TRANSCRIPT OF PROCEEDINGS

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THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

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DAY 2

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CHAIR: Good morning, everyone. I will ask Commissioner Mason to make the acknowledgement to country this morning.

COMMISSIONER MASON: I wish to pay my respects and acknowledge the First Nations people of the lands on which the Royal Commission is sitting today. We recognise the Arrernte people, the traditional owners and custodians of the Mparntwe or Alice Springs. We recognise the Wurundjeri people of the Kulin Nation, where the City of Melbourne is now situated. We recognise the Gadigal people of the Eora Nation, the traditional custodians of the land on which the City of Sydney is now located. We acknowledge and pay respects to the Ngunnawal people, whose land is where the City of Canberra is now located.

We also wish to acknowledge the traditional custodians of the various lands on which you are all virtually appearing from, any First Nations peoples who are participating in this hearing and those First Nations peoples who also identify as LGBTIQA+, including our sister girls and brother boys. Thank you, Chair.

CHAIR: Thank you, Commissioner Mason. Yes, Ms Eastman.

MS EASTMAN: Thank you, Commissioners. Good morning and good morning to everyone following the proceedings.

We turn to the final panel which will be part of the public aspect of this hearing. This morning we will touch upon the issues of sexual and reproductive rights for women and girls with disability. Some of the material that we may cover today may be distressing for some people. I ask now for the relevant contact numbers be displayed for people to contact if they feel they need to speak to someone in relation to the information they hear today. Commissioners, you will see the contact numbers are up on the screen.

Our witnesses for this panel are Ms Carolyn Frohmader and Dr Linda Steele. I will wait until I can see them on the screen. There they are.

MS CAROLYN FROHMADER

DR LINDA STEELE

Good morning. Thank you very much for joining us. Ms Frohmader is in Hobart in Tasmania, and Dr Steele is in Sydney.

Commissioners, a copy of their CVs and their extensive experience in advocacy, writing and research for women and girls with disability are in the Tender Bundle material. I think we have decided that we will not spend a lot of time telling you about what they have done, but they are very keen to tell you about what they presently do and the issues relevant for these proceedings.

Can I check with Ms Frohmader and Dr Steele, firstly, are you happy if we use first names?

MS FROHMADER: Yes.

MS EASTMAN: Secondly, are you happy to avoid long introductions?

MS FROHMADER: Very much so.

MS EASTMAN: We will get straight into the topic.

CHAIR: Before we do that, can I welcome you both and thank you for coming to the Royal Commission to give evidence. If at any time you want to take a short break, please let us know and that can be arranged.

In order to allow you to know where everybody is, because we are scattered all over the place, Commissioner Galbally is in Melbourne, Commissioner Bennett is in Canberra, Commissioner Mason is in Alice Springs and I am in the Sydney hearing room, as is Ms Eastman. So that is where we all are.

I will now asks Ms Eastman to continue. Thank you.

MS EASTMAN: Now, I want to start --- we have used a lot of expressions and terms in the hearing over the course of yesterday and we will again today. When we talk about sexual and reproductive rights, and sexual and reproductive rights of women and girls with disability, I want to make sure, for the conversation we are about to have, that we are all clear about what we are talking about.

Carolyn, I will start with you. I will preface this by saying some of the material you have provided to the Royal Commission is a statement from Women with Disability Australia about sexual and reproductive rights. It very, very helpfully sets out all of the relevant international human rights law standards that talk about these rights.

However, I am really keen today to move from what the UN says and what is in the treaty to talk about what it means for women and girls with disability on the ground, in the day-to-day, everyday lives of women. So, what are sexual and reproductive rights and what will we be talking about this morning?

MS FROHMADER: Well, sexual and reproductive rights are inherent to everybody. It's an absolute fundamental human right. So, essentially, it's about the right of everybody to make their own choices about their bodies, to have full control over their body, their sexuality, their health, relationships, if and when to get married or not, if and when to have children or not, without any form of discrimination, coercion or violence.

I think at the heart of sexual and reproductive rights it is, essentially, about individual choice. The right of all women to actually make decisions and informed choices about their own bodies and what happens to them.

MS EASTMAN: Sexual and reproductive rights, fundamentally, about who we are as human beings, the choices we make in our lives, the way in which we want to present, and our identities. Some of that will be very public and some of that will be

really private.

When you talk about that choice, it is sometimes the choice, isn't it, as to what is in the public side of our lives and identity and the things we want to keep in our private and personal spaces. Is that important to think about when we talk about sexual and reproductive rights? I am opening this up for a conversation. Linda, feel free to jump in and, Carolyn, I am keen to hear from both of you.

MS FROHMADER: I know. I think that sometimes when people talk about sexual and reproductive rights, they focus very much on reproductive rights, whereas sexual rights are very important as well because sexual rights aren't necessarily about reproduction, although they can be. So, sexual rights are about making sure that everybody can encompass sexual activity, sexual orientation, pleasure, intimacy, all those types of things, and to feel loved and be loved. That is different for everybody and it is very personal.

So, although sexual and reproductive rights are interrelated, it's very important to understand sexual rights on their own, if that makes sense?

MS EASTMAN: I see that Linda has dropped off the screen but we will keep going and I hope she will pop back.

CHAIR: There was a message that came up about a fire drill.

MS FROHMADER: Oh no.

MS EASTMAN: Carolyn, you may have been following the proceeding yesterday. We talked about a lot of issues in terms of violence and abuse of women and girls with disability. Questions of violence and abuse can also arise in relation to a person's sexual rights and reproductive rights.

