[2004] FamCA 297

FAMILY LAW ACT 1975

IN THE FAMILY COURT OF AUSTRALIA

(By Court Order
the File Number is Suppressed)

RE ALEX : **Hormonal Treatment For Gender Identity Dysphoria**

BEFORE: **Nicholson CJ**

DATES OF HEARING: **15 December 2003, 8 and 15 January 2004 and 22 and 23 February 2004, 8 April 2004**

DATE OF JUDGMENT: **13 April 2004**

APPEARANCES:

(By Court Order the Names of Counsel and Solicitors has been Suppressed)

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Introduction

1. I have before me an application concerning a 13 year old who I will refer to as "Alex" in this judgment in order to preserve anonymity. At the commencement of the proceedings, I made an order pursuant to s 97(2) of the *Family Law Act* 1975 ("the Act") closing the proceedings from the public and prohibiting any identifying disclosure of Alex. It was common ground in the proceedings that this judgment should avoid any indication of such matters.

2. Anatomically, and in the eyes of the law, Alex is a girl. However Alex has been diagnosed as having what some of the experts define medically as a gender identity disorder and has a profound and longstanding wish to undergo a transition to become male in appearance. I think it questionable whether this condition is properly described as a disorder. I prefer the expression "dysphoria" which I think is a more accurate description and will use the terminology throughout the remainder of this judgment. A definition appears below in par 100.

3. No surgical intervention is sought or indeed contemplated by any of the parties or witnesses while Alex is under the age of at least 18 years.

4. The key issue before me is whether I should authorise medical treatment involving the administration of hormonal therapies that will begin what is colloquially described as a "sex change" process. In order to reach this decision I must be firmly satisfied upon clear and convincing evidence that the proposed treatment is in Alex's best interests: see *Re Marion (No. 2)* (1994) FLC ¶92-448 applying the standard established by *Briginshaw v Briginshaw* (1938) 60 CLR 336.

5. The application was brought by Alex's legal guardian with a view to the commencement of treatment coinciding with Alex beginning secondary school. Alex wants the proposed treatment to start as soon as possible. All

of the evidence before me supports such intervention. It indicates that hormonal treatment would be in Alex's best interests and would benefit Alex's mental and emotional health. Some differences emerged, however, among the experts as to the precise course and timing of the hormonal treatment.

The Application

6. The application filed on 12 December 2003 sought by way of final orders, a declaration pursuant to sub-ss 67ZC(1) and (2) of the Act. Section 67ZC was introduced by the *Family Law Reform Act* 1995 (Cth). It provides a statutory grant to the Court of a broad welfare jurisdiction that is similar to the ancient *parens patriae* jurisdiction: see the recent discussion in a different context by the majority of the Full Court in *B and B and Minister for Immigration and Ethnic Affairs* (2003) FLC ¶93-141 pars 210-247 and the cases referred to therein. Section 67ZC is the statutory basis for the Court's jurisdiction to approve or refuse permission for special medical procedures: see the discussion in *Re GWW and CMW* (1997) FLC ¶92-748 at 84,106- 9, per Hannon J

7. Alex is under the legal guardianship of a government Department ("the Applicant") as a consequence of a currently operative care order made by a Children's Court under a child welfare law. The present application was brought by the Applicant with the written consent of a child welfare officer as defined by s 60 of the Act. With such written consent, there is no doubt that Alex can be the subject of an order by this Court while in care: see s 69ZK of the Act.

8. I will return to a discussion of the special medical procedures jurisdiction conferred by s 67ZC at a latter point in these reasons. For introductory purposes, it is sufficient to say that I found that the further considerations which go to the question of jurisdiction justified the role of the Court in deciding whether to hear the application. Those considerations are:

- The question of whether Alex can give effective consent to the proposed procedure; and
- The nature of the proposed procedure.

9. The respondents to the application were Alex's mother and the aunt with whom Alex lives. The aunt is an older sister of Alex's mother. The consistent evidence is that the mother is estranged from Alex.

10. On 18 December 2003 I ordered that service upon Alex's mother be deemed effected by the Applicant causing a sealed copy of this application and documents in support of it to be sent by pre-paid mail to her last known address. The service documents were returned. Markings on the envelope indicated that the mother was not known at that address. On 15 January 2003, I ordered that the requirement for serving the mother with the present application be dispensed with. The mother did not play any part in the proceedings.

11. Alex's aunt gave evidence before me but although a party to the proceedings did not seek to be represented or represent herself as a party.

Additional Parties

12. I appointed a Child Representative on the first occasion that the matter was before me. I would record my appreciation that the responsible legal aid authority expedited the process of approving the necessary funding.

13. Subsequently, at my invitation, the Human Rights and Equal Opportunity Commission ("the Commission") intervened without objection in the proceedings pursuant to s 92 of the Act. The Commission indicated that it would confine itself to making submissions on the human rights principles applicable to the case and would not seek to be heard in respect of the evidence specific to Alex. It was agreed that the detail of the Commission's submissions should be in written form with an opportunity for the Applicant

and the Child Representative to respond within seven days. No submissions in response were in fact filed.

14. For the sake of completeness, I record that I permitted a representative of a statutory Office concerned with the rights and interests of people with disabilities to observe the proceedings, again without objection. The Office did not seek to intervene.

15. I hasten to add that my approval of the presence of the Office as an observer was not because any of the parties or I construed that Alex has a disability but rather because Offices of this type are also concerned with matters of this nature, particularly as they affect children and young people. I therefore took the view that it is in the interests of the broader community for such an Office to have the benefit of observing the proceedings in circumstances where Alex's privacy was safeguarded.

Terminology

16. For quite some time Alex has wanted to be referred to as a male. The evidence is consistent on this issue.

17. The issue was canvassed at an early stage of the proceedings and it was submitted both by the Applicant and by the Child Representative appointed for the proceedings that I should use the male pronoun when referring to Alex in this judgment and when recounting evidence. I will do so. When I had a private meeting with Alex at his request and with the agreement of the Applicant and the Child Representative, he confirmed that this was his preference. This approach was also generally adopted by witnesses and the legal representatives in the course of the hearing process.

18. Although the Act and the applicable caselaw speak in terms of a "child", I prefer to use the expression "young person" when I refer to Alex in this judgment, having regard to his age and maturity.

The Final Orders Sought in the Initiating Application

19. The initiating application sought a declaration that the Secretary of the Department, as the legal guardian of the Alex, is authorised to consent to the following medical procedure on his behalf:

> *"(a) that the child be administered a combination of oestrogen and progestogen on a continuous basis until the child turns 16*
> *(b) on going psychiatric assessment*
> *(c) that the further hearing of this matter be adjourned to 6 months before the child's 16th birthday to consider authorisation to consent to the child being treated with an LHRH analogue and testosterone administered either in oral form, by monthly injection or by 6 monthly subcutaneous implant*
> *(d) any other order that this Honourable Court deems met [sic]."*

20. Oestrogen and progestogen are female hormones. The effect of continuously administering a combination, which is in effect a contraceptive pill without the usual one week break, would be to suppress Alex's menses.

21. LRHR analogue is a drug which would suppress the release of gonadotrophins from the pituitary gland. All ovarian menstruation would be suppressed for as long as Alex continued the treatment. Testosterone is a male sex hormone which would begin the process of masculinisation. It would have certain irreversible effects such as deepening of Alex's voice, the promotion of facial and body hair, muscular development and enlargement of the clitoris.

22. In final submissions, I was asked to make a declaration which provided authorisation in different terms. In effect, it was submitted that any declaration I make should now authorise all the treatment that is envisaged by the orders sought in the initiating application.

