designated officer for a hospital must not give an authority under section 24B in respect of a person unless, where the respiration or the circulation of the blood of the person is being maintained by artificial means, two registered medical practitioners, neither of whom is the designated officer and each of whom has been for a period of not less than five years a registered medical practitioner, have each certified in writing—*
>
> *(a) that the practitioner has carried out a clinical examination of the person while the respiration or the circulation of the blood of that person was being maintained by artificial means; and*
>
> *(b) that, in the practitioner's opinion, at the time of examination, death of the person would occur as a result of the withdrawal of the artificial means of maintaining the respiration or the circulation of the blood of the person."*

Following submissions made my me last year, currently Queensland is considering whether pre-mortem retrieval should be allowed.

GOING TO COURT FOR RETRIEVAL

There are a series of cases that have been decided in our courts, for example, in Queensland, New South Wales and South Australia among others whereby the grieving widow is pressing the court immediately to take action to enable retrieval of the sperm. The kind of pressures were best described to me by a colleague in Brisbane who, on Christmas Day, was hosting lunch, when she received the call – which was to make an urgent application to the Supreme Court for retrieval. She then did so, abandoning her guests, tracking down a judge on Christmas Day, appearing before the judge and obtaining the order. A hugely stressful experience for all involved. A highly costly experience and as several judges of the Supreme Courts of Queensland and New South Wales have said, the court in fact did not have jurisdiction[13].

No one in those circumstances should be applying to the Supreme Court for a retrieval order. In all circumstances they should be relying on the processes under the local human tissue laws. These laws have (with the exception of Western Australia) one of two names: *Human Tissue Act* or *Transplantation and Anatomy Act*. They are State and Territory laws and form a national scheme about human tissue.

HUMAN TISSUE LAWS

Jurisdiction	**Law**
ACT	*Transplantation and Anatomy Act 1978*
New South Wales	*Human Tissue Act 1983*
Northern Territory	*Transplantation and Anatomy Act 1979*
Queensland	*Transplantation and Anatomy Act 1979*
South Australia	*Transplantation and Anatomy Act 198*
Tasmania	*Human Tissue Act 1985*

[12] *Human Tissue Act 1982* (Vic), s. 24D.
[13] For example, *Re Creswell* [2018] QSC 142.

Jurisdiction	Law
Victoria	*Human Tissue Act 1982*
Western Australia	*Human Tissue and Transplant Act 1982*

I will now give a step by step journey through a retrieval in my home state of Queensland. Every State and Territory has slightly different procedures unique to that jurisdiction.

Step 1 – Interfering with a corpse

Section 236 of the *Criminal Code 1899* (Qld) provides:

> *"(1) A person who, without lawful justification or excuse, the proof of which lies on the person, neglects to perform any duty imposed on the person by law, or undertaken by the person, whether for reward or otherwise, touching the burial or other disposition of a human body or human remains is guilty of a misdemeanour.*
>
> *Maximum penalty—2 years imprisonment.*
>
> *(2) A person who, without lawful justification or excuse, the proof of which lies on the person, improperly or indecently interferes with, or offers any indignity to, any dead human body or human remains, whether buried or not, is guilty of a crime.*
>
> *Maximum penalty—5 years imprisonment."*

Section 48(1) of the *Transplantation and Anatomy Act 1979* (Qld) provides, relevantly:

> *"(1) A person shall not –*
>
> *(a) remove tissue (other than blood) from the body of a living person for use of any of the purposes referred to in section 10 or 11 except in pursuance of a consent or an authority that is, under part 2, division 3, sufficient authority for the person to remove the tissue or as authorised under part 2, division 6;*
>
> ...
>
> *(c) remove tissue from the body of a deceased person for any of the purposes referred to in section 22(1) or 23(1) –*
>
> *(i) except in pursuance of an authority that is, under part 3, sufficient authority for the person to remove the tissue; and*
>
> *(ii) if the deceased person is one in relation to whom section 45(1)(b) is relevant – except where a certificate given in relation to that person in accordance with section 45(2) is in existence ...*
>
> *Penalty: maximum penalty – 100 penalty units or one years imprisonment."*

Section 48(3) provides, relevantly:

"Nothing in subsection (1) … applies to or in relation to –

(a) anything done in pursuance of an order by a coroner under the Coroners Act 1958 or the Coroners Act 2003; or

(b) any other act authorised by law."

Step 2 – Is the consent of the coroner required?

Ordinarily the first inquiry that needs to be made is whether the coroner believes they have jurisdiction. If the coroner believes that they have jurisdiction, then the consent of the coroner is required.

Section 24 of the *Transplantation and Anatomy Act 1979* provides:

"(1) This section applies to a deceased person—

(a) whose death must be reported under the Coroners Act 1958, section 12 or 13 or the Coroners Act 2003, section 7; or

(b) in respect of whose death a coroner is directed by the Minister for the time being administering the Coroners Act 1958 to inquire into the cause and circumstances of the death or is directed by the Minister under the Coroners Act 2003, section 11 to investigate.

(2) A designated officer or a senior available next of kin, as the case may be, shall not authorise the removal of tissue from the body of a deceased person to whom this section applies unless a coroner has consented to the removal of the tissue.

(3) Section 22 (5) or, as the case may be, 23(3) does not apply in relation to a deceased person to whom this section applies unless a coroner has consented to the removal of tissue from the body of the deceased person.

(4) A coroner may give a direction, either before or after the death of a person to whom this section applies, that his or her consent to the removal of tissue from the body of the person after the death of the person is not required and, in that event, subsections (2) and (3) do not apply to or in relation to the removal of tissue from the body of the person.

(5) A consent or direction by a coroner under this section may be expressed to be subject to such conditions as are specified in the consent or direction.

(6) A consent or direction may be given orally by a coroner and, if so given, shall be confirmed in writing within 7 days.

(7) Where a consent has been given under subsection (2), a report in writing on the condition of the tissue removed shall be furnished to the coroner concerned within 7 days—

(a) by the medical practitioner who effected the removal; or

(b) where there is a group of medical practitioners concerned in the removal— by 1 of the group designated by the leader of the group before the removal is effected or, failing such a designation, by the leader of the group."

The effect of section 24 is that, without the consent of the coroner, no further step can be taken. My experience, however, is that when asking for the consent of the coroner (which is easier during business hours) phoning ahead of time before sending an email, so that the officer in the coroner's office knows the story of the matter means that when the email is sent, results in the consent is given quickly, or the coroner states in writing that it is not within the coroner's jurisdiction. The latter is very helpful, because while the coroner's jurisdiction is unclear, any doctor will be unwilling to perform the operation, given that to do so might be illegal.

A problem arose in the well-known case in Queensland *Re Cresswell* [2018] QSC 142 – where the coroner didn't have any objection to the treatment, but didn't provide consent. The requirement of the legislation instead is a positive one - that the coroner must consent to treatment if the body is within the coroner's jurisdiction.

The consent does not need to be in writing initially: section 24(6), but if given orally, shall be confirmed in writing within seven days. Assume that the coroner has given oral consent, the retrieval has then occurred and the coroner then has not given written consent. Quite simply, the oral consent has been given and at the time of retrieval there was a lawful retrieval. The fact that the coroner then did not reduce that consent to writing is an administrative failure which does not impact the lawfulness or otherwise of the retrieval.