We want to talk about this topic today to have an understanding about the extent to which women and girls with disability are denied their sexual and reproductive rights. That fits in to how the Royal Commission is looking at violence, abuse, neglect and exploitation of people with disability.

This is something you have looked at a lot. What can you tell the Royal Commission about the nature and degree to which there is interference with the sexual and reproductive lives of women and girls with disability in Australia, and some of the areas where there is that interference with the rights?

MS FROHMADER: I guess, first of all, I would like to say, having been in my position as CEO of Women with Disability Australia for almost 25 years, that women and girls with disability consistently state, and always have done, that they see their sexual and reproductive rights as one of the most urgent and unaddressed issues.

MS EASTMAN: Why is that?

MS FROHMADER: You talked before about in what ways are women and girls with disability denied their sexual and reproductive rights. I could probably talk about this for two days but for the purposes of trying to make the most of the time, things like --- I talked before, generally, about what we mean by sexual and reproductive rights and, importantly, individual choice and informed decision making.

If we look at women and girls with disability and we look at some of the ways their rights are denied in this way, we can go through things like forced and coerced sterilisation, forced contraception or limited choices around contraception, denial of sexual expression, poorly managed birth and pregnancy, forced and coerced abortion, termination of parental rights, denial of marriage or, alternatively, forced or coerced marriage, exclusion from sexual and reproductive health information, education, services, screening. Everything from things like breast and cervical cancer screening, bone density screening, menopause services, to name just a few.

I said before about the denial of the right to sexual expression, exclusion from legislation and policy frameworks and services that are designed to address gender-based violence. One thing I would like to say that has been a very common theme I have seen in my role is that women and girls with disability are often seen only in the context of their impairment. They're not actually seen as women first, they're seen as their disability or their impairment first. That can often mean they don't get access. They are not necessarily even seen as sexual beings, so often are denied basic things like screening for domestic and family violence.

I could talk about all of those things in detail, but one of the things I really want to stress this morning and to make absolutely clear is that the two most critical issues in the context of the denial of sexual and reproductive rights for women and girls with disability are forced sterilisation and forced contraception.

The reason I want to pick out those two issues particularly is not to trivialise any of the others, by any means, but the very fact that it is 2021 and we live in a wealthy country, yet it is still completely legal to sterilise a girl on the basis solely of her impairment --- in the absence of a life-saving emergency, I should make clear --- and it is also perfectly legal to sterilise an adult woman with disability without true and informed consent.

MS EASTMAN: Can I ask you some questions about this. We are trying to get Linda Steele back on. This is an area where Linda has done a lot of research and looked at the issues.

For people following us, can I step back. When we talk about sterilisation and contraception, sterilisation may involve a surgical procedure to render a woman infertile.

MS FROHMADER: That's right.

MS EASTMAN: There may be a range of different medical procedures that could enable that to occur.

MS FROHMADER: Yes.

MS EASTMAN: When we talk about contraception, we talk, perhaps, about medical or drug use to manage a woman's reproductive menstrual cycles and reproductive capacity.

MS FROHMADER: That's correct.

MS EASTMAN: When we talk about force and using that adjective, we are looking at circumstances where the woman herself has not made the decision to be sterilised. So it's the absence of the woman's consent to undergo the medical procedure, be it a surgical procedure or consent to the medication?

MS FROHMADER: Yes.

MS EASTMAN: Am I right in understanding that?

MS FROHMADER: Yes, and of course there is lots of terminology: forced, involuntary, therapeutic, non-therapeutic, authorised, non-authorised. At the end of the day, when we talk about forced sterilisation, it is about the performance of a procedure which results in a permanent loss of reproductive capacity, in the absence of the free and informed consent of the individual who undergoes that procedure. That includes instances where that consent has been authorised by a third party such as a parent, court, legal guardian, tribunal, judge, without that individual's consent.

MS EASTMAN: Can I ask you some questions about that, again, so people following us will see the steps. A person, a woman or a young woman with disability might consent to a particular procedure and it is important that she has informed consent. When we talk about forced sterilisation or forced contraception, we talk about where that decision making is substituted.

MS FROHMADER: That's right.

MS EASTMAN: Some somebody steps in to make the decision.

MS FROHMADER: That's right.

MS EASTMAN: That process of decision making can either really translate or make the situation about medical decisions or legal decisions, it seems. A doctor might say:

> *This is in the woman's best interests to undergo a procedure that will render her infertile and never capable of having children.*

A doctor can make that decision. It could be that the parents of the young woman with disability seek the assistance of a medical practitioner for that procedure to be done.

But there is also the legal side of it and Linda has covered this in her articles. Sometimes courts are asked to make decisions ---

MS FROHMADER: That's right.

MS EASTMAN: --- that authorise the medical practitioner to perform that particular procedure.

MS FROHMADER: That's right.

MS EASTMAN: We have seen, historically, the courts having a role in stepping in and making the decision. Linda has talked about this in some of her articles. But I want to ask you, in your experience, how do judges know that this will be a decision that should be made if it is forced? When you talk about force, you talk about taking away consent and someone else is making that decision for them.

I am interested in do you know how judges go about it. I am not asking you from a legal perspective but from your experience with women and girls. What is your perception of how courts do this?

MS FROHMADER: So really, you know, the courts --- there is really --- if I could group it into four sort of themes that why judges and courts have actually approved or authorised the sterilisation of often very young girls, often before they have even commenced puberty or gone through puberty or commenced menstruation. There are probably four main areas.

One is really a eugenics based argument in a sense. It's about the fear of women with disability reproducing more children with disability. That is a very --- that has been a quite common reason. The fear of, oh well, we had better get this young woman sterilised because she has a genetic condition with a 50 per cent chance of it being passed on. However, it is very rare that you would see such a decision being made for a young girl without a disability with a genetic disorder.