23. I raised with the parties whether any declaration I make should be prescriptive as to the nature of the hormonal treatment or whether I ought to

make a declaration which permits the attending physicians the latitude to adapt the hormonal intervention as the treatment progresses. This would permit some clinical discretion as to whether, for a period of time, the analogue would be administered on its own before testosterone was also administered.

24. On the final day of the hearing process, the Child Representative submitted the following minute of proposed orders:

> *"1. That until further order the child [birth name] be known as, addressed as and accommodated by the name [male name] and it is requested that all relevant Government departments and/or agencies give effect to this order and it is further ordered that any requirements for parental consent for any purposes associated with the use of the name of the child be dispensed with and that the consent being the signature of a duly authorised officer of the [Department] be the sole authorisation required including but not limited to the following purposes: -*
>
> *a. Any application to register a change of name pursuant to the [relevant legislation]*
>
> *b. Any application for the issue of [a] passport in respect of [the child].*
>
> *c. Any application and/or request for the issue of a Medicare card in respect of [the child].*
>
> *d. Any application to any authority for identification and/or Learner's Permit including [relevant agencies].*
>
> *e. Without binding the children's court … it is requested that in any future applications and/or orders the Court consider referring to the child by the name [male name].*
>
> *2. That the Child Representative, … be duly authorised to communicate with, attend and generally facilitate the issue of the identifying material referred to [in] the previous paragraph and to explain these orders to appropriate persons.*
>
> *3. That without the Department admitting the necessity for this order, the Secretary of the said Department ensure that all medical expenses not covered by Medicare including psychiatric and endocrinology expenses, blood tests, ultrasounds and like invoices for [the child] together with all accommodation, education, travel and like expenses including all fees and like payments payable for [the child's] current school are paid by the Department.*
>
> *4. All extant applications be adjourned to a date to be fixed.*
>
> *5. Reserve liberty to apply to any party and further reserve liberty to apply on an urgent basis to intervene in the these proceedings to:-*
>
> *a. [an educational body associated with the child]*
>
> *b. the Principal of the School from time to time currently attended by the child.*
>
> *c. the [Office which observed the proceedings]*

6. I request that the Administrative Judge [of the Court responsible for the child's area of residence] as soon as practicable appoint a Judge Manager of these proceedings.
7. Liberty to the applicant and the Child Representative to provide a copy of this order to all persons and/or organisation[s] relevant to the advancement of [the child's] interests.
8. Certified for Senior Counsel and Solicitor appearing as Counsel."

25. The Applicant submitted that the responsibilities identified in proposed order 2 were properly those of the Department Secretary as guardian. I suggested that if an order for such matters were made, it could provide for the Secretary to keep the Child Representative informed and this suggestion was acceptable to the Child Representative.

26. There was discussion in respect of proposed order 3 which I suggested be expressed by way of a notation, a suggestion that did not pose difficulties for either the Applicant or the Child Representative.

27. I raised with the parties whether proposed order 4, which would have the desirable effect of maintaining the appointment of the Child Representative (albeit in an inactive role unless needed) might be alternatively expressed but there was no disagreement that such continuation of the appointment was desirable.

Sources of Evidence

28. I would take this opportunity to express my appreciation to all of the parties, legal representatives and witnesses who participated in these proceedings. Their contributions were very helpful to me in addressing the novel issues presented by this case. In my estimation, all were genuinely motivated and focussed upon ensuring the best possible outcome for Alex. It goes without saying that no issues of credit arose in this case.

The Applicant

29. The initiating application was accompanied by a supporting affidavit from Alex's caseworker, Ms R. The annexures to her affidavit included social history and psychiatric reports prepared in 2001 and 2002 for Children's Court care proceedings. Ms R has been Alex's caseworker since June 2002.

30. An impressive array of expert medical witnesses with significant publication records and both clinical and teaching experience also gave evidence in the proceedings.

31. Professor P is an Associate Professor in the Department of Psychiatry at a university faculty of medicine and a consultant child psychiatrist at a hospital for children. Alex was first seen by him in December 2002 for an assessment of mental health issues relating to Alex's gender identity dysphoria and depression. He has seen Alex on a roughly monthly basis since then and has been involved in a number of inter-disciplinary discussions concerning him.

32. Alex was referred to Professor P by Professor W, who is an Associate Professor in the Department of Paediatrics at the same university as Professor P and a Paediatric Endocrinologist at the same hospital as Professor P. He has seen Alex three times since November 2002 at approximately six month intervals.

33. Both Professor P and Professor W have an on-going treatment role with Alex.

34. A Dr. N also gave evidence. She is a Consultant Psychiatrist and specialist in child and adolescent psychiatry, particularly gender issues. She has published extensively in the area of sex gender and identity. At the request of the Applicant, Dr. N assessed Alex and prepared a report focussed on Alex's gender identity issues in anticipation of the present application. She also filed a supplementary report. She is not in a treatment role with Alex.

35. Dr. C is an overseas expert. He is a Consultant Child and Adolescent Psychiatrist and an Honorary Senior Lecturer at an English university medical school. He is the director of a specialist clinical service for children and adolescents with gender identity dysphoria. Dr C was requested to comment on current research and treatment options for gender dysphoria. Although he did not see Alex, he was also asked to make comment on a recommended course of treatment based on the facts and opinions outlined in the reports of Ms. R, Professor W, Professor P, and Dr. N. I treat his evidence as it pertains to Alex in light of this limitation.

36. Professor P, Professor W and Dr N filed a further affidavit after having the opportunity to peruse the material filed by Dr. C and in response to particular matters which I raised during the hearing. In the case of Professor W and Dr N, my questions arose after they together with Dr. C gave evidence together by way of telephone link up and made comments on each other's reports.

37. Dr. G is the Head of the Department of Paediatric and Adolescent Gynaecology at the same hospital as Professor P and Professor W. She has not seen Alex. Following some questions I raised at the hearing on 15 January 2004, Dr G swore an affidavit wherein she provided information on the proposed treatment for Alex and:
    - Whether there are any studies regarding the effect on fertility from taking the contraceptive pill (oestrogen and progestogen) for three years;
    - The impact of taking LHRH analogue with testosterone as compared with administration of the analogue without testosterone for a period of six months first.

38. The Applicant also called Mr H, the principal of the primary school which Alex attended and it also called the principal of his new secondary school, Mr. D. Both schools provide a faith-based education setting. Mr. H and Mr. D gave all of their evidence orally.

The Child Representative

39. Leave was granted to the Child Representative to issue a subpoena to obtain the mental health file associated with Alex's care proceedings in the Children's Court. It was received into evidence. It contains a report by a child psychiatrist, Dr J, who was not called as a witness.

40. The Child Representative also arranged for the preparation of a Family Report by a counsellor external to the Court - Mr. T who is a probationary psychologist under supervision during his training period. Mr. T had been working as a counsellor in the community with Alex between August 2001 and early September 2003. Mr. T was identified as the most appropriate person to make such a report given the relationship he had built up with Alex through counselling him in respect of gender identity and also on matters such as his anger towards his mother and step-father, his behaviours at home, his peer relationships, and his anxiety about situations where he might have to reveal that he has a female physical appearance.

The Hearing Process

41. The evidence in these proceedings was adduced though a hearing process that differed in a number of respects from the traditional form of trial of children's issues in this Court. I think it is fair to say that the court record indicates that the legal representatives and witnesses shared my view that the procedural modifications to the hearing process enhanced the depth and richness of the evidence, and thereby better served the aim of an outcome which will be in Alex's best interests. I consider that a format such as this is usually to be preferred, at least in relation to special medical procedure cases.