If the coroner's consent is not required or the coroner has given consent, then the next step is whether there has been valid donor consent by the deceased.

Step 3 – Has the deceased given consent?

Section 22(5) of the *Transplantation and Anatomy Act* provides:

> *"Where a deceased person, during his or her lifetime, by signed writing consent to the removal after death of tissue from his or her body for any of the purposes referred to in subsection (1)(c) [including use of the tissue for other therapeutic purposes than transplanting it to the body of a living person, or for other medical or scientific purposes] and the consent had not been revoked by the deceased person, the removal of tissue from the body of the deceased person in accordance with the consent for any of those purposes is hereby authorised."*

It is clear from the case authority in Queensland[14], New South Wales[15], Victoria[16] and Western Australia[17] that to provide the use of the sperm for assisted reproductive treatment of the widow of the deceased is a therapeutic or medical purpose.

Where the deceased's body is not in hospital, then section 23(3) of the *Transplantation and Anatomy Act* applies:

> *"Where a deceased person, during his or her lifetime, by signed writing consent to the removal after death of tissue from his or her body for any of the purposes referred to in subsection (1) [the same as in the previous provision] and the consent had not been revoked by the deceased person, the removal of tissue from the body of the deceased person in accordance with the consent for any of those purposes is hereby authorised."*

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[14] *Re Cresswell* [2018] QSC 142 at [68]; *Re Floyd* [2011] QSC 218.
[15] *Re Edwards* [2011] NSWSC 478; (2011) 81 NSWLR 198 at [32]
[16] *AB v Attorney-General* [2005] VSC 180 at [118]; *Y v Austin Health* [2005] VSC 427; (2005) 13 VR 363 at [39].
[17] *GLS v Russell-Weisz* [2018] WASC 79 at [218].

I should say that the definition of *tissue* in each of the State and Territory legislation is clear as including eggs, sperm and embryos. The definition of tissue is not consistent across the various Acts, however.

Step 4 – If the deceased gave consent, has the consent been revoked?

The effect of section 22 of the Act is that if the consent of the deceased has been given, consideration must then be given as to whether the consent has been revoked and whether the deceased objected to the donation. If the deceased objected to the donation, then you cannot proceed any further.

DID THE DONOR OBJECT TO DONATE?

If the answer is no, then the next step is to determine where the body is.

Step 5 – Is the body in a hospital?

We then look at parallel paths - whether the body is in a hospital or not. Typically, the body will be in a hospital.

Step 6 – The body is not in a hospital

As the body is not in a hospital, the next required step is whether there is a senior available next of kin of the same or higher order who objects? If the answer is yes, you cannot proceed. If the answer is no, then there is a written authority required of the senior available next of kin. Assuming that that authority is then given, then the next step is to enable the retrieval.

Eric the electrician

Eric was electrocuted at work. He was taken to hospital and declared brain dead.

His widow wanted to retrieve his sperm. As it was in Queensland, this could not be done before death.

Over two days my office made about 50+ phone calls and innumerable emails to enable the retrieval. The Coroner recommended that the body be moved to the morgue as soon as possible after death, to avoid the restrictions that the hospital was imposing that the doctor needed to be accredited with the hospital.

Fertility specialists with three different IVF clinics who specialised in posthumous retrieval were contacted to undertake retrieval. Only one was available.

At 4pm Friday the hospital advised that Eric had died - and that he was a registered organ donor. There was then a rush by the hospital to retrieve organs ahead of the posthumous retrieval - and a determination by the hospital for the body NOT to go to the morgue.

The retrieval occurred on the Friday night. Luckily, the doctor at the hospital, the retrieving specialist, scientist, and my law partner were all available on Friday night to enable the retrieval.

Viable sperm was retrieved.

Step 7

The relevant person will then need to consent to storage in accordance with the usual practices of the clinic of any gametes. As seen in the example below, the relevant person may or may not be the senior available next of kin.

Step 8 – Where the body is in a hospital

This is governed by section 22 of the *Transplantation and Anatomy Act*:

"(1) Subsection (2) applies if—

(a) the body of a deceased person is in a hospital; and

(b) it appears to a designated officer for the hospital, after making reasonable inquiries, that the deceased person had not, during his or her lifetime, expressed an objection to the removal after death of tissue from his or her body; and

(c) the senior available next of kin of the deceased person has consented to the removal of tissue from the body of the deceased person for—

(i) transplanting it to the body of a living person; or

(ii) use of the tissue for other therapeutic purposes or for other medical or scientific purposes.

(2) The designated officer may, by signed writing, authorise the removal of tissue from the body of the deceased person under the consent.

(3) The senior available next of kin of a person if he or she has no reason to believe that the person has expressed an objection to the removal after the person's death of tissue from the person's body for any of the purposes referred to in subsection (1) (c), may make it known to a designated officer at any time before the death of the person that the senior available next of kin has no objection to the removal, after the death of the person, of tissue from the body of the person for any of the purposes referred to in subsection (1) (c).

(3A) For subsections (1) (b) and (3), a deceased person is not to be taken as having expressed an objection to the removal after death of tissue if—

(a) the deceased person expressed an objection but subsequently withdrew it; and

(b) the designated officer, or the senior available next of kin of the deceased person, believes the withdrawal is the most recent and reliable indication of the deceased person's wishes.

(4) Where there are 2 or more persons of a description referred to in section 4, definition "senior available next of kin", paragraph (a)(i) to (iv) or (b)(i) to (iv), an objection by any 1 of those persons has effect for the purposes of this section notwithstanding any indication to the contrary by the other or any other of those persons.

> *(5) Where a deceased person, during his or her lifetime, by signed writing consented to the removal after death of tissue from his or her body for any of the purposes referred to in subsection (1)(c) and the consent had not been revoked by the deceased person, the removal of tissue from the body of the deceased person in accordance with the consent for any of those purposes is hereby authorised.*
>
> *(6) A consent under subsection (1)(c), and a communication under subsection (3) by the senior available next of kin, must be in writing.*
>
> *(7) However, if it is not practicable for the consent or communication to be given in writing because of the circumstances in which it is given, it may be given orally.*
>
> *(8) If the consent or communication is given orally under subsection (7), the designated officer must ensure that, as soon as practicable—*
>
> > *(a) the fact of the giving of the consent or communication and the details of the consent or communication are reduced to writing and placed on the deceased person's hospital records; and*
> >
> > *(b) reasonable attempts are made to have the consent or communication confirmed in writing by the senior available next of kin.*
>
> *(9) The designated officer must ensure that a document obtained under subsection (6) or (8) (b) is placed on the deceased person's hospital records as soon as practicable.*
>
> *(10) Subsection (8) does not affect the operation of subsection (7)."*

Step 9 – Does any senior available next of kin object?

If there is an objection, that would appear to be the end of the matter: section 22(3):

> *"The senior available next of kin of a person if he or she has no reason to believe that the person has expressed an objection to the removal after the person's death of tissue from the person's body for any of the purposes referred to in subsection (1)(c), may make it known to a designated officer at any time before the death of the person that the senior available next of kin has no objection to the removal, after the death of the person, of tissue from the body of the person for any of the purposes referred to in subsection (1)(c)."*

Step 10

Not only must the senior available next of kin not object, but must consent. This is required under section 22(1)(c):

> *"the senior available next of kin of the deceased person has consented to the removal of tissue from the body of the deceased person for—*
>
> *(i) transplanting it to the body of a living person; or*
>
> *(ii) use of the tissue for other therapeutic purposes or for other medical or scientific purposes."*

Once that consent is obtained, then the designated officer is in a position to authorise the removal.