So that's one, the genetic argument about not wanting women with disability to have more children with disability. There is an assumption that's the case when it's not necessarily the case.

The next theme, I would say, is what I call 'for the good of the state, the community, the family, services', et cetera, which is essentially about burden of menstrual management, burden of care. That is a really, really common theme that has run through the reasons why courts have actually approved sterilisation for young girls, largely with intellectual disability but not only.

MS EASTMAN: Just on that, can I ask you --- I think Linda Steele is now on the phone.

DR STEELE: Yes, I am.

MS EASTMAN: Jump in, and I'm sorry it makes it a bit tricky. But, Carolyn, that issue around menstrual management and suppression, looking at Linda's articles and the history, that raises two issues. One issue is an assumption that young women with disability can't manage menstruation. Secondly, rather than looking at alternatives to a sterilisation procedure that will render that young woman infertile, it is seen in the literature as the easy way; let's just get it all done in one go. Is that what you are talking about: it's just easier and neater and cleaner and not as messy, so let's do it in one go?

MS FROHMADER: It's also that, sort of, underpinning all of that is this view that women with disability are a burden, that they are somehow less than human. I will give an example from some of the comments made by judges around reasons. Often when we talk about sterilisation as a way of stopping young girls going through menstruation, these have been sole reasons, the sole reason why some of these young women have been sterilised.

One judge said:

> *Menstruation will be yet another hazard and perhaps mitigate against her chances of being adopted should her mother die.*

MS EASTMAN: Carolyn, there is a bit of background noise.

DR STEELE: Sorry, that is because I'm not in the building because of a fire drill. Sorry.

MS EASTMAN: Linda, can I ask you to pop on the mute button.

DR STEELE: Sure. You will tell me when you would like me to ---

MS EASTMAN: I will let you know when to bring you in. Or Carolyn, if you want Linda to come in at any point, let us know. We just have to be --- the whole world is on fire drills, technology and the like. We'll just go with the flow this morning on this.

MS FROHMADER: Absolutely. Usually when I'm doing something like this, the council turns up outside to drill jackhammers or something.

MS EASTMAN: I don't think there has been an online hearing that hasn't had a leaf blower, a garbage truck, a jackhammer or something else.

CHAIR: Helicopters.

MS EASTMAN: So it's absolutely fine. We've had an earthquake, that's true.

MS FROHMADER: There are also other reasons. Judges have said, well, caring for her is an onerous responsibility on her parents and sterilisation would make the task of caring for her somewhat less onerous, and it will also make it easier for her carers if they had one less medication to administer. So there are many of these things.

Again, to give another quick example of a statement made by a judge:

> *It would be wisest to avoid problems rather than to wait and see if she copes with menstruation. Surely there is no need for her to suffer the problems that may arise with menstruation.*

That is the second theme about burden and there are some examples there.

The next one is a, sort of, two-pronged one, which is about notions of incapacity. One is incapacity for parenthood. Again, I'm talking here about reasons that have been used to sterilise young women and girls with disability. Well, she's never going to have a child, she doesn't need a uterus, she's not going to miss it if she's never going to have a child. If she had a child, it would be an absolute disaster.

So that, sort of, assumed incapacity for parenthood. Let's just get rid of it altogether and we don't have to worry about it.

The next thing is linked to incapacity for parenthood, which is the notion of incapacity to develop and evolve. In these contexts, courts have actually seen that sterilisation is --- well, she only has the mind of a 2-year-old, so we might as well just get it done, sterilise. That has been, again, a really common theme.

Again to quote from a judge:

> *There is no prospect she will ever show any improvement in her already severely retarded mental state.*

In this context, incapacity is assumed to be permanent, as in the individual has no capacity to actually develop or evolve. That's another rationale that has been used.

The last one I will talk about, and this goes to forced contraception as well, but is about prevention of sexual abuse. That has been a really common theme in sterilisation authorisations by courts and tribunals. There are some really horrible, horrible things that have been stated in this context.

So, this is one case where approval was given for the sterilisation of a 16-year-old disabled girl, with her attractive looks forming part of the reason. The judge said:

It is unlikely that she will ever have the capacity to understand and voluntarily enter into a sexual relationship. It is, however, well documented that disabled children are particularly vulnerable to sexual abuse and she is quite an attractive girl.

Another one, quickly, along the same lines:

It is unlikely she will ever have any form of relationship involving sexual intercourse. She could, of course, be the victim of a sexual assault and with her normal physical development and attractive looks, that cannot be discounted.

It is absurd really, if you think about this logically. Forced sterilisation, forced contraception will never overcome the risk of sexual abuse, otherwise every woman in Australia would be walking around having been sterilised.

MS EASTMAN: Can I bring Linda in at this point. Linda, in terms of those areas that Carolyn has discussed and those extracts from the court decisions, to actually get to a court or tribunal, it does require somebody to make an application to approach the court or tribunal. Looking at your research, Linda, the people who approach the courts or the tribunals for these decisions are the parents or medical and health practitioners. Is that usually who makes the applications?

DR STEELE: Yes. I think there might have been one or two instances with children of a guardian or worker in a school, a residential school, this was in the '80s or '90s, but otherwise with adults, yes, it might be a parent who is still involved in personal care or it could, alternatively, be a guardian who applies. Because, yes, this consent to sterilisation is not within the scope of guardians or authority, it needs to be approved by a Guardianship Tribunal or the Family Court or the Supreme Court.