42. The hearing process was conventional in so far as the evidence in chief was mostly in affidavit form. At the request of the parties, I ordered that all documents including affidavits and exhibits in these proceedings be

available to the parties and that the parties be at liberty to provide such material to their expert witnesses.

43. The hearing process was, however, different in the following major ways:

- The hearing was conducted in an inquisitorial rather than adversarial format. In substance, I indicated the type of evidence that I required and what further evidence was needed, after discussions with the parties' legal representatives and some of the witnesses;
- The hearing was conducted in a private conference room setting around a table using portable recording equipment. Official transcription services were used to ensure a formal record;
- I did not require the aunt and the school principals to give their evidence in chief by affidavit and took such evidence *viva voce*;
- It was agreed that the hearing would not necessarily follow the traditional course of each party having a single sequential opportunity to cross-examine witnesses one by one but rather that the questioning of witnesses may alternate between the legal representatives, other witnesses and myself as evidence was proffered. Thus, the hearing often took the form of an orderly discussion between witnesses and legal representatives (including, sometimes, instructing solicitors) and myself;
- A distinct benefit of the discussion format from my perspective was hearing witnesses engage in a dialogue in respect of each other's evidence. For example, observations made by Alex's primary school principal were commented upon by his secondary school principal and, on another occasion, there was a very illuminating discussion among medical experts concerning the recommended nature and timing of hormonal treatment in which each commented upon the evidence given by others during the course of a telephone link up;
- The nature of the proceedings lent themselves to more than one hearing date rather than a single continuous fixture. This enabled parties to provide further expert material and for witnesses to consider the evidence of other witnesses and to respond in a considered way to

material points of difference. The time taken in hearings was considerably less than would have been the case if a traditional format had been employed;

- I was informed that Alex wished to meet with me in private and without objection, indeed with the encouragement of the parties, I did so;
- So far as the discussion with Alex was concerned, he requested that aspects of it remain confidential. I have honoured that request and insofar as I have acted upon any of the contents of that discussion, I have only done so after referring relevant aspects of it to the witnesses; and
- Given the intricacies of the evidence, I arranged for the production of transcripts following each hearing session. A copy was provided to the parties through my chambers as soon as it became available.

Interim Substantive Orders

44. Without foreclosing how the case would be decided, on 15 January 2004 the Applicant sought interim orders permitting Alex to be enrolled in his first year at secondary school under an ostensibly male first name. The Child Representative supported the making such an order.

45. The Applicant also sought a further interim order permitting Alex to commence the first stage of hormonal treatment – the reversible oestrogen and progesterone therapy – having regard to the expert evidence, the support of the Applicant and also the agreement of Alex's aunt that he be assisted as soon as possible.

46. It was submitted that the initiation of the first stage of treatment would bring Alex a sense of relief. The Applicant drew attention to the following remarks by Professor P in his supplementary report of 13 January 2004:

> *"… the urgency of treatment is such that it should begin as soon as possible. [Alex] says that if treatment is delayed and she has to go to*

high school with the presence of periods and increasingly feminised body, [he] will be extremely distressed and disadvantaged by that."

47. The evidence of Professor W and Dr N was to similar effect.

48. The Child Representative neither supported nor opposed the making of such an order. He made reference to the long and consistent expression of wishes by Alex in relation to gender identity, and the support in the anticipated process of transition that is being offered to Alex by his caregiver aunt, in particular, and by the Applicant. He said that on the other side of the balance was the damage that would be caused by unfulfilled expectations.

49. For the reasons which I delivered *ex tempore* that day, I decided to make the interim orders sought. In essence, I was satisfied that it was in Alex's best interests that his entry into a new school be in the identity which all the expert evidence finds to be that of a male and that he would obtain an important sense of emotional relief in being permitted to do so. I also found that it was in Alex's best interests for the reversible hormonal treatment to commence and that the evidence indicated it would not be immediately effective. I was both assured and satisfied that Alex would be clearly counselled that my decision was only an interim one so that his expectations were not that this would be the final position I would reach.

Background History

50. In this section of my reasons, I set out Alex's social history so far as it is relevant to the present application and within the requirements of anonymity which I mentioned earlier. It begins to explain the gender identity issues which have arisen for Alex. I will devote a separate section to a more in-depth discussion later in these reasons.

Family Circumstances

51. Alex was born overseas and was the only child of his married parents. Alex told Professor P that although his parents fought, his father loved his mother. Dr N reported that Alex said that Alex felt rejected from an early age by his mother who he believes "was affectionless and harsh": affidavit filed 15 December 2003.

52. Alex and his parents lived with his paternal grandparents when he was very young. The household included an uncle who Alex described as "crazy, he'd fight with me": affidavit of Professor P filed 12 December 2003. It is not clear from Professor P's report whether this is the same uncle who Alex told him had tried to "touch" Alex in a sexual way, but had not proceeded to do so.

53. Alex's father died when he was five or six years old, apparently from a cerebrovascular incident. The death was clearly devastating to Alex. He had spent almost all of his waking and sleeping time with his father.

54. Alex said that they slept in the same bed and he would bathe and shower with his father. None of the evidence suggests any sexual advances by the father towards Alex. Alex told Professor P that apart from the attempted touching mentioned above, he had not been subjected to sexual assault or interference on any other occasion.

55. Alex said that his father taught him karate and to punch and to kick and to be self-protective. Alex described their relationship as "like best friends; he told me if he was sad and I told him how I felt" and said his father "protected [Alex] from [Alex's] own mother who [Alex] said had no love for [Alex]": affidavit of Professor P filed 12 December 2003.

56. Professor P described Alex's account of the death as follows:

> *"[Alex] related the process of [his] father's death with great distress, saying that [he] still vividly remembers the events around his death. [He] thought something had "blown up in [the father's] head" and [the father] died on the way to hospital. [Alex] could not see his body for some three*

days afterwards and still has vivid flashbacks to events around his death. [The father] frequently enters [Alex's] nocturnal dreams.
…
[Alex] said [his father] was gentle "like a girl". He was "a good man, he'd speak to people like a man and my mum's family loved him so much". At times [Alex] felt that [his father] hadn't died and that [his father] was just sleeping. At times [he] speaks to [his father] although he knows [his father] is not able to respond. It feels like "[father]'s smiling in my mind."" (affidavit filed 12 December 2003).

57. Professor P noted in his report that although Alex reported being able to feel at times that his father was alive and able to communicate with him, "[t]here is no evidence of delusions" and "[t]his phenomenon seemed consistent with his own process of bereavement and socially not unacceptable way of managing the loss of [his] father."

58. A few years after the death, Alex's mother married a man who sponsored the mother and Alex to Australia. Alex has two younger step-siblings. It would seem that the mother's family was opposed to her remarriage and, according to the evidence of Alex's aunt, the mother ceased all contact with her family. Alex told Dr N that he remains angry at his mother for remarrying, and that he felt that his step-father was "often rejecting and now he has *'turned'* [his] mother against him".

59. Alex and the mother arrived in 2000. Although Alex had little English when he came to Australia, he is now in mainstream education and at the time of the hearing, he was about to make the change from primary to secondary school.

60. Alex was living with his aunt at the time of the hearing with the support of the Applicant as his legal guardian. The aunt's daughter, a university student, also lives at home.