Step 11 – Does the designated officer authorise removal by signed writing?

Section 22(2) provides:

> *"The designated officer may, by signed writing, authorise the removal of tissue from the body of the deceased person under the consent."*

The critical element here is *may*. Whether the designated officer authorizes is a matter of discretion. The key in enabling the removal is to set the scene for the authorised officer, so that there is seamless paperwork to show that all the requirements of the legislation have been met, and thereby removing any reluctance on the part of the designated officer to authorize removal.

Step 12 – Who is the senior available next of kin?

Next of kin is defined in section 4 as meaning:

> *"(a) In relation to a child – a person referred to in paragraph (a)(i)-(iv) of the definition 'senior available next of kin'; or*
>
> *(b) in relation to any other person – a person referred to in paragraph (b)(i)-(iv) of that definition."*

Senior available next of kin is defined in section 4 as meaning:

> *"(a) in relation to a child – the first of the following persons who in the following order of priority, is reasonably available –*
>
> *(i) the spouse of the child [child is not defined so it would be assumed to be someone under the age of 18 years, marriage to someone under the age of 18 years being allowed under special circumstances authorised by a magistrate under the Marriage Act 1961 (Cth)];*
>
> *(ii) a parent of the child;*
>
> *(iii) a sibling, who has attained the age of 18 years, of the child;*
>
> *(iv) a guardian of the child; and*
>
> *(b) in relation to any other person – the **first** of the following persons who, in the following order of priority, is reasonably available –*
>
> *(i) the spouse of the person;*
>
> *(ii) a child, who has attained the age of 18 years, of the person;*
>
> *(iii) a parent of the person;*
>
> *(iv) a sibling, who has attained the age of 18 years, of the person."*

In other words, there is a descending test. As seen in the example below, provided that someone fits the category of senior next of kin, for example, spouse, then the fact that others may object, such as an adult child, is not a requirement of the Act. However, if the senior available next of kin consented, but an adult child (or parent or sibling) vehemently objected, then the designated officer (for a body in the hospital) may be reluctant to authorise removal.

NHMRC

Every IVF clinic operating in Australia must have accreditation from the Fertility Society of Australia and New Zealand. A condition of accreditation is to comply with the National Health and Medical Research Council, *Ethical Guidelines on the use of assisted reproductive technology in clinical practice and research* (2017, updated 2023). The *Ethical Guidelines* in effect act as licensing conditions. They specify how posthumous use can occur.

The *Ethical Guidelines* apply nationwide. However, ART legislation in those States where it applies, adds additional requirements or restrictions about posthumous use.

ART legislation affects, directly or indirectly, five Australian jurisdictions. In those States and Territories where there is a conflict between the law and the *Ethical Guidelines*, the law prevails. In the other three jurisdictions, consideration is only as to the NHMRC.

Jurisdiction	**NHMRC**	**ART Act**
ACT	NHMRC	
New South Wales	NHMRC	*Assisted Reproductive Technology Act 2007*
Northern Territory	NHMRC	Repromed practitioners must so far as possible comply with their South Australian licenses, in accordance with an agreement of supply with the Northern Territory Government.
Queensland	NHMRC	
South Australia	NHMRC	*Assisted Reproductive Treatment Act 1988*
Tasmania	NHMRC	
Victoria	NHMRC	*Assisted Reproductive Treatment Act 2008*
Western Australia	NHMRC	*Human Reproductive Technology Act 1991; Human Reproductive Technology Directions 2021*

As of March 2024:

- there is a Government Bill in the ACT Legislative Assembly to regulate ART, including posthumous use.
- the Queensland Government is proposing to have an ART Act enacted in 2024, which may include provision about posthumous use.

The broad rule of practice is that where posthumous use is prohibited (Western Australia) or greatly restricted, New South Wales, Victoria and South Australia, then widows will be seeking to move sperm to NHMRC jurisdictions, primarily the ACT and Queensland. However, if the ACT Bill is enacted, then posthumous use can only occur in the ACT (when the person did not give written consent to posthumous use) with the approval of the Supreme Court.

In the case where a sister was considering making her eggs available for her brother's surrogacy journey, no treatment would have been allowed in Australia, but the eggs may have been exported to a suitable jurisdiction overseas. In the case of Victoria, or Western Australia if that donation to a sibling were proposed, then the export would have had to have been approved relevantly by VARTA or the Reproductive Technology Council and would almost certainly have been refused because treatment could not be provided on similar lines in Victoria or

Western Australia respectively. However, if the terminally ill person exported their gametes overseas, then there is no restriction on the ability to do so.

NEW SOUTH WALES

On the face of it, if the gamete provider has not provided written consent to use posthumously, then the gametes or embryos cannot be used.[18]

However, with rare exception in the cases, judges have not been prepared to look a grieving widow in the eyes and tell her that the sperm cannot be used. In several cases, the Supreme Court of New South Wales has held[19] that the widow, being the person who caused the sperm to be retrieved, or the person who by being the legal personal representative of the deceased, is the person administering the estate, has control of the sperm under a contract of bailment, that is a right superior to that of the IVF clinic. She can then determine what happens with the sperm, not be dictated to by the clinic. Therefore, she can cause the sperm to be taken by a courier company to go to a clinic interstate or overseas.

This approach is consistent with the approach in Queensland, where these clear words were said by a Supreme Court judge[20]:

> *"The conclusion, both in law and in common sense, must be that the straws of semen currently stored with the respondent are property, the ownership of which vested in the deceased while alive and in his personal representatives after his death. The relationship between the respondent and the deceased was one of bailor and bailee for reward because, so long as the fee was paid, and contact maintained, the respondent agreed to store the straws. The arrangement could also come to an end when the respondent died without leaving a written directive about the semen, but plainly the bailor, or his personal representatives, maintained ownership of the straws of semen and could request the return of his property. Furthermore, it must be implied into the contract of bailment, that the semen would, if requested, be returned in the manner which it was held, which preserved its essential characteristics as frozen semen capable of being used. Any extra costs associated with that redelivery would be at the applicant's expense.'*

In essence, no offence would be committed by the clinic if it could be demonstrated that the widow has the legal right to hold the sperm – and she can then direct that the sperm be supplied to a courier company which in turn can supply to an IVF clinic interstate.

Courts have either determined that the widow's right to possess the sperm is that it forms part of the estate of the deceased (for example, where it was provided to the clinic by the deceased for storage, as in *Bazley*) and she is the legal personal representative of the deceased, or that the retrieval and storage of the sperm was at her direction, as in *Re Cresswell*[21]):

> "*Sperm removed from the deceased is capable of constituting property, where work and skill is exercised in relation to the removal, separation and preservation of the sperm. While Doodeward referred to the body part acquiring different attributes as a result of the exercise of work or skill, in Doodeward, the body in question was only preserved (albeit that it acquired pecuniary value). The state of the preserved sperm has been found to be sufficient for it to be capable of being property.*

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[18] *Assisted Reproductive Technology Act 2007* (NSW), s.23.
[19] For example, *Re Edwards*.
[20] *Bazley v Wesley Monash IVF* [2010] QSC 118 at [33].
[21] At [163].