MS EASTMAN: There must be, surely, a process for the judges or the tribunals to make these decisions. It seems that an approach based on working out what the person's best interests are has been the way to guide the decision-making.

What does applying a best interest approach mean for the woman or girl who will be subject to a medical procedure such as sterilisation, where she is not making the decision but somebody else is? Linda, can you tell us a little bit about how best interests work? You probably anticipate where I will go next, that is, a human rights based approach compared to a best interests approach?

DR STEELE: I just preface the discussion of the different tests by saying that, ultimately, allowing sterilisation when it's not consented to by the individual is seen by many as a form of violence. Generally, if we think about the definition of criminal assaults in law or the common understanding of what illegal violence is, it's about when someone does something to you that you haven't agreed to.

Obviously in law there are some exceptions and one exception is where someone else is lega

lly authorised to give that consent. But that legal authorisation by someone else relies upon the assumption that the individual herself is incapable of consenting. The second assumption is that it is legitimate to give that role to someone else.

If we begin from the starting point that non-consensual sterilisation, sterilisation that isn't consented to by the individual, is a form of violence, it's a form of violence that is allowed by law but it's still violence. Then the issue of whether one test or other is better, whether dressing up a test in human rights, whether we train judges to be really well versed in disability and disability rights, whether we train lawyers, all of those issues are kind of irrelevant to some extent if we see sterilisation per se as violence.

The more we try to improve the procedural framework of that sterilisation, it is simply further embedding that violence in legal process and further exacerbating the complicity of law, of courts, in enabling that violence to occur.

Turning to the two different tests, the best interest test has been criticised in many different contexts in relation to people with disability, in relation to children and, historically, in relation to the way in which the paternalistic idea of 'we know best' also played out in relation to First Nations people. The idea of best interest is that because someone is considered to lack the capacity to take care of their own welfare and health and safety, someone else should be able to step in and make some reasoned judgment about what would be the best set of circumstances or the best intervention for someone.

In the context of people's disability and children in relation to sterilisation, that idea of best interest has been about taking the individual in their current circumstances and determining --- their current imperfect circumstances, in the sense of perhaps having a lack of access to services or support or their family having a lack of access to support, and in the context of that, working out what is the best way to alleviate perceived issues of care, of personal hygiene, of safety, particularly for parents or disability services.

That question of best interest is a very individualised question. It's not taking a step back and saying, hang on, how come this individual is in these circumstances where they might need additional support and, structurally, what has failed this person or this family? Secondly, taking a step back and questioning what stereotypes or ideas around women and girls with disability sexuality or their menstruation are informing our assumptions that sterilisation is something that we need to consider.

So the best interests is kind of an empty concept that has been referred to as being capable of being filled by whoever is making that judgment. Interestingly, though, the idea of best interest is very subjective in terms of it’s ableist but also gendered.

There was an interesting comment made by the judges in Marion's case, which is the leading High Court decision on a non-therapeutic sterilisation of girls with disability. They say the fact that we are considering best interests in relation to sterilisation

means that it is potentially a procedure that could be in the best interests of a girl. But another procedure, we couldn't even comprehend it ever being in the best interests. They use the example of a parent wanting to cut off the foot of their child to facilitate begging and making money.

So the best interests operates at that individual level of here is a girl before the court, what is going to be in their interests. But there is a prior structural assumption that it is possible that sterilisation could be in the best interests of a girl, as compared to other procedures.

Obviously, the example of cutting off a foot is perhaps a bit facetious of a court to use. But we can think of the many other personal care and support needs that women and men and boys and girls and people of any gender with disability might need across their lives. There is no explicit legal option or legal doctrine around enabling various other bodily processes and bodily organs and parts to be removed. There is something particular about menstruation and sexuality of women and girls with disability that makes this even possible for us to legally consider.

MS EASTMAN: Linda, I know we are using the distinctions forced, unforced or consent, therapeutic and non-therapeutic. There are different adjectives we can use to describe. But will there be cases where women with disability may require a medical procedure that may assist them address health issues? Are there circumstances where there is any role for a court, guardian or tribunal to make these decisions at all?

DR STEELE: There is the possibility that sterilisation will be a byproduct of surgery to address a serious medical condition, such as cancer. That is a possibility, although it's a very rare possibility. But otherwise, no.

The idea is if someone cannot give their free and informed consent to have parts of their body removed or to have bodily processes restricted in some way in relation to reproduction and sexuality, that no one else should be able to make that decision on their behalf

MS EASTMAN: If somebody said, well, why don't we look at this as an absolute last resort, would that be consistent with a human rights approach, that it has to be just last resort?

DR STEELE: Yes, yes. All those tests allow --- again, that idea of what tests are used is stepping in after and, kind of, bypassing --- stepping in after a more foundational question of hang on, why is the law even involved in these really intimate and personal experiences for women and girls, things that are not generally shared publicly or decided upon by other people in relation to other women and girls.

At a time when we are seeing more focus in relation to women without disability around issues of women's autonomy, so law reform in relation to sexual consent and decriminalisation of abortion in Crimes Acts legislation, at the same time, abortion

and sterilisation keeps on going in disability-specific legislation.

I should also add one thing, sorry, before we go to what Carolyn was noting around the reasons for sterilisation. We've seen, particularly in the context of guardianship legislation, because it emerged out of deinstitutionalisation, it is seen as substituted decision making to support people trying to live in that community. Obviously we can critique that because it is self-facilitating legal violence.

But when sterilisation is being authorised in the context of guardianship legislation, there is also this idea that --- it's not necessarily framed as being about protecting women or girls or alleviating a burden, but also facilitating their community inclusion and participation and their ability to be involved in relationships.