61. I now turn to summarise the course of the Applicant's involvement.

Protective Intervention by the Applicant

62. When Alex was 10 years old, approximately nine months after he arrived in Australia, a child protection alert was made and the Applicant undertook an investigation. It concluded that Alex had been rejected by his family and that the mother did not wish to work towards Alex returning to her care. The mother had said that she did not want Alex in her life and did not want to see him again.

63. The Applicant's reports to the Children's Court identified circumstances including the following as leading to the initiation of child protection proceedings:

- The mother and step-father has taken six months before enrolling Alex in an English Language School.
- Alex presented as very aggressive to students and had assaulted peers.
- The mother had said that Alex had tried to kill his step-brother by running into him with his bicycle and had poked something into the younger child's ear until it bled.
- At home, Alex slept in his own bedroom while the mother and the younger two children slept in a locked separate bedroom to prevent Alex from entering.
- The mother had said that there is no love between her and Alex and his step-father had said that he has no relationship with Alex and did not see Alex as important.
- The mother has said that Alex had threatened to kill his step-siblings and that she wanted Alex out of the home.
- The mother had said that in their country of origin, she had asked the authorities to take Alex away but they had refused.

64. The reports indicated that the child protection alert to the Applicant also identified the following as a "concern":

> *"[Alex] presents as very masculine and wears boy's clothes. The mother has said that [Alex] has told her that he wants to be a boy and the school*

state that [he] has used the boys' toilets at school". Affidavit of Ms R filed 12 December 2003, Annexure "NR3".

65. During the course of the investigation and subsequently, Alex was placed in substitute residential care. Alex's mother refused attempts by the Applicant to arrange for her to have contact with Alex and would not become involved with decisions concerning Alex's day to day care, safety or well-being. That situation persists.

66. In his assessment for the 2001 Children's Court proceedings, Dr J considered "that there is a long-standing conflictual relationship between [Alex and his] mother which appears to be exacerbated by incomplete mourning of the loss of [his] father by [Alex]". Dr J also said it appeared that Alex's mother demonstrated "paranoid ideas" regarding Alex, an assessment which seems referable to the mother's fear that Alex is a follower of the devil and would kill family members. Alex told Dr J that if he was to live with his aunt, his mother would accuse him of "trying to plot to kill [his] family".

67. Dr J said that Alex denied experiencing suicidal ideation and reported Alex to have said:

"That's a silly thing. I have a normal life. I want to be male and play with other males. My mother prohibited me from this."

68. Dr J reported that Alex acknowledged having perceptual disturbances, that he would hear his own voice or the voice of his father, and that Alex had said "somebody can read my mind and the thoughts in my mind". Dr J said however that "[t]here was no evidence of delusional disorder or thought disorder" and that Alex's orientation and cognition were intact.

69. Dr J recommended that the Applicant assume responsibility for what may be described as Alex's residence and day to day responsibility. He also recommended:

> *"[Alex's] identification with being a male should be reviewed in the context of [his] incomplete mourning of [his] father's loss in the long-standing conflictual relationship with his mother…[His] level of depression should be monitored and treated as necessary both pharmacologically and psychotherapeutically."*

70. Attempts to reconcile Alex with his immediate family were unsuccessful. Alex's mother and step-father excluded Alex from the application they made for permanent resident status. Both wrote to the Applicant in October 2001 renouncing their relationship with Alex: see Affidavit of Ms R filed 12 December 2003, Annexure "NR4" and "NR5".

71. Contact was, however, established with Alex's maternal family and in particular with his aunt, and Alex began residing with the aunt and her daughter in August 2001. Alex was then enrolled in the primary school at which Mr. H is the principal.

72. Ultimately, in its report to the Children's Court, the Applicant recommended that it assume guardianship responsibilities for Alex.

73. Final Orders assigning guardianship responsibilities to the Applicant were made in November 2001. The Applicant's guardianship responsibility is expected to continue until Alex is 18 years of age.

74. Alex's placement with his aunt suffered a temporary breakdown in late 2002. His primary school principal, Mr H, was concerned that Alex appeared depressed and was experiencing suicidal thoughts. In evidence before me he said:

> *"[Alex] was in my office and [he] was definitely quite distraught and wanting to kill [himself] because nobody was taking this whole thing seriously about the gender."*.

75. Alex's aunt also reported to Ms R that Alex's behaviour was becoming increasingly difficult to manage around this time. Ms R said in oral

testimony that despite an aggressive outburst which brought matters to a head, Alex's aunt continued to want him to live with her. Ms R said:

> *"We had to put him in a placement though because he was actually threatening to kill himself and saying he would rather be dead and didn't want to live this way, that he wasn't a girl and didn't want to be a girl. I felt very seriously that he actually meant that.*
>
> *He has detailed to me before I was his worker that there are times when he has tried to kill himself, throwing himself down stairs and things like that. I don't have any evidence that he's done that but knowing how determined he can be I certainly wouldn't play down that or the risk of that in the future."*

76. In the circumstances, the Applicant as guardian decided that it would be in Alex's best interests to remove him from the care of his aunt and into a foster care placement. This was to enable Alex to be more closely monitored than his aunt could do given her other commitments and also to allow his aunt a period of respite.

77. Alex returned three months later to live with his aunt. The temporary placement breakdown drew further attention to issues associated with Alex's gender identity. There was the psychiatric assessment by Dr J to which I have referred, which led to Ms R's facilitation of the involvement of the witnesses Professor P and Professor W.

78. I now turn to the evidence relating to Alex's sense of his gender.

Alex's Gender Identity

79. Professor W's supplementary report of 13 January 2004 confirms that Alex has:

- no ambiguity in sexual characteristics;
- normal female chromosomes;
- hormone levels typical of an adolescent female; and
- female reproductive organs.

80. It is common ground in the material before me that Alex has a long-standing, unwavering and present identification as a male.

81. In evidence before me, Alex's aunt acknowledged that she had initially tried to dissuade Alex from presenting as male and that she has had difficulty coming to terms with the proposed treatment. Now, however, she accepts him as a boy and introduces him socially as such. She said that she is supportive of the proposed treatment and sees it as "reasonable" and "logical". She said she would be very worried for Alex if the treatment did not proceed because he would react very badly to the disappointment.

82. Alex's aunt also said that since the commencement of plans to assist Alex become recognised as a boy, he has been happier, with improved behaviour and he "seems to have some direction and some plan for the future".

83. Dr N's supplementary affidavit filed 9 January 2004 states that Alex would be "intolerant of and resistant to" behavioural treatment aimed at reversing his male gender identification and behaviour. She is also of the view that there is minimal probability of Alex accepting a female role.

84. Mr H, his primary school principal, recounted that the question of which toilet Alex would use became a major issue. He would wear nappies to school because he was required to use the female toilets but refused to do so. A solution was reached whereby Alex would use the enclosed toilet for people with disabilities within the student toilet block.

85. In response to a question from me concerning the reactions of other children to Alex, Mr H said:

> *"[He] was very defensive, wouldn't allow anybody in and so basically [he] would talk to me and the first teacher that [he] had [he] made a reasonable relationship with [him], the second teacher - and that continued. So I would counsel the teacher about the issues that were presenting, things like [Alex] would deliberately stand between the two*

lines – [he] wouldn't line up with the boys and [he] wouldn't line up with the girls. Always making a statement about all these things. So it was a matter of counselling the staff to say, "Well, we need to accept this," and staff did. In grade 6 - when [he] went into grade 6 more and more [he] wanted to identify as male and the kids kept saying "him" and [he] would tell them. [He] also had two little cousins and [he] told the two little cousins to tell all [his] classmates that [he] was really male. We had to deal with that issue as well, and so eventually it was just accepted that [Alex] was different.