While there is some support for the notion that sperm or tissue separated from the human body is a thing which is property capable of ownership, without the exercise of any such work or skill, those cases are limited to where the separation occurred while the donor was living and the donor consented to the removal of the sperm.

The sperm of a deceased, not removed while they are living, is not capable of being property and does not form part of the assets of his estate upon death;

Prima facie, the person entitled to possession of any sperm removed and preserved will be the party who has exercised the work and skill to extract and preserve the sperm or the principal for whom they act."

The effect of these decisions has meant that widows can export.

My experience, however, is that it is much cheaper for the client to cause a detailed legal letter to be written to the clinic to set out that there is compliance with the law – and therefore allow the widow to lawfully export, instead of having to make application to the Supreme Court.

Test cases, after all, are very interesting, except when they're your own. From the client's point of view, what is sought to be achieved is the export. If this can be achieved by writing a letter than obtaining a court order, the letter is to be preferred.

SOUTH AUSTRALIA

South Australia limits the ability to provide posthumous treatment to the sperm or an embryo created from the sperm – but does not contemplate the possibility of using eggs. Section 9(1)(iv) of the *Assisted Reproductive Treatment Act 1988* (SA) (and no widening under the *Assisted Reproductive Treatment Regulations*) restricts treatment as follows:

"(iv) If –

(A) the donor of the relevant human semen has died; and

(B) before the donor died –

- *the donor's semen was collected; or*
- *a human ovum (being the ovum of a woman who, immediately before the death of the deceased, was living with the donor on a genuine domestic basis) was fertilised by means of assisted reproductive treatment is in the donor's semen; or*
- *an embryo had been created as a consequence of such assisted reproductive treatment; and*

(C) before the donor died, the donor consented to the use of the semen, fertilised ovum or embryo (as the case requires) after the donor's death in the provision of the proposed assisted reproductive treatment; and

(D) if the donor gave any directions in relation to the use of the semen, ovum or embryo (as the case requires) – the directions have, as far as is reasonably practicable, being complied with; and

(E) the assisted reproductive treatment is provided for the benefit of a woman who, immediately before the death of the donor, was living with the donor on a genuine domestic basis."

Quite simply, if posthumous retrieval is obtained, the sperm cannot be used. Nevertheless, South Australian authority makes is plain that the sperm can be exported[22]. This is on the same basis as that in NSW, namely that the widow is the person who is lawfully entitled to possess the sperm.

Currently there is a Bill before the South Australian Parliament which will widen the effect of s.9 of the ART Act:

"Section 9(1)(c)(iv)—delete subparagraph (iv) and substitute:

(iv) if—

(A) the human reproductive material—

- *in the case of human semen or a human ovum—was collected from a person who has died (the donor);*

or

- *in the case of a human embryo—was created from gametes of a person who has died (the donor); and*

(B) before the donor died, the donor consented to the use of the human reproductive material after their death in the provision of the proposed assisted reproductive treatment;

and

(C) if the donor gave any directions in relation to the use of the human reproductive material—the directions have, as far as is reasonably practicable, been complied with; and

(D) the assisted reproductive treatment is provided for the benefit of a person who, immediately before the death of the donor, was living with the donor on a genuine domestic basis (whether the treatment is carried out on that person or on another person for the purposes of a lawful surrogacy agreement)."

The Bill has passed the Legislative Council but is yet to reach the third reading in the Legislative Assembly. It is a Government Bill.

VICTORIA

Although there has been a recent, welcome, change in Victoria, the restriction in Victoria remains that the deceased must have provided written consent. Section 46 of the *Assisted Reproductive Treatment Act 2008* (Vic) provides:

"A registered ART provider may use a person's gametes, or an embryo created from the person's gametes, in a treatment procedure after the person's death only if—

[22] *Re H (No 3)* [2013] SASC 196.

(a) the treatment procedure is carried out—

(i) on the deceased person's partner; or

(ii) by the deceased person's partner commissioning a surrogacy arrangement in accordance with Part 4; and

(b) the deceased person provided written consent for the deceased person's gametes or an embryo created from the deceased person's gametes to be used in a treatment procedure of that kind; and

(c) the Patient Review Panel has approved the use of the gametes or embryo; and

(d) the person who is to undergo the treatment procedure has received counselling under section 48."

Patient Review Panel approval is required for use:

"(1) In deciding whether or not to grant approval for the posthumous use of gametes or an embryo, the Patient Review Panel must have regard to the possible impact on the child to be born as a result of the treatment procedure.

(2) Without limiting subsection (1), the Patient Review Panel must have particular regard to any research on outcomes for children conceived after the death of one of the child's parents.

Without that written consent, posthumous treatment is not possible in Victoria. In the words of VCAT[23]:

"There is no discretion in the ART Act to permit posthumous use of gametes without the written consent of the deceased person. Absent written consent to the use of his gametes by the applicant's husband, after his death, for a treatment procedure of the sort sought by the applicant, namely the creation of an embryo formed of his gametes, as we have already noted, a registered ART provider is not permitted to carry out a treatment procedure using those gametes."

Further:

"45. As we have noted in our reasons, the language of s46(b) is clear and unequivocal. Written consent for the deceased person's gametes to be used posthumously in a treatment procedure of the kind contemplated must be provided. The NHMRC guidelines referred to by Ms Hunt Smith make it clear that they are subject to any overriding statutory provisions, such as those contained in s46(b). Even were it possible to form the view that the applicant's late husband's consent to posthumous use of embryos formed using his gametes implied consent to posthumous use of sperm to create embryos for use by the applicant, that would be insufficient to satisfy s46(b).

46. *Whilst views may differ as to whether express written consent to the posthumous use of gametes should be required before a treatment procedure can be undertaken by a surviving partner, Parliament has made the decision that express written consent is required. Care should be taken to ensure that applicants who have already had to deal with the untimely death of a partner, and who are*

[23] *XVT v Patient Review Panel (Human Rights)* [2018] VCAT 1902 at [37].

contemplating assisted reproductive treatment involving the posthumous use of their late partner's gametes, are not given a false hope that approval for treatment can be given where there is a clear statutory bar to it. If reform of the law, by removing the requirement for express written consent to posthumous use of gametes or embryos, is thought to be desirable, it is for Parliament to consider representations from interested parties about the case for change, and to determine whether to amend the law. Neither the Panel nor the Tribunal can override the clear will of Parliament as expressed in statute.