I think that is quite a perverse logic because it overlooks the fact that this kind of equality or inclusion that women and girls are apparently able to access through sterilisation depends upon this intervention that is removing parts of their body or stopping bodily processes that are actually core to how a lot of people identify and experience their bodies in the world.

Certainly, a lot of the testimony that Carolyn and WWDA has collected speaks to the way in which sterilisation actually robs from women, who have had that done to them, such core aspects of their identity and their ability to identify as women or humans or relational beings. I think that's an added tension around potentially assuming that guardianship law is going to offer a more progressive or supportive framework for approving these procedures.

MS EASTMAN: I will jump in there because this is an area the Royal Commission will examine in some detail at a future hearing, and the Royal Commission is very interested in looking at models around guardianship and substituted decision making and supported decision making.

Can I move on from the topic of sterilisation, because I know you both want to talk about a range of other aspects of sexual and reproductive rights, not just sterilisation. Can I ask you to, perhaps, step a few paces back.

Carolyn, you have talked about what some of the reasons might be for justifying sterilisation and that is an inability to have a sexual or intimate relationship, an inability to be a parent, or attitudes around women with disability even being sexual or capable of having relationships.

Can I ask you to talk a little bit about some of those assumptions and how you see that having a bearing on when and how sexual and reproductive rights are interfered with, denied and not readily understood by everyone around the women and girls with disability?

MS FROHMADER: Yes. These are particularly major issues for women with disability in segregated settings, particularly group homes and other forms of

institutional residential settings.

MS EASTMAN: So what is happening in those settings?

MS FROHMADER: Well, basically, some women with disability have lived in those institutions for years and years and years and they've never been given any choices. They are not even --- you know, we have members who say "What's forced sex?", or have never been able to --- they're not allowed to have a boyfriend or a girlfriend. You know, they're not allowed to --- they're not even allowed to have privacy. They are not allowed to make choices about what they would like to do.

I want to also try and give some practical examples. We know of women with disability, particularly intellectual disability in those types of settings, who have been used by service providers to provide sex to men with disability in other group homes, for example, as a way of addressing the man's challenging behaviours, as they were termed. Women with intellectual disability have been told "That's your boyfriend", pushed inside the door and been used in that way.

We know of women with disability in these settings not having access to money or being under financial management orders, or whatever, and basically being heavily exploited in their local communities where, if they provide sex, the man will give them a packet of cigarettes or a bag of lollies or $10 or something.

We also have examples of women with disability being forced --- I use the words "forced marriage". Forced marriage is usually understood in the context of faith-based communities, but we have examples of women with disability being coerced into marriage, enforced marriages. For example, a woman with a mild intellectual disability living in the community, being coerced by a much, much older man to get married and virtually being --- it's a form of slavery. It's like a sexual slave and to do all the housework and the cooking, and everything.

It has not been researched at all in Australia, as far as I'm aware, the issue of forced marriage in relation to women and girls with disability.

MS EASTMAN: Carolyn, how do these stories come to you? Some people following this might say if this is happening in Australia, that's astonishing.

MS FROHMADER: Yes.

MS EASTMAN: How is it that the stories are coming to you but we are not hearing these more generally in the community, that people are forced into marriages and the nature of their relationship renders them under that complete coercive control which we were talking about yesterday in the hearing.

MS FROHMADER: Firstly, a lot of women with disability aren't believed, and I'm sure that was discussed yesterday. Having been in my job for 25 years, Women With Disabilities Australia is an organisation that women with disability trust, so we are

told stories in all sorts of ways. Often, it might be crisis calls, it might be email, it might be a whole range of ways. Obviously, for some women with disability that has been over a number of years to actually develop that rapport and trust where they are confident to explain and tell their story.

Some women with disability who have tried to report these types of issues to the police, for example, have just been told, "She's making it up. You're mental." I have witnessed that myself, supporting women with disability to try and report rape to the police, where the first statement that comes out of the policeman's mouth was, "Well, do you reckon she's making it up? They all make it up." So there's that sort of denial, for a start.

Yes, I'm really sorry to say this does happen in Australia and it continues to happen in Australia.

I think that one of the things --- if we talk about segregated settings, group homes, et cetera, after deinstitutionalisation from the big institutions, some of these places, they are out of the public view, there's no public scrutiny. Some of these group homes might be up the back of a dirt road in a country town somewhere. So the situation for women and girls with disability living in segregated residential institutions is just horrific.

MS EASTMAN: Is there a way forward? And these are very distressing circumstances to talk about and, Carolyn, you have carried this for so many years.

MS FROHMADER: Yes.

MS EASTMAN: But you remain optimistic, don't you, that there can be better inclusion ---

MS FROHMADER: Yes, but ---

MS EASTMAN: --- and respect and recognition for the rights of women and girls. Where do we head?

MS FROHMADER: I want to say one thing: yes, I'm optimistic; however, I'm also very, very angry.

I know we don't want to get into the nature of every international human rights treaty, and all the rest of it, however, since 2005 --- Australia is a signatory to seven international human rights treaties and since 2005, every one of those treaty monitoring bodies have strongly recommended that the government introduce national legislation to prohibit sterilisation of children, all children, except in a life-saving emergency, and to prohibit the sterilisation of adults with disability without their prior free and informed consent, except in the absence of a life-saving emergency.

We have lodged formal complaints against the Australian government to the United Nations, we have held national forums of women and girls with disability to talk about their experiences of sterilisation and the impact, and yet I was looking at a report the other day from 1990, where a forum was held with women and girls with disability in Victoria, and one of the participants said:

> *I think there should be a sterilisation law. I think there should be a law that goes in to Parliament that stops the sterilisation of women and girls with intellectual disability.*

I was thinking, it's 31 years later and we are still asking for the same.