When we went on camp, for the grade 6 camp, [he] did Indian arm wrestles with all the boys and, of course, beat everybody. So that actually got [him] some kudos and [he] also in that year, in grade 6, [he] played in the cricket team and [he] was the only supposed girl that played in the cricket team with the boys. So there was a whole acceptance and nothing was - while every now and then things were talked about, it was never a big issue. We sort of tried to keep it as contained as possible, counselling the individual teacher or the other specialist teachers that dealt with [Alex] because [he] can be very defiant and wouldn't do certain things. The first year [he] did go swimming, the second year [he] wouldn't, [he] refused to go swimming. The third year [he] went swimming and enjoyed it.

What we did was we always tried to accommodate the needs of the individual person, in this case [Alex]. When [he] went on camp [he] didn't want to go in with the girls' dorm, [he] wanted to go in the boys' dorm. I said, "You can't do that," so in actual fact we had [him] a separate room by herself near the staff and [he] had [his] own amenities and the kids accepted that quite readily because there was already a special treatment of [his] case and we treat other people with similar sorts of needs, so that was camp. For swimming what we did was we actually used the disabled change room and [he] actually went there by [him]self and this is in grade 6. So we sort of came to an agreement that we would try and work things through. What I always did was have a meeting with [him] and discussed the issues as I saw them for the school and also what was in [Alex's] bests interests and so usually [he] would sort of comply and say, "Right, okay, well, we'll go this way.".

86. Professor P describes Alex as lively, engaging and personable with a tall, striking appearance and "a fairly masculine face and demeanour".

87. Dr. N's report states that "[t]here is a well documented history of early-onset and persistent cross gender identification and male behaviour": affidavit filed 15 December 2003.

88. Ms R reports that Alex's mother had said that Alex "always acted like a boy since [he] was a small child" and that his cousin (the daughter of his aunt) has told Ms R that Alex had "always been masculine" and that his mother used to dress him in boy clothes when he was little. The aunt's evidence before me was in similar terms.

89. Professor P records that Alex had said that his father "had tried to make [him] like a boy since [he] can remember". Alex told Professor P:

> *"…he tried to make me a boy; he bought me boy things, he played with me like a boy – lots of action, fighting, punching and karate."*

90. Alex's mother reportedly told Dr. J:

> *"[He] didn't like dolls. He liked playing with tanks and a sword. [He] had few female friends and was closer to his father than towards his mother."*

91. Ms R commented that "[i]n the past, [Alex] has been noted to respond with anger when it is reinforced to [him] that [he] is a girl". This corresponds with Professor P's record that "[Alex] said [he] felt very angry and resentful and talked of wanting to punch people who might have confronted [him] about [his] gender."

92. During an access visit in June 2001, Alex told his family that he was a boy but that he knew that papers relating to him referred to him as a girl and that the person who had written it "was stupid". Ms R's affidavit continues at pars 41-43:

> *"41. … The family laughed at this statement and did not continue with the discussion.*
>
> *42. The department file notes indicate that on 14 June 2001 [Alex] requested that [he] see a doctor to confirm that [he] is a boy. According to the notes [he] told the doctor that [he] "knows [he] is a girl but would like to be a boy".*
>
> *43. [Alex's] gender identification includes [Alex] telling other people that [he] is a boy and using the boys' toilets at school, particularly when [Alex] was first enrolled at the current school. [Alex] was repeatedly informed of the expectation by [his] school that [he]*

> *must use the girl's toilets. [Alex] then started wearing nappies to school and reported to me as recently as 18th November 2003 that [he] would not drink any liquids all day so that [he] did not need to use the toilets during school time."*

93. Professor P's affidavit filed 12 December 2003 states:

> *"[Alex] has presented a consistent account of the development of [his] own gender identity to myself and to many other professionals involved in [his] care. [He] says [he] has always thought of [himself] as a boy, even though [he] had apparently limited understanding of the human body when first seen in the current context.*
> *…*
> *[He] said that [he] grew up in [his] first years of life believing that [he] was a boy."*

94. Professor P reported that Alex had told him that he was distressed about being trapped in a girl's body, that he had been very sad and miserable with his situation for a long time, and that he had wanted to die. Professor P noted that menstruation is extremely distressing because it reminds him that he is not a boy and that Alex is frightened of continued breast development because it will make it impossible to present himself as a boy.

95. Professor P's report said:

> *"[Alex] reports that before [his] father died [he] has wanted to be a boy. [He] used to try and urinate standing up and [his] father would take him to the male toilets. [Alex] said "he taught me to pee like a boy".*
> *…*
> *[Alex] talked of feeling angry with God for having [him] trapped in the wrong body and for [his] father dying and [his] mother not loving [him]. [He] said that [he] have (sic) never seen [his] mother's naked body and [he] said [he] was very distressed when at five years of age [he] did see [his] mother and asked her why her body was different. [Alex] said [he] thought that the whole world was male. [He] said that [he] had never seen [his] parents being "sexy together". [Alex] said that some time (sic) [he] dreams at times [he] has a "dick" [H]e talks of having some picture in [his] mind of having "sex with a girl"."*

96. Earlier in the report, Professor P said:

> *"[Alex] is adamant that [he] is not "gay or lesbian". [He] sees this as the worst insult that anyone could make to [him]. [He] says [he] is a boy and would like to have relationships with a girl. Initially, [he] thought he may*

have children of [his] own but now realizes that if in the long run he proceeds to become a more biological male person he would be unable to have [his] own children."

97. Under the heading "Formulation", Professor P concluded:

"[Alex] is a bright, engaging biologically normal 12 year old girl who has a strong, persistent, longstanding belief and desire to live life as a male. [He] wished to be a boy even though this has its disadvantages within [his] social and family network. [He] has repeatedly stated his desire to be a boy and has behaved as such, going to boys toilets, dressing in boys clothes, boys hairstyles and boys games and activities. [He] has stopped having relationships with girls as a heterosexual type relationship. [He] feels angry and cheated that [his] body is female and angry that [he] has periods.

[He] has fantasies and persistent thoughts that he would develop a penis. [He] has asked for surgical treatment in order that this might be done. [He] is aware that this is a long, expensive, difficult, process that [he] would not be able to undertake until [he] was at least 18 years of age.

[Alex] has been extremely distressed by [him] feeling trapped in his body. [He] has experiences (sic) of major depression with suicidal ideation."

98. Professor P's diagnosis was that of: (1) Gender Identity Dysphoria and (2) History of recurrent depressive episodes (which Professor P said was not "current" as the time of the report).

99. Dr N reported in congruent terms:

"3. GENDER IDENTITY ASSESSMENT

[Alex] presents as an androgynous appearing young person in male clothes with masculine mannerisms and gestures. [He] gives a clear account of persistent cross-gender identification and insisted that [he] "is male inside". [He] is aware that [he] has a normal female body and has been learning about the effect of sex hormones, puberty and hormonal interventions for gender dysphoria.

[Alex] is of the firm belief that [he] "is male" and requires intervention for bodily change. [He] requests hormones to limit further breast development and prevent "hip development". [He] would like facial hair, increased muscle bulk and strength. [He has thoughts of becoming a father in the future and adopting a child.

[Alex] has feelings of sexual attraction towards girls but is adamant that this is a male and not as a lesbian. [He] does not want girls to think of

[him] as a girl and sees [him]self as in long-term relationships with women as a heterosexual man. [Alex] has not had any sexual experiences and could not describe the sort of sexual behaviour she might engage in as a male. [He] said [he] would tell a female partner [he] "could not ever have children as a man and has no penis" but had not considered how this might impact on a sexual relationship.