47. *Finally, we note that by s31(b)(i), gametes cannot remain in storage after the end of 10 years, unless a longer storage period has been approved under s31A. The materials before us indicated the 10 year period for storage permitted by s31(b)(i) expired in August 2018. We were advised the Panel had approved storage for a further 5 years, until August 2023. By s31A(2), the Panel may approve a longer storage period, if it considers there are exceptional circumstances for doing so, in circumstances where the person who produced the gametes is unable to give written approval, or their written approval cannot be obtained. There were compelling arguments for granting an extension. Had a longer storage period not been approved, the gametes would have had to have been destroyed before the application for review could be heard and determined. However, and acknowledging we have not had the benefit of submissions on the point, we have some reservations about whether an inability to give or obtain written approval extends to inability due to death, as opposed to physical or mental incompetence, or absence."*

As seen with the other States, where treatment has been unable to occur in Victoria because the regulator refused approval, nevertheless permission has been given to export the deceased's sperm to a more friendly jurisdiction interstate.[24]

WESTERN AUSTRALIA

Clause 8.7 of the *Human Reproductive Technology Directions 2021* states:

> *"8.7 No posthumous use of gametes*
>
> *Any person to whom the licence applies must not knowingly use or authorise the use of gametes in an artificial fertilisation procedure after the death of the gamete provider."*

Clause 6.5 of the *Directions* says:

> *"6.5 Export of donated gametes, embryos or eggs undergoing fertilisation for use in an artificial fertilisation procedure*
>
> *A person to whom the licence applies must not, without the approval of the Council permit or facilitate the export from the State for use in an artificial fertilisation procedure, gametes, embryos or eggs undergoing fertilisation where donation of human reproductive material has been involved."*

The Reproductive Technology Council has the ability to approve the export of donated gametes, embryos or eggs undergoing fertilisation: clause 6.6.

[24] *AB v Attorney-General* [2005] VSC 180.

I had a number of matters from Western Australia where sperm was either being stored or had been retrieved. The question that arose for me was whether there was a *donation* of the sperm from the deceased to his widow? If the answer were that was no donation, then quite simply, although the sperm could not be used in Western Australia, it could be lawfully exported for use somewhere else such as Queensland or the ACT. If the sperm were donor sperm, however, then it could not be exported without consent of the RTC – which was almost certain to refuse export. In my view, the sperm in question could not reasonably be considered to be donated.

Solicitors acting for a widow where her former de facto partner had an unexpected cardiac arrest (and his sperm was retrieved) wrote to the RTC seeking permission for export whilst at the same time saying that they didn't consider that the RTC had the authority to approve (because the sperm was not donor sperm).

The reaction of the RTC was predictable, which was to claim that the sperm was donor sperm, and to refuse the export. After all, if posthumous use is banned in WA, why would it be appropriate for the regulator to allow that sperm to be sent interstate for posthumous use?

The facts of the case[25] are set out clearly in the judgment:

> *"20 On 27 January 2016 Gary suffered cardiac arrest in a shopping mall opposite the place where the plaintiff was working. He was unconscious by the time he was admitted to Royal Perth Hospital and did not regain consciousness before being pronounced brain dead by clinical staff at the hospital on 2 February 2016. Staff at Royal Perth Hospital listed the plaintiff as Gary's next of kin, and the plaintiff was engaged, with other members of Gary's family, in the discussions with hospital staff with respect to organ donation and the discontinuance of life support. In the result, after a number of discussions, it was agreed by all, including the plaintiff, that life support would be discontinued and that Gary would be allowed to die.*
>
> *21 Gary was moved to the mortuary at Royal Perth Hospital at about 2.00 pm on 3 February 2016. One of the staff at the hospital alerted the plaintiff to the possibility of Gary's sperm being extracted after his death. The following morning, the plaintiff returned to Royal Perth Hospital in order to ascertain what she needed to do in order to cause Gary's sperm to be extracted from his body. She eventually made contact with a medical practitioner working with a fertility centre in a suburb of Perth who indicated that he was qualified and available to undertake the procedure. Later that day, the plaintiff met with the medical practitioner and a senior member of the medical staff at Royal Perth Hospital, and it was agreed that the process would be undertaken that day. After the process was undertaken, the plaintiff was advised by the medical practitioner that the sperm extracted from Gary's body appeared to be viable, and capable of sustaining conception.*
>
> *22 The straws of sperm were transported from Royal Perth Hospital to a fertility clinic associated with the medical practitioner and have been held in storage cryopreserved frozen since then. The plaintiff has paid all the storage fees charged by the fertility centre.*
>
> *23 In December 2016, Gary's son, JDT, signed a statutory declaration in which he consented to the plaintiff having 'all of the rights and use of Gary's gammet's [sic]' upon the proviso that the plaintiff will not contact him or his immediate family, with the exception of his mother, in relation to any child that might result from the*

[25] *GLS v Russell-Weisz* [2018] WASC 79.

use of Gary's gametes, and on the further condition that the plaintiff not make any request for any financial, personal or emotional assistance.

24 The plaintiff has attached to her affidavit statements by her mother and a friend of Gary's corroborating her evidence to the effect that Gary had said, on occasions, that his sperm should be extracted and frozen in order that it might be used in case anything happened to him. Both also corroborate the plaintiff's evidence to the effect that she and Gary regularly discussed having children at some time in the future. A statement from the plaintiff's sister to the same effect is also attached to the plaintiff's affidavit.

25 In June 2016, and again in July and August 2017, the plaintiff undertook a number of medical tests with respect to her fertility, and with respect to her capacity to conceive using Gary's sperm in an IVF procedure.

Communications with the RTC

26 On 5 July 2017, solicitors acting on behalf of the plaintiff wrote to the RTC advising that the fertility centre storing the sperm extracted from Gary had been asked to export the sperm to a fertility clinic in Canberra, in order that it might be used to impregnate the plaintiff in Canberra. In the letter, the solicitors requested the approval of the RTC for the export of the sperm pursuant to cl 6.5 and cl 6.6 of the Directions, while at the same time asserting that those clauses of the Directions were not engaged because the proposed export did not involve human reproductive material which had been donated.

27 On 25 July 2017, the executive officer of the RTC responded to the plaintiff's solicitors requesting further information in support of what the RTC took to be an application under cl 6.5 and cl 6.6 of the Directions. That information was supplied under cover of a letter from the plaintiff's solicitors dated 15 August 2017, which again asserted that cl 6.5 had no application to the plaintiff's circumstances because her case did not involve donated human gametes.

28 On 6 October 2017, the executive officer of the RTC wrote to the plaintiff's solicitors advising that in the view of the RTC, its approval was required before the sperm could be removed from Western Australia. The Executive Officer further advised that the RTC had decided not to approve the export of gametes for a purpose that would be prohibited in Western Australia being, relevantly, the purpose of using Gary's gametes posthumously contrary to cl 8.9 of the Directions. Other reasons for refusing approval were given in the letter but, as there is no challenge to the decision of the RTC other than the assertion that its approval is not required, it is unnecessary to give any further consideration to the reasons given by the RTC for refusing approval." (emphasis added)

As Chief Justice Martin said:

"It should be noted that the HRT Act does not prohibit the posthumous use of human gametes, or the export of human gametes from the State. The only reference to such matters in the HRT Act is in section 18(1)(f) which provides that the Code of Practice may make provision for such matters. Because no Code of Practice has been promulgated, it follows that the RTC has never promulgated subsidiary legislation of general application with respect to such matters. However, the CEO has used the power to issue directions with respect to matters for which provision could be made in the Code to issue the Directions imposing obligations upon licence holders, which include

provisions relating to such matters, as will be seen. It will also be seen that the Directions were issued by the CEO on the advice of the RTC."