However, it has been very firmly backed by international human rights law and not only international human rights monitoring bodies, but also the World Medical Association, the International Federation of Gynaecology and Obstetrics, and yet it is absurd.

Sorry, I'm raving on a bit now. Feel free to say, "Shut up, Carolyn."

MS EASTMAN: No, keep going. I will jump in and apply my protective interruption, but I did want to ask you about this because your material has this aspect of being angry and asking how many more international rights can we have, but at the same time you are optimistic.

I think optimism comes in terms of what you think, based on your experience, can be done. Part of this is about translating these rights into Australian law and practice and into how we work as a community. That's what I am reading in your material.

MS FROHMADER: Yes, definitely. So it's like, if we talk about moving forward, if we talk about a human rights approach, you know, one of the issues that has been really annoying about the whole sterilisation matter is that it's just been bogged down for year after year after year after year by legalistic debates about who can sterilise, who can authorise it for whom, under what circumstances, in what jurisdiction, and so on.

It's actually not a matter for --- it is unlawful. You can't do it if a woman doesn't consent. You simply can't do it. I would like to think, if we are talking about a human rights approach to women and girls with disability in relation to their sexual and reproductive rights, we need to be able to enjoy the same rights as all other women and girls on an equal basis. I can't imagine what it would feel like for a non-disabled woman to have a third party making decisions about what contraception she is going to take.

We have women with disability who have been on long-acting injectable contraceptives like Depo-Provera injections. They were put on it when they were 15 or 14, are still on it now at nearly 50, with no clinical indication whatsoever. They have been told things like it's the flu injection. Some women with intellectual

disability I'm talking about largely here have been told it's the flu injection. Others have been told this is an injection all nice ladies have. All nice ladies have this injection.

So when we are talking about a woman who is nearly 50 being put on a long-acting injectable contraceptive that has huge problems with side effects, particularly when you look at the fact it's often combined with psychotropic medications, for that long, these women miss out on --- well, Depo-Provera can do things like mask menopause. It can also cause early menopause.

There are cases of women with disability complaining of being in back pain for months and months and months and being told it was because they were obese and they needed to exercise more. Then us having to fight to say, well, when was the last time this woman had a bone density test, given she has been on these injectable contraceptives forever. No, she's never had one of those. Go and get the bone density test and the woman is riddled with osteoporosis.

These are the sorts of things that I'm angry about, still angry about. But if we are talking about a human rights approach, we just want what all other women have and that is autonomy over our bodies. The right to make our own decisions about what happens to our bodies.

Sorry, would you like me to keep going?

MS EASTMAN: At this point, I'm mindful of the time and I think the Commissioners might have some questions they want to ask. I will ask the Commissioners if they have any questions at this point. Hopefully Linda is still on the line, and we might come back after the Commissioners' questions just to wrap up on a way forward.

We have talked about this being the beginning of a conversation, not the end of the conversation. I would be keen to hear from both of you how do we keep the conversation going, so we can think about a way forward. Tapping into the optimism, Carolyn, even if it's just a little tiny of slither of optimism, how do we move forward. Commissioners?

CHAIR: I will ask my colleagues if they have any questions. I will start with Commissioner Galbally. Do you have any questions?

COMMISSIONER GALBALLY: Thank you very much for coming forward today. I would like to ask you, Carolyn, you touched on group homes and segregated settings and painted a picture of it almost being hard to get one's head around. I wonder if you could go into that in more detail about women and girls, because there are girls living in these settings, and what this means for them about being able to be women in the way you have described? Thanks.

MS FROHMADER: Thanks, Commissioner. Obviously segregation, by its very

nature, particularly when we're talking about living environments, open --- women and girls with disability in those settings are at particular risk of interference in their sexual and reproductive rights. In fact, they're not even seen as women. They're seen as residents.

As I said before, we know anecdotally --- there has been some research in Australia but not very much --- that menstrual suppression and forced contraception is widely used in these types of settings. It gets back to this issue, as I said before, around burden, women and girls with disability being seen as burdens of care. It is also quicker and cheaper to just have women with disabilities in these settings on these types of drugs because they can also --- I'm not a doctor, but they can also suppress sexual desire.

I would also, if it's okay, like to ask Linda if she wants to answer some of that question in relation to --- can she hear me?

DR STEELE: Yes. Thank you, Carolyn. I guess just very briefly agreeing with what Carolyn has said that, yes, the segregated setting itself is the problem and then a whole other layer of problems compound with the fact that people with disability are being segregated from the rest of society. That segregation is where people live or work or study, but also in our legal systems as well.

But in terms of the segregated residential setting, there was a Victorian senior practitioner's report a few years ago now that looked at menstrual suppression in facility services or residences. One of the things he found was when women were on menstrual suppression, a lot of them were also subject to other restrictive practices. So the interventions in their reproductive and sexual lives were just one part of this way in which their lives more broadly were being controlled and limited. Restrictive practices and guardianship laws were a big part of that as well.

I will stop there because of the noise, sorry.

MS FROHMADER: Commissioner Galbally, I would also say that there is no regulatory authority that actually requires monitoring of the use of these types of drugs in these types of service settings because they are not always necessarily seen as a chemical restraint. I don't want to go too far down that path because that brings in a whole raft of other issues that we don't have time to discuss.

But segregated settings are a dangerous place for all people with disability, quite frankly, and I'm sure that some of the things the Royal Commission has heard to date would support that. So in terms of --- sorry, I was just thinking, Kate, you asked me a question about moving forward. Does that answer your question, Commissioner?