[Alex] has previously considered genital reconstruction surgery but at the time of this assessment is ambivalent about this and was not clear if [he] needed penile construction. [His] main preoccupations are with unwanted breast development and menstruation and [his] desire to maintain a masculine appearance. [He] has some feelings of genital aversion and said, "I feel my body is disgusting".

[Alex] has dreams of being in a male body and projects into the future as a male. [He] has thoughts of being a priest or a doctor and helping others. [He] wishes to be accepted by God [his church] *as a male and has some feelings of sadness that the church may not be readily accepting of a transgendered person.*

4. FORMULATION

[Alex]'s cross-gender identification appears to have emerged in the context of an idealised physically close relationship with [his] father, rejection and emotional abandonment by [his] mother, and [his] father's desire for [him] to be a male. This cross-gender formation is stable and there is no evidence that [Alex] has ever developed a psychological identification as female. [His] investment as male simultaneously expresses anger towards [his] mother and maintains closeness with [his] dead father.

[Alex]'s feelings of anger, depression and alienation appear to centre around a need to be validated in [his] gender-identity and to rebuild a sense of emotional connection to others. [He] is preoccupied with feelings of rejection and estrangement from others, which may reflect early emotional abandonment. [Alex] can articulate a desire to be close to others but is wary of rejection:

"My heart is cold, like ice. I love no one, I don't let anyone in. My mother had a key but chose not to use it. I want a new family."

[Alex] feels "sad most of the time" and describes urges to self-harm. [He] has cut [his] arm with a knife and on one occasion hit [his] head on a wall. [He] stated that the hope of being able to be a male has prevented [him] from further acting upon these impulses.

In my opinion [Alex] has a clear Gender Identity Disorder and some additional personality vulnerabilities and unresolved attachment trauma. These issues will need ongoing psychotherapeutic support focussing on

consolidation of [his] gender identity and strengthening [his] capacity for reciprocal relationships.

5. DIAGNOSIS

1) Gender Identity Disorder, transsexual type.
2) Dysthymic Disorder"

Gender Identity Dysphoria

100. Dr C's report dated 12 January 2004 provides the following summary of what he described as Gender Identity Dysphoria in children and young people:

> *"A useful definition of gender identity was given by Stoller who defined it as:*
>
> > *"A complex system of beliefs about oneself: a sense of one's masculinity and femininity. It implies nothing about the origins of that sense (e.g. whether the person is male or female). It has, then, psychologic connotations only: one's subjective state" (1992)."* ['Gender identity development and prognosis: a summary'. In *New Approaches to Mental Health from Birth to Adolescence* (eds C. Chiland & J. G. Young), pp. 78-87. New Haven, CT: Yale University Press.]
>
> *This refers to the self-perception of being male or female and needs to be differentiated from sexual orientation, which refers to the person's attraction for a member of the same sex, the other sex or both; otherwise known as homosexual, heterosexual or bisexual orientation. Some authors refer to these preferences as sexual identity. Gender Identity Disorder or Gender Dysphoria describes a condition characterised by the incongruence between the self-perception of being male and female and the phenotypical body. The diagnostic criteria for gender identity disorders in children and adolescents as defined in the "Diagnostic and Statistical Manual of Mental Disorders (4th edn) (DSM-IV) by the American Psychiatric Association, 1994", are listed on page 2 of* ***attachment 1****…"*

101. Attachment 1 is an article published by Dr C. The diagnostic criteria appearing therein are as follows:

"Criteria for diagnosis of gender identity disorders from the Diagnostic and Statistical Manual of Mental Disorders (4th edn) (DSM-IV; American Psychiatric Association, 1994)

A. *A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)*
In children the disturbance is manifested by four (or more) of the following:

- *repeatedly stated desire to be, or insistence that he/she is, the other sex;*
- *in boys, preference for cross-dressing or simulating female attire; in girls, insistence on only wearing sterotypical masculine clothing.*
- *strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex;*
- *intense desire to participate in the stereotypical games and pastimes of the other sex;*
- *strong preference for playmates of the other sex.*

In adolescents and adults, the disturbance is manifested in symptoms such as:

- *stated desire to be the other sex*
- *frequent passing as the other sex*
- *desire to live and be treated as the other sex*
- *conviction that he/she has the typical feelings and reactions of the other sex*

B *Persistent discomfort with his/her sex or sense of inappropriateness in the gender role of the sex*

In children, the disturbance is manifested by any of the following: in boys, the assertion that their penis and testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or aversion towards rough and tumble play and rejection of male stereotypical toys, games and activities; in girls, the rejection of urinating in a sitting position, assertion that they have or will grow a penis, or assertion that they do not want to grow breasts or menstruate, or marked aversion toward normative female clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g. request for hormones, surgery or other procedures to alter sexual characteristics physically to simulate the other sex) or belief that they were born the wrong sex.

C The disturbance is not concurrent with a physical intersex condition

D The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning"

102. Dr C's summary then continued:

"Gender identity disorders in children and adolescents can persist into adulthood leading to a condition commonly known as transsexualism, or be a transient experience with the individual developing a self-perception in accordance with his/her biological body. A good proportion of children with Gender Identity Disorder who do not become transsexual adults may develop a homosexual or a bisexual orientation (Green 1987). An important part of the work with children and adolescents with Gender Identity Disorder is to assist them in the development of their gender identity and to monitor the consistency of the experience of their gender identity, which is incongruent with their biological body. After puberty (age 15-16) gender identity disorders tend to persist into adulthood although in a number of cases this can still be a transient experience not leading to adult transsexualism.

As far as causation of gender identity disorders is concerned no single cause has yet been found with certainty. A number of authors would agree that many factors (biological, psychological and social) need to be present simultaneously and work together during a critical period of development to produce a full-blown gender identity disorder."

Alex's Sexual Identity

103. The lack of express consideration of the distinction between gender identity and sexual identity in the reasons for judgment of *Re A* (1993) FLC ¶92-402 has been the subject of comment: see J. Millbank (1995) "When is A Girl A Boy? Re A (A Child)" 9 *Australian Journal of Family Law*, 173. It is therefore perhaps important to underline that in coming to their diagnosis of gender identity dysphoria, both Professor P and Dr N expressly considered the possibility that Alex's wish for treatment emanates from his attraction to girls. Each reported that Alex responded in a hostile manner to the suggestion that he may be a lesbian.

104. Such a reaction was also seen by Ms. R. She said in oral evidence:

"…early on I actually raised the idea with him that he may simply have a same sex attraction and that this is where his gender issues arise from. He quite vehemently denied that it was anything to do with that. I'm still not totally convinced in every single way possible that that isn't part of the issue for him. We could actually be looking at two separate issues rather than just one that's all indicative of the same thing. So I've always advocated that we take the timely sort of approach and not rush into anything and have made sure that he understands that there's a whole range of people in the community and just because he sees a man and a woman and a couple of children and that seems to be the bulk of what he would be exposed to in his own life, that that does not mean that that's all there is in the world.

I take him to places (…) where he sees a far greater diversity of people and genders and images and try and get him to see that may be a far more effeminate looking male might walk past and a very much more masculinised looking woman might be nearby and that this is a whole range of things and it's quite acceptable to be anywhere within that range and that as he gets older he has more power within himself and more options about what he chooses for himself and that what he's dealing with right now doesn't have to continue to be his reality."