Chief Justice Martin then described two scenarios:

- Scenario 1

  The use of sperm from an identified man to fertilise an egg from an identified woman, the man and the woman being known to each other and usually, but not always, either married or in a de facto relationship

- Scenario 2

  The use of sperm from a man who is not known to, or any form of relationship with, a woman whose egg is fertilised using that sperm.

His Honour made plain that the scenarios weren't intended to be exhaustive and:

"78 In Scenario 1 above, the artificial fertilisation services provided by the holders of storage and practice licences will be utilised to fertilise an egg from a known and identified woman using sperm from a known and identified man. Married or de facto couples undergoing IVF procedures provide a common example of this scenario. Other less common examples might include a single or lesbian woman who wishes to conceive a child using sperm from a man she has chosen for that purpose, but with whom she is not in a relationship. The use to which the plaintiff wishes to put the sperm extracted from Gary's body also comes within this scenario.

79 In Scenario 2 above, the artificial fertilisation services provided by the holders of storage and practice licences will be utilised to fertilise the egg of a woman utilising sperm from a man with whom she is not in a relationship and who is not previously known to her. The sperm might be chosen randomly from amongst a bank of sperm samples provided to a licence holder by men who are willing to allow their sperm to be used for this purpose. Alternatively, the sperm might be selected from amongst the bank of samples held by a licence holder by reference to the characteristics of the provider of the sperm - such as the colouring of skin, hair, eyes or other genetic characteristics. Men providing sperm to licence holders for use in this way are commonly described as 'sperm donors', and the bank of samples held by licence holders provided by such donors are commonly described as 'sperm banks'.

80 The critical characteristic which distinguishes Scenario 2 from Scenario 1 is that in Scenario 2, the person providing the sperm to the relevant licence holder authorises the licence holder to determine the use that will be made of the sperm provided and, in particular, authorises the licence holder to determine the eggs with which they will be matched. In common parlance, the words 'donor' and 'donation' are used to describe the process by which that authority is conferred upon the licence holder. By contrast, in Scenario 1, the licence holder has no authority to determine the gametes which will be matched to produce a fertilised egg and is only authorised to match gametes provided by the two specifically identified individuals. These circumstances would not be described as involving 'donation' in common parlance.

81 It is clear from the HRT Act as a whole that the words 'donor' and 'donation' are consistently used throughout the Act in a manner which corresponds with the common parlance to which I have referred and, in particular, to describe a

circumstance in which gametes have been provided to a licence holder together with the authority to determine the manner in which those gametes will be used and, in particular, the gametes with which they will be matched to produce a fertilised egg. That point can be made good from a consideration of each occasion upon which the words 'donation' or 'donor' are used in the Act, which I will address, for convenience, in the order in which they are found in the Act.

…

84 Returning to the two scenarios which I set out above, and taking the most common example of Scenario 1, each member of a couple engaged in an IVF programme would be described as undergoing that course or cycle of treatment and would, for that reason, come within the definition of 'participant'. By contrast, a person who had provided gametes to a licence holder on terms which authorise the licence holder to determine the use to which the gametes would be put could not be described as undergoing any form of treatment or cycle of treatment. A parliamentary intention to include such persons within the definition of 'participant' can be gleaned from the way in which that word is used in other sections of the Act. For example, s 18(2)(a) provides that the Code of Practice may establish criteria as to the consent required of 'participants'. It seems reasonable to infer that the parliament would have intended that the Code should make provision for the precise terms of the consent provided by those who provide gametes to licence holders on terms which confer upon the licence holder the authority to determine the manner in which the gametes will be used."

His Honour said at [85]:

"There is no reason to suppose that in its context the word 'donation' should bear any other meaning than the meaning in common parlance to which I have referred - that is, the circumstance in which gametes are provided to a licence holder with authority to determine the manner in which the gametes will be used. It would not be reasonable to attribute to the parliament, based on the words which have been used or their context, an intention that 'donation' would include cases falling within the first scenario to which I have referred - namely, the use of artificial fertilisation procedures to produce a fertilised egg from gametes provided by two known and identified people."

In other words, Gary was not a donor and the sperm could be exported.

NHMRC

The *Ethical Guidelines* say at page 79:

"The possibility that an individual might be conceived following the death of one of their parents is understandably controversial. This situation might arise via the:

- *use of gametes or embryos collected and stored prior to death of a spouse or partner*
- *collection of gametes from a deceased person, or a person who is dying and their subsequent use.*

In such situations, clinicians are faced with a number of considerations, including:

- *relevant state or territory legislation*

- *respect for the deceased or dying person*
- *respect for the desire of the surviving spouse or partner to have a child*
- *possible (and unknown) effects on the welfare of the person to be born, having been conceived following a parent's death*
- *possible (and unknown) effects on the welfare of existing children within the family unit who may be affected by that birth."*

Paragraph 8.22 provides:

> *"8.22 Respect the wishes of the person for whom the gametes or embryos were stored*
>
> *Regardless of the relevant individual's position on the posthumous use of their stored gametes or embryos, there may be a legal impediment to such use in some states or territories and a court order may first be required.*
>
> *8.22.1 Where permitted by law, clinics may facilitate the posthumous use of stored gametes or embryos to achieve pregnancy, if:*
>
> - *the deceased person left clearly expressed directions consenting to such use following their death (see paragraph 4.6.4)*
> - *the request to do so has come from the spouse or partner of the deceased person, and not from any other relative*
> - *the gametes are intended for use by the surviving spouse or partner*
> - *the conditions of paragraph 8.23 are satisfied.*
>
> *8.22.2 Where the deceased person has left clearly expressed directions that object to the posthumous use of their stored gametes or embryos, clinics must respect this objection and not facilitate the posthumous use of the stored gametes or embryos to achieve pregnancy.*
>
> *8.22.3 Where the deceased person has not left clearly expressed directions regarding the posthumous use of their stored gametes or embryos, where permitted by law, clinics may facilitate the posthumous use of stored gametes or embryos to achieve pregnancy, if:*
>
> - *the request to do so has come from the spouse or partner of the deceased or dying person, and not from any other relative*
> - *the gametes are intended for use by the surviving spouse or partner for the purposes of reproduction*
> - *there is some evidence that the dying or deceased person would have supported the posthumous use of their gametes by the surviving partner, or at the very least, there is no evidence that the deceased or dying person had previously expressed that they do not wish this to occur 81 Ethical guidelines on the use of assisted reproductive technology in clinical practice and research*

- *the surviving spouse or partner provides valid consent (see paragraph 4.5).*
- *the conditions of paragraph 8.23 are satisfied."*

The first requirement is that the *Ethical Guidelines* make plain that there may be a legal impediment to use in some States or Territories and a court order may first be required. It is clear that a court order for use is not required in:

- ACT
- New South Wales (with care)
- Northern Territory
- Queensland
- South Australia (if the restrictions under the *ART Act* are met)
- Tasmania
- Western Australia (where posthumous use is prohibited)

The only place that requires an order to be made is Victoria, where if the restrictions are met, permission is required from the Patient Review Panel.

Applications for posthumous use to the Patient Review Panel

Year	Number
2010	2
2011	6
2012	3
2013	6
2014	4
2015	4
2016	4
2017	2
2018	2
2019	5
Total 2010-2019	**38**

As I said above, there has been the habit by lawyers, being uncertain of the law, to bring application to court to seek to authorise treatment – when in my view that authority in many cases is not required. If the widow is in effect the owner of the sperm, then she can determine its use.