COMMISSIONER GALBALLY: Yes, it does. The only other question I had is that, and you've sort of answered it, it doesn't sound like there is monitoring or record keeping, and there is no research into this question in Australia of segregated settings and forced sterilisation and menstrual intervention. There is no research or data

collected, as far as I can gather from your answer?

MS FROHMADER: In relation to sterilisation, the only --- the data issue is just a nightmare. One of the things that came out of the 2013 Senate inquiry into involuntary sterilisation of people with disability was an agreement to try to collect better data. I think the Office of the Public Advocate in Victoria was given some money to actually start a project around that. The Family Court didn't want to participate, so it was only then around state and territory Guardianship Tribunals and their equivalents.

What happens now is that every year there is a one-page document placed on the Australian guardianship --- the national website. It actually just gives, by jurisdiction, the number of authorisations --- sorry, the number of requests for sterilisation and the number of approvals.

Unfortunately, that is only restricted to what is called adults with cognitive disability. That is not defined. But we do know even from that very crude data that between 2016 and 2020 there have been 31 approvals.

MS EASTMAN: Carolyn, just on that, we have included in the Tender Bundle for this session those one-page Australian sterilisation reports, so the Commissioners have that to see with each jurisdiction. Sorry to jump in there, but to let you know we have included that.

COMMISSIONER GALBALLY: That doesn't tell us of the incidents in group homes?

MS EASTMAN: No. Can I jump in? I'm applying protective interruption to everybody today and I'm sorry about that. I'm conscious of the time and I'm also conscious of the Commissioners wanting to ask questions but also to hear the reflections of Carolyn and Linda on optimism.

CHAIR: Perhaps I can ask Commissioner Mason and then Commissioner Bennett if they have questions they wish to put?

COMMISSIONER MASON: No, thank you, Chair.

CHAIR: Commissioner Bennett?

MS BENNETT: Thank you, Carolyn and Linda. Going back to that reference about the tribunal data which you have clarified, Carolyn, is only cognitive disability adult sterilisation for periods. The latest one from July '19 to '20 said that there were eight and five of them were in the Victorian jurisdiction. So apart from the inadequacy of the data, which is the point you have made, in addition to non-surgical, five of them being in Victoria, does this reflect the point you have made that there is no national legislation and some states do have legislation preventing?

There are four jurisdictions where there were no approvals given --- maybe Linda might know the answer to this --- but four jurisdictions where it was approved and, as I said, Victoria has five of the eight.

MS FROHMADER: I might pass that one over to Linda, but there is obviously massive problems with that data set. Linda, do you want to answer that?

DR STEELE: Yes, thank you. I can't speak to the exact reasons in terms of Victoria but there are different legal tests for sterilisation in the different guardianship jurisdictions. In New South Wales, for example, the tribunal needs to be satisfied that the treatment is the most appropriate form of treatment for promoting wellbeing and it's necessary to save life or prevent serious damage to health.

In contrast, in Queensland and South Australia, for example, sterilisation can be authorised by a tribunal where it's medically necessary or where it's necessary for contraception or menstrual purposes where other interventions are not suitable. There is a vast range in terms of when sterilisation can be authorised. Again we would say: whatever the tests, they shouldn't be authorised at all.

I want to point out, in terms of data, that even though we might have some data from the Guardianship Tribunal, that quantitative data around how many decisions are being made, unfortunately, because the sterilisation is authorised by Supreme Court and Guardianship Tribunal and Family Court as part of the parens patriae jurisdiction, the general principle of open justice which we have across our courts to allow public access to court hearings and court decisions is a long-standing legal principle, but that principle of open justice does not apply in the parens patriae jurisdiction. It's at the discretion of the judge or tribunal.

That's supposed to be because these jurisdictions are protective and private. But if we shift everything and say, hang on, these decisions are allowing violence to occur, they are not protecting women and girls from violence, then I think it's so important we have more transparency around all of the decisions that are being made. Whether they are de-identified or not is another question.

But to simply have those numbers is not giving us that depth of detail about what kinds of assumptions and ideas and knowledge around women and girls with disability are held by individual judges or enabled by psychological expertise or legal principles. We're not getting that level of information and that's really important to have.

COMMISSIONER BENNETT: Thank you.

MS EASTMAN: Chair, I assume you have no questions?

CHAIR: No.

MS EASTMAN: Can we end on your suggestions or recommendations about a way

forward, even if those are further matters that need more careful attention, research or consideration. Carolyn, can I ask you to comment on that and, Linda, perhaps let me know if you agree with Carolyn or if there is anything extra you want to add.

MS FROHMADER: Obviously, this is a massive area and I would also like to point out that it is also an issue that affects men and boys with disability, but obviously probably not to the same extent as women and girls. It is a massive area to properly unpack, yet it is an area that has been totally denied.

It has been an area where we can't even get into our national policy frameworks. So the frameworks to advance and promote the rights of people with disability, so Australia's Disability Strategy, or the National Plan to Reduce Violence Against Women and Their Children, although I'm hopeful there because there is a new one about to be developed, or Australia's National Framework For Protecting Australia's Children.

It's like you can't even talk about sterilisation or menstruation or these types of forms of violence. They're not even recognised in our national policy frameworks.

But one of the things moving forward, obviously law reform is critical. I will keep badgering on and I will say there is absolutely no reason for Australia to keep stalling on law reform in the area of forced sterilisation.

Also, ending segregation, and I'm not talking about tomorrow. I know that people can get very distressed if you start talking about closing down special schools, as they're called, or group homes, or whatever.