105. Ms R is deeply involved in Alex's well being but of course is not an expert witness of the question of the distinction between gender identity and sexual identity in respect of Alex. I mention though, that notwithstanding that Ms R is not utterly convinced that sexual identity issues are not at play in his wish to have treatment, she and the Applicant are in favour of the staged treatment process.

106. I do not understand the expert witnesses to be ruling out the possibility that with adolescent development Alex may reconsider his gender identity as a male and that if such a change in self-image transpires, he may come to view himself as a lesbian. It is not, however, the current assessment of his state of mind and sense of self.

107. In light of the adamant nature of Alex's gender identification and the on-going concern as to how traumatised he would be if the proposed treatment were not to otherwise go ahead, I would not delay treatment merely because of the theoretical risk that Alex is constructing his self image

as "really" male when in fact he is "really" a female lesbian and will come to see himself that way over time.

108. It is true that if Alex does shift in his self-perceptions after testosterone has begun being administered he will have certain irreversible masculine characteristics. I am satisfied, however, that in the course of the proposed treatment, which includes ongoing psychological and psychiatric assistance, there will be attention to whether there emerges a change in his self-perceptions which impacts upon the treatment plan I am asked to authorise.

The Treatment Proposed for Alex

109. Professor P and Dr N identified the question of the form of hormonal intervention to be within the specialist knowledge of Professor W and were supportive of what he proposed. All medical witnesses considered that it is essential that Alex continue to receive on going psychiatric and psychological support.

110. Professor W's supplementary report of 13 January 2004 was prepared after having had the opportunity to peruse the material provided by Dr C.

111. Dr C's report made the following diagnostic comments upon the assessments contained in the first affidavits filed by Professor P, Professor W, and Dr. N:

> *"I have read the very interesting and comprehensive reports by Professor [W], Professor [P] and Dr. [N]. From these reports it seems clear that [Alex] presents with a very well-established gender identity disorder. The self-perception of being a boy dates from a very early age. How much [his] particular family dynamics and traumatic events in [his] life have contributed to the development of her gender identity is difficult to establish with any certainty. Part of a therapeutic exploration with [Alex], if [he] was able to engage in such a process, could be aimed at exploring the foundation of [his] 'atypical gender identity organisation' and relate [his] early experiences to her past and current perception of [his] identity. However even if some understanding could be reached*

through this work, this may not necessarily lead to a change in [his] convictions as far as [his] gender identity is concerned. One of the aims of this process would be to establish the level of consistency in [his] convictions or whether there is some flexibility in developing alternative self-perceptions. From the report it seems that [his] convictions about being a boy are clear and firm at present. However one should not discount the possibility that [he] might shift during the course of [his] adolescent development…"

112. As a first stage intervention, Professor W recommended the continuous administration of Microgynon 30, a combination oral contraceptive pill recommended by Dr G. He said:

"The active pills are taken consecutively and continuously without using the 7 sugar pills that come in every pack. It is almost inevitable that one period would occur 4-6 weeks after the start of treatment but after that, there is a high chance that menses would be completely suppressed. Breakthrough bleeding may occur occasionally, in which case a gynaecological consultation would be obtained."

113. Professor W commented that the advantages of this "completely reversible" treatment are that it is routinely used for the suppression of menses as well as for contraceptive purposes, Alex's breasts are unlikely to grow much more as they are already well developed, height growth is not likely to be adversely affected, and bone density will be allowed to increase in the normal way. He said that Alex will need to be warned about the increased risk of thromboembolism associated with the taking of oestrogen and smoking tobacco.

114. Dr G's affidavit of 18 February 2004 did not express concern that the continuous use of the oestrogen and progestagen pill for 3 years would have an irreversible effect on Alex's ovarian function and fertility in the unlikely event that he were to decide not to proceed with his transition.

115. Professor W favoured this option over the administration of a subcutaneous implant of a GnRH analogue which he said would reduce Alex's oestrogen secretion to prepubertal levels. It would render him hormone deficient and at risk of developing osteoporosis and the hormone withdrawal side effects that are similar to women going through menopause.

116. I pause to mention that it was not suggested to me that any difference in the expert evidence by referring to LHRH or GnRH analogue was of substance to my decision.

117. Professor W recommended that if Alex at age 16 still holds the desire to be a boy he would recommend the commencement of a GnRH analogue therapy combined with subcutaneous testosterone implants which would induce irreversible masculinisation such as voice change, muscle growth, facial and body hair, growth of the clitoris and behavioural effects "that would make [Alex] more assertive/aggressive and have a stronger sexual urge."

118. Dr C suggested a slightly different approach to the proposed treatment in that there would be a period of GnRH analogue therapy alone before the introduction testosterone. He explained as follows:

> *"The Royal College of Psychiatrists' Guidance 1998 (see **attachment 3**, Gender Identity Disorders in Children and Adolescents – Guidance for Management) recommends that young people have had some experience of themselves in the post-pubertal state of their biological sex before starting any physical intervention. In the case of [Alex], [he] has already had periods and I suppose [he] is very distressed by them and would like them to be stopped. Professor [W] has suggested the use of a combination of oestrogen and a progestogen in tablet form to achieve this. Following this intervention it remains an issue if and when it would be appropriate to use a hypothalamic blocker, such as the GnRH analogue, Leuprorelin, to stop the natural production of oestrogens and give [Alex] an experience of [his] body once more without female sex hormones, as in a pre-pubertal state. Our paediatric and adolescent endocrinologists advise that it is reasonable to initiate this intervention once pubertal growth and development is complete and usually not below the age of 16 years. It is important to monitor bone mineral density carefully to avoid the risk of osteoporosis in adult life. For this reason it is also not recommended to use the analogue for longer than one year, at which point it would either need to be stopped or contrary sex hormones introduced, which in the case of [Alex] would be testosterone. This paves the way to stage three. The potential advantage of this intervention is that in our experience a small percentage of teenagers do not want to proceed any further with hormonal treatment after the "hormonally neutral" period on the analogue. We do not know why this occurs but it does seem that it gives*

particularly adolescents more time to reflect on their own gender identity while in this neutral biological state."

119. Dr C also said that use of the analogue alone has the advantage of enabling the introduction of testosterone in a flexible and gradual way. He said that there had been no formal research on the use of the analogue alone for a period of time but that he had not seen any major problems in clinical practice.

120. The approach suggested by Dr C was commented upon by Dr N in oral testimony. She agreed that a period of the analogue by itself may reduce libido which "gives these adolescents time to think about the issues, about emotional relationships and delaying sexual intimacy which might be very helpful".

121. The desirability or otherwise of administering the analogue without testosterone for a period of time was also considered by Dr G who said in an affidavit filed 18 February 2004:

"LHRH analogues are used fairly regularly in gynaecology – particularly for the treatment of endometriosis, for 6 month periods. It is difficult to predict the extent of side effects that will be experienced by any individual. It is fairly common to commence treatment – and then respond if necessary to side effects if they develop. In this case, the appropriate hormonal replacement to avoid symptoms would be androgens – presuming that this remains the wish of this young person. Thus the decision can be delayed and decided upon clinically at the time, with treatment being commenced if and when symptoms develop or at six months if no problems occur during the suppression phase."

122. Professor W embraced the "middle course" advised by Dr G. He remarked that he would not wish there to be an order of the Court which prevented him from treating the symptoms of the analogue administered by itself. Professor P made the further recommendation with which I entirely agree, that any orders I make be framed in terms of providing treatment opportunities available to Alex rather than imposing a requirement of taking such treatment.