Australia is a common law country. The basic premise of our law is that unless an action is specifically prohibited by law, it is lawful. Therefore, unless there is some specific statute or court decision that prohibits action being taken, then that action (such as the use of sperm posthumously) is lawful.

The next statement in 8.22.1 which says the circumstances in which clinics may facilitate the posthumous use, where permitted by law, is that the law generally permits the use, subject to the restriction under the *NHMRC Ethical Guidelines* or specific statutes (i.e. New South Wales, South Australia, Victoria and Western Australia). If there were clearly expressed directions by the deceased and the treatment is to be by the spouse or partner of the deceased for their reproduction and the counselling, information and independent oversight has been complied with, then treatment can be provided.

Consistent with the *Human Tissues Acts*, if there is an objection by the deceased, then treatment cannot be provided: 8.22.2.

The *Guidelines* state the obvious (which somehow the Parliaments of New South Wales, South Australia and Victoria cannot accept) – which is that sometimes while people may think that they are going to have a family, they may not have in fact set out express directions about posthumous use. Who expects, after all, to die of a sudden cardiac arrest or a brain haemorrhage (such as falling off a skateboard while not wearing a helmet) or having an unexpected drug overdose while partying?

What then needs to be established for 8.22.3 are those requirements, namely:

- The request has come from the spouse or partner of the deceased or dying person not from anyone else.
- They are for that person's reproduction.
- There is some evidence that the dying of a deceased person would have supported the posthumous use of their gametes by the surviving partner, or at the very least, there is no evidence that the deceased or dying person had previously expressed that they do not wish this to occur.
- The surviving spouse or partner provides valid consent.
- The conditions at paragraph 8.23 are satisfied.

Guidelines 8.23 and 8.24 provide:

> *"8.23 Allow sufficient time before attempting conception and/or pregnancy*
>
> *8.23.1 Given the enduring consequences of the decision, clinics should not attempt conception or a pregnancy using stored gametes or embryos unless:*
>
> - *sufficient time has passed so that grief and related emotions do not interfere with decision-making*
> - *in addition to the requirements outlined in paragraph 4.1, the surviving prospective parent (the spouse or partner) is provided with sufficient information to facilitate an accurate understanding of the potential social, psychological and health implications of the proposed activity for the person who may be born*
> - *the surviving prospective parent (the spouse or partner) has undergone appropriate counselling (see paragraph 4.3)*

- *an independent body has reviewed the circumstances and supports the proposed use.*

8.24 Posthumous use of gametes or gonadal tissue collected from a child or young person for the purpose of fertility preservation 8.24.1 Gametes or gonadal tissue collected from a child or young person for the purpose of fertility preservation (see paragraphs 8.4 – 8.6) can only be used posthumously if the person for whom they were stored reached adulthood before their death and the conditions of paragraphs 8.22 – 8.23 are satisfied."

In dealing with paragraph 8.23, the factors are:

- Sufficient time has passed so that grief and related emotions do not interfere with decision making.

  How long is sufficient time will vary with the individual case. There is no great science to what is sufficient time. For some widows, it may be two years, for others it may be six months. I would certainly say as a rule of thumb to have as a minimum six months. It will depend, primarily on the views of the counsellor as to whether the widow is ready to proceed.

- That the widow or widower is provided with sufficient information to facilitate an accurate understanding of the potential social, psychological and health implications of the proposed activity for the person who may be born.

  Quite simply, this would normally be undertaken by a fertility counsellor.

- The surviving prospective parent (the spouse or partner) has undergone appropriate counselling.

- An independent body has reviewed the circumstances and supports the proposed use. The last one can be the most problematic. If the IVF unit has its own ethics committee, then that's easy – you can go to the ethics committee for approval. Most IVF clinics from my experience don't have their own ethics committee anymore, so approval would be by a fertility counsellor or a lawyer specialising in the field.

Independent body is defined in the explanation to the *Ethical Guidelines*:

> *"An institution, group or person involving decision – or policy – making who is able to provide an 'independent' or 'disinterested' opinion or advice.*
>
> *May include a clinical ethics committee, a regulatory body or board, a tribunal or a magistrate, a Human Research Ethics Committee, a counsellor, or another relevant expert. The appropriateness of the body will be determined by the particular circumstances, and may be prescribed by legislation."*

PUTTING IT ALL TOGETHER

An example of retrieval

At the time the decision is made to retrieve, consideration must be given as to whether there could be the ability to use. There's little point going through the exercise of seeking retrieval if all that is going to be incurred is considerable cost and stress to be able to store sperm or eggs and not be able to use them.

In 2021 I was contacted by a fertility doctor where a man had come from New South Wales to the Gold Coast to party and had died suddenly and unexpectedly. I was told, when I spoke to the doctor, that 22 hours had passed since the man was declared dead. No time pressure! The man had a fiancée, but they never lived in a de facto relationship for religious reasons. He also had a mother and a father (who had separated for 20+ years) and several adult siblings.

The first question to be identified was, could someone use the sperm? In my view, the answer to that is yes. The fiancée would be able to use because she would be considered the *partner* of the deceased. The term *partner* is not defined in the *Ethical Guidelines* to be restricted to a spouse or de facto partner. The fact that they were not living in a de facto relationship I think was beside the point. They were engaged with the intention to be married.

However, she was not the senior available next of kin who could authorise treatment. Given that they were not living in a de facto relationship, the fiancée was not any of the categories of senior available next of kin.

The man's body was in a hospital. I had to work out who my immediate client was – and that was the deceased's mother, who wanted the retrieval to occur, on behalf of the fiancée. This meant of course that there was a plethora of telephone calls (about 70+ calls in about 2½ hours for my associate and me). The views of the mother and the fiancée were at one – they wanted the sperm to be retrieved so that it could be used to enable the fiancée to become a mum (and the deceased's mother to become a grandmother). They were quite supportive of each other.

As one might expect to occur, in a chaotic world, the mother was driving down the highway to return to Sydney. She only had intermittent contact due to gaps in the cellular network.

The coroner's office immediately indicated that it was a matter within their jurisdiction. The email to the coroner's office elicited a quick response that the coroner consented to treatment. Phone calls before emails help to lay the groundwork of things getting done.

One of the greatest difficulties was to find the authorised officer of the hospital. Thankfully this came from the IVF doctor via the morgue. When I telephoned the hospital and spent 20 minutes on hold to be told that there was no authorised officer, I knew that that statement was not true. The coroner's office was also helpful providing the contact details for the morgue and therefore, the authorised officer.

I quickly prepared:

- A consent by the mother for the authorised officer.
- A letter to the authorised officer setting out the circumstances of what had occurred.
- A statutory declaration by the mother setting out the history and why she consented (meeting all the requirements of the *Transplantation and Anatomy Act 1979* (Qld)).

Why the mother had to be the person consenting was because she was the senior available next of kin under the *Transplantation and Anatomy Act*. The requirement is that the senior available next of kin be the first of the following persons who, in the following order of priority, is reasonably available:

1. The spouse of the person.
2. A child, who has attained the age of 18 years, of the person.
3. A parent of the person.

4. A sibling, who has attained the age of 18 years, of the person.

As I said, the fiancée was not the spouse.