What I'm talking about here is one of the things that Chair Sackville said at the very beginning of this Royal Commission, that we needed a social transformation, we needed this Royal Commission to actually be looking towards a social transformation.

In terms of some of these issues, particularly ending segregation, we're talking about what do we need to do as a country to start transitioning away from segregation of people with disability and too stop treating them as 'other'. I could go into really specific detail about training and financial supports and more independent advocacy, and all those sorts of things.

But the other thing I want to get said before we finish is Australia has a responsibility to provide redress to those women and girls who were sterilised without their consent. We have some members who were told they were having their appendix taken out and didn't even know until they wanted to have children. We have members who were sterilised at the age of seven because they had a mild vision impairment.

One of the things that is really important about redress --- and it's not just about money and compensation, it's about all the things that make up redress, so guarantees

of non-repetition and apologies. The very important thing about redress is that it sends a very clear message to the community about what's not acceptable.

If we're talking about changing attitudes towards women and girls with disability, and so on, I see that we cannot move forward unless we are prepared to address the past. Well, we can, but we have to address the past.

Linda, do you want to add a couple of things there because I don't want to run out of time and not have you say something.

DR STEELE: Yes. I agree with everything Carolyn has said. Just to emphasise the importance of ending that segregation across society in residential and school, et cetera, settings, but also in the justice system. That includes repealing substitute decision making laws and also addressing how substituted decision making is enabled through the court jurisdictions as well. It's not just all about the legislation.

Definitely the issue of redress has been about responding to injustices and violations but also it is about preventing violence, moving forward. If we look at transitional justice frameworks, if we look at the UN Van Boven Principles on human rights violations and reparations, it is always framed as being more than simply that legal understanding of remedies, where you are responding to something that has happened in the past, and it's the connection between the past, what is happening now and a better future. So it is certainly something that fits within the Commission's aspirations of transforming society and of preventing violence, moving forward.

MS EASTMAN: Can I thank both of you again. I said this yesterday: I feel like we have just started the discussion, so it will certainly be an ongoing area of interest for the Royal Commission. Can I thank you both very much for your time and for sharing these experiences with us today. Chair?

CHAIR: I would like to add my appreciation to both of you. I know it is not necessarily easy to give evidence in a forum such as this. On behalf of all the Commissioners, we appreciate that you have been prepared to do that and to share your experiences with us.

We are also very grateful for the very detailed printed material we have received that we have read and will continue to read very carefully. That is a very important contribution to our work.

Thank you very much for your appearance today, for giving both the oral evidence and the documentary material we have received. Thank you.

MS FROHMADER: Thank you very much, Chair and Commissioners.

DR STEELE: Thanks.

THE WITNESS WITHDREW

MS EASTMAN: Chair and Commissioners, that concludes the public aspect of the hearing. We will now move into the closed and private session.

Before doing so, we have circulated the proposed list of tendered documents to the parties and, Chair, we have provided to you a list of the documents we seek to tender. We are happy for you to make that order and we will publish the tender documents on the website shortly.

CHAIR: I understand there is no objection to the tender, that the tender has been distributed to all parties with leave to appear. On that basis, I will admit into evidence the documents that are identified in the material that has been circulated to the parties given leave to appear. I take it that is Bundle A, Bundle B and Bundle C?

MS EASTMAN: That's right.

The second matter is that while we will now go into the private session, this hearing will continue, hopefully in person, towards the latter part of March next year in Hobart, COVID permitting. Commissioners, I don't ask you to make any directions in relation to the receipt of any additional material at this stage or to prepare Counsel Assisting submissions. We had in mind that we will do that in a thorough way when we have the second part of the hearing.

But we do encourage anyone who has followed the proceedings over the last day or so, who wishes to share their stories with the Royal Commission, to please come forward and we would welcome to hear people's experiences. We can do so in a form that keeps the information private. You can share your experiences with the Royal Commission through submissions, and information is available on the Commission's website. There is also the option of applying for a private session with the Royal Commission.

Commissioners, our next hearing will be on 8 and 9 November. Perhaps it is timely, in light of the comments made by Ms Frohmader and Dr Steele, that we will focus on the convention of the rights of persons with disabilities. We will look at how the convention and international human rights law can make their way into Australian law practice and community attitudes and expectations. So that is the next proposed hearing.

Commissioners, from this point onwards the proceedings will close and we will welcome the lesbian, bisexual, transgender, intersex, queer and questioning and asexual plus participants, who will join us in the closed session. Thank you, Commissioners.

CHAIR: Thank you, Ms Eastman. Before we conclude the open hearing, I would

like to thank everybody who has been involved in preparations for this hearing and, of course, the witnesses who have appeared and given evidence that we have heard over yesterday and this morning.

These are extremely important issues. They are also issues that are not necessarily easy to talk about and we appreciate the willingness of the witnesses from whom we have heard over the last day and a bit.

I also want to thank everybody within the Commission who has been associated with the preparation for, and conduct of, this hearing. We have been operating, as we all know, for a long time in the midst of a COVID-19 pandemic that has altered the way in which we have to proceed. It is a tribute to the commitment and skill of everybody who is involved in preparing for and conducting these hearings that, even given earthquakes, helicopters and everything else we have had to endure, that they have been conducted so smoothly. So, we do very much appreciate the work that has gone into the preparation and conduct of the hearings.

We will now adjourn and the proceedings will resume with the in-camera session. As Ms Eastman has indicated, there will be another hearing on 8 and 9 November.

MS EASTMAN: Thank you, Chair. For present purposes and the Commissioners, we will adjourn, just to reconstitute the hearing room and the arrangements. Thank you.

HEARING ADJOURNED AT 11:07 A.M.

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