123. There is an ongoing commitment by Professor P and Professor W to providing Alex with treatment services. They are, however. professionally affiliated with the same hospital for children and it may be that Alex will begin to receive service from a different medical centre once he turns 16 years of age. There has been consultation in respect of Alex's case with the most likely other medical centre and having heard both Professors, I am satisfied that Alex's mental health and endocrinological treatment would be monitored by a team approach and would, if need be, be the subject of appropriate handover to another medical service centre.

The Future Arrangements in Which The Proposed Treatment Would Occur

Residence and Guardianship

124. The evidence discloses the possibility that Alex may wish to change his living arrangements in the period before his 18th birthday. To some extent, it seems that such a wish is associated with a desire to reinvent himself in his male presentation in his home life as well as at school. There is no question about the depth and genuineness of his aunt's care.

125. As I am not asked in these proceedings to make any orders in respect of residence, it is sufficient for me to say that I am satisfied that the Applicant would be able and willing to assist Alex in this regard providing that his reasons for doing so were in his best interests and that his preferences are practicable and realistic.

126. The aunt, in evidence before me, said she was pleased and appreciative that the Applicant's responsibility and involvement would continue and that it is of assistance in her providing Alex with a family home as he can be difficult at times.

127. Like his aunt, Alex himself is also content for the Applicant's continued involvement. As I have commented, he has a good working relationship

with his caseworker, Ms R. Professor P noted Alex's confidence in Ms R in his first report.

128. Ms R has also deposed that she has a close relationship with Alex and appreciates that he would be disappointed if she were to leave her position with the Applicant. If that were to occur, she said she would ensure that there was sufficient overlap time to introduce and familiarise a new caseworker. She also said she would be open to maintaining contact with Alex after leaving her current position, if that were permitted by the Applicant.

129. While on the subject of Ms R, I might take the opportunity to say how impressed I have been with the dedication that she has shown in relation to Alex. It is a dedication that goes well beyond what her duties would normally require and I consider that he has been very fortunate to have her support. It is fashionable in some circles to criticise Departmental workers. I consider that Ms R's professionalism is more representative of Departmental workers than that stereotype and is much to be commended.

130. Alex is appreciative of the action being taken on his behalf by the Applicant to arrange the expert assessments he has had and also for the present application to the Court seeking the commencement of hormonal treatment.

131. There are additional practical benefits to Alex from continued Departmental guardianship. One aspect of such responsibility is to meet Alex's medical and allied health expenses and the Applicant will continue to meet them until Alex turns 18 years of age so long as it is his guardian: see Affidavit of Ms R sworn 20 February 2004. The Applicant also meets Alex's educational expenses until the age of 18 years.

132. Some further financial assistance may be available in anticipation of needs arising after Alex's 18th birthday. Ms R gave evidence that usually, discussion of such issues would be part of the planning process associated

with the discharge of guardianship and transition to independence. It would occur when Alex is 17 and a half years old.

133. Both Mr T and Ms R said that Alex has voiced concern about how he would be able to afford the cost of continuing treatment beyond his 18th birthday, particularly if he decided to seek surgical intervention. In the above-mentioned affidavit, Ms R deposed:

> *"In rare cases where a child is disabled or has special needs which require surgery or financial assistance shortly after he/she turns 18 years old, [the Applicant] may provide some assistance if it is apparent that there are not other financial resources available. These decisions are made on a case by case basis. [The Applicant] may be in a position to provide financial support shortly after [Alex] turns 18 if he is seeking surgery. However [the Applicant] is unlikely to consider providing assistance if [Alex] is undergoing surgery several years after he turns 18 old."*

134. Ms R's affidavit then made reference to surgery associated with Alex's desire to live as a male. It indicated that she had been informed that the "current cost of surgery is approximately $5,000 if one has private health insurance at the top level" and that the expert clinician consulted on this matter had said that the clinician "will not usually contemplate surgery for a patient prior to 21 years old."

135. Ms R's affidavit continued:

> *"Whilst the cost of surgery is significant, I am aware that [the aunt] has banked all he carer's payments into a joint bank account with [Alex] with the intention of [Alex] having full access to them at the age of 18 years old… Carer's payments will continue until [Alex] is 18 years of age unless [Alex] leaves school and obtains employment or is the recipient of other Government benefits. If [Alex] remains at school until 18 years of age and Alex and [his aunt] do not withdraw funds from the account, there will be in excess of $60,000 for [Alex] to access at the age of 18."*

Educational

136. Pursuant to my interim orders, Alex is now enrolled under his newly chosen male name at secondary school. By the time I heard evidence from his principal, Mr D, Alex had been at school for a couple of weeks. He said:

> *"We're only two or three weeks in but things seem to be going okay. But there will be significant issues."*

137. The very practical question of which toilet Alex uses has been resolved. He uses a male toilet that is not used by the other students except for special reasons. It is in the staff area and used by students who may have celiac disease or irritable bowel syndrome.

138. Mr D said that it had been determined in conjunction with Alex, that only a limited number of teachers would be informed of his medical issues. He said:

> *"They may need to know that the student has special needs and there needs to be some sympathetic awareness of that, but they do not need to know the specifics because it is not relevant to designing the learning experience for that student."*

139. Additional support mechanisms have been established for Alex and the school is receiving external assistance and guidance in managing issues as they arise, for example, how Alex may participate in sporting activities. The Applicant has committed to being part of this assistance structure and this was an important factor for Mr D in making a judgment as to whether the enrolment should proceed.

140. Mr D explained that the school has developed "quite comprehensive anti-harassment, anti-bullying policies and procedures" which involve a range of responses, and Mr D, correctly in my view, saw Alex as not "being different from the other student who's the subject of unwarranted attention either verbal or physical…":

141. Mr H, Alex's primary school principal said that he had never been approached by parents concerning Alex's gender identity. Mr D said in

response that the secondary school has anticipated the possibility of parents' adverse reactions if Alex were to disclose his transition to a fellow student. I found Mr D's answers reassuring:

> *"I guess the strategies would include meeting such people and assuring them - asking them perhaps, first of all, to indicate in what ways their child is at risk or under some sort of threat, then if there is a perceived risk to deal with that and talk through that. But I would be challenging them to establish their bona fides to make any comment at all in the first instance. I wouldn't be kind of a defensive mode I can assure you. I'd be saying, "Well, you've got to convince me that there's a case to be answered here before we" –but then if there is a concern about the influence on their child of another child in terms of friendship we would deal with that through counselling and discussion and contact. That's not unusual in secondary schools in terms of, for example, same sex - emergent same sex orientation. It's quite common that students can sometimes be the unwanted recipients of attention of other students and families can sometimes express concern about, "What's the impact of this friendship on my child?" and "What are you doing about this? So we've sort of dealt with that over the years routinely…*
>
> *…*
>
> *I see the pastoral issues for the secondary school are similar to disclosure about same sex attraction which is increasingly common. More and more adolescents are feeling more comfortable about coming out at school rather than waiting until they leave school. We've had a number of students at our last place over the last few years who have quite provocatively come out in various ways. A bit like [Alex] sort of saying, "Well, I want to be" –some of them are a bit naive about the expected kind of response to that…"*

142. I was also advised by the Child Representative that consideration had been given to what would happen if it transpired that a disclosure led to risks to Alex's safety in the school. In such circumstances, the Applicant in conjunction with the associated educationalists involved in Alex's case would be able to find a different school placement for him.

Jurisdiction

143. In this section of my judgment I explain why I found that I have jurisdiction to hear the present application.

144. Notwithstanding the agreement or the silence of the parties as to questions of jurisdiction, it is incumbent upon a court to be satisfied that it has jurisdiction