As the deceased did not have any children, that did not apply. Therefore, the senior available next of kin was *a parent of the person* i.e. of the deceased. Therefore, the mother was the senior available next of kin.

The fact that the deceased had a number of adult siblings was irrelevant.

The body was in a hospital.

The consent by the senior available next of kin, in effect, requires the consent of both of them if there are more than one, if reasonably available. The first requirement is that *the senior available next of kin* of the deceased person consents to the removal of tissue: section 22(1)(c). The second is that the senior available next of kin if he or she has no reason to believe that the deceased has expressed an objection to the removal of tissue after death, they make it known to the designated officer at any time before the death of the person, that the senior available next of kin has no objection to the removal, after the death of the person, of the tissue: section 22(3). However, where there are two or more persons of a description as to senior available next of kin, an objection by any one of those has effect for the purposes of the section notwithstanding any indication to the contrary by the other or any other of those persons: section 22(4).

Therefore, the consent that is required needed to be by one of the senior available next of kin, but any objection by any other senior available next of kin needed to be negatived. The mother, as I said, was travelling down the Pacific Highway to Sydney. Her statutory declaration was sent to a firm of solicitors in a town ahead of where she was driving, with arrangements for it to be printed and executed when she arrived there. The form was settled with her whilst she was on the road.

Her ex-husband of 20+ years happened to be in Brisbane on his way to the Sunshine Coast to return to Sydney. Thankfully, he was cooperative and came to my office and executed a statutory declaration drafted for him, by which he also consented to removal. That statutory declaration of course was also provided to the designated officer. Within a period of 3½ hours (half an hour of which was the father not being able to find his way up in the lift to my office, to the consternation of my associate) all of the requirements of the legislation were met – and retrieval was able to be undertaken.

NHMRC EXAMPLE

Fiona was recently widowed when her husband had a stroke. They had been trying to conceive through IVF, but had been unsuccessful.

Fiona went to lawyers in New South Wales who obtained an urgent order from the Supreme Court to retrieve the sperm. As I have said in this paper, such an order was unnecessary. Nevertheless, it was obtained and the sperm was retrieved and stored.

I subsequently wrote to the clinic, pointing out the case law from the New South Wales Supreme Court in effect provided that Fiona had the right to determine what happened with the sperm, and that there had been in all respects compliance with the NHMRC *Ethical Guidelines*. The clinic then agreed to release the sperm to Fiona to be transported to Queensland to a Queensland clinic. Fiona was able to avoid having to bring a second application in the Supreme Court – a likely saving of A$20,000-$30,000 or more.

Separate correspondence with accompanying statutory declaration to the Queensland clinic by me set out how there had been full compliance with the NHMRC *Ethical Guidelines*. Full disclosure of the correspondence with the New South Wales clinic was also made.

Treatment was approved.

My client was delighted when she became a mother.

In the preparation of this paper, I am indebted to fertility counsellor Narelle Dickinson for telling me that there is scant research about how children turn out when they are conceived from posthumous sperm. It is a relatively rare and new phenomenon and it will be only a question of time when the smoke clears.

However, what we can say with some certainty following the extraordinary amount of research undertaken by Professor Susan Golombok at the University of Cambridge, Center for Family Research, is that however children are conceived – through surrogacy, egg donation, sperm donation, gay parents, lesbian parents and the like, they turn out about the same. One such study concerned 51 solo mothers compared with 52 two parent families all with a 4-9 year old child conceived by donor insemination standardised interview, observational and questionnaire measures and maternal wellbeing, mother-child relationships and child adjustment were administered to mothers, children and teachers.

There were no differences in parenting quality between family types apart from lower mother-child conflict in solo mother families. Neither were there differences in child adjustment. Perceived financial difficulties, child's gender, and parenting stress were associated with children's adjustment problems in both family types. The findings suggested that solo motherhood, in itself, does not result in psychological problems for children. It was noted that studies have shown that single mothers by choice are generally well-educated women in professional occupations who become mothers in their late 30s or early 40s. In spite of having chosen to parent alone, the majority of solo mothers do so not from choice, but because they do not have a current partner and feel that time is running out for them to have a child. Many single mothers by choice report that they would have preferred to have children within a traditional family setting, but could not wait any longer because of their increasing age and associated fertility decline. As was pointed out by a researcher, if they wanted to become mothers, they did not actually have a choice.

They go on to say that there is a large body of research on the psychological wellbeing of children in single mother families formed by divorce. These studies have consistently shown that children whose parents divorce are more likely to show emotional and behavioural problems than are children in intact families. However, the children's difficulties appear to be largely associated with aspects of the divorce, rather than single parenthood, in itself. One factor that has been found to be related to children's adjustment problems is conflict between parents. The financial hardship that is often experienced by single parent families following divorce has also shown to be associated with children's psychological problems. Furthermore, a number of studies have demonstrated a link between parental depression, poor parenting quality, a negative child outcomes and single parent families following divorce.

Furthermore:

> *"Unlike divorced or unmarried single mothers who have had unplanned pregnancies, single mothers by choice, make an active decision to parent alone, and thus differ from those who unintentionally find themselves in this situation. Children of single mothers by choice have not been exposed to parental conflict and are less likely to have experienced the economic hardship or maternal psychological problems that commonly result from*

marital breakdown and unplanned single parenthood. Nevertheless, they grow up without a father from the start and, for those conceived by donor insemination at a fertility clinic, do not know the identity of their biological father. Even in countries where the use of anonymous donors is prohibited, children are not able to discover his identity until late adolescence. This makes them distinct from most other children of single mothers, whose fathers may be absent but whose identity is known."

GRANDPARENTS

There have been a number of media reports from India, the UK/US; and Israel and the US, the last two authorised by a judge or regulator, about grandparents having a child from the sperm of their deceased son.

There would appear to be no reason – *as a matter of law* - in those States that rely only on the NHMRC *Ethical Guidelines*– that grandparents be able to use their late son's sperm (or a daughter's eggs) in order to create another child. The restrictions in the *Ethical Guidelines*, whilst setting out how posthumous use can occur, do not prohibit such a use.

However, as Professor Frederick Kroon, Professor Kelton Tremellen and Julian Savulescu make plain, the use of gametes posthumously is a highly fraught area ethically. Such a step, to enable grandparents to use their late child's gametes in order to be able to reproduce to replace their child, should be approached with a great deal of trepidation.

The current ethics committee opinion of the ASRM is:

"Posthumous gamete (sperm or oocyte) retrieval or use for reproductive purposes is ethically justifiable if written documentation from the deceased authorizing the procedure is available. Retrieval of sperm or eggs does not commit a center to their later use for reproduction, but may be permissible under the circumstances outlined in this opinion. Embryo use is also justifiable with such documentation.

In the absence of written documentation from the decedent, programs open to considering requests for posthumous use of embryos or gametes should only do so when such requests are initiated by the surviving spouse or partner."

IVF clinics, as with other businesses, operate under social licence. If it is seen that the proposed treatment is ahead of where the Australian public might consider is appropriate, then one can expect, as we have seen in the past, a legislative response to prevent a recurrence.

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8 March 2024
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RETRIEVING SPERM/TESTES/EGGS/OVARIAN TISSUE FLOWCHART-QUEENSLAND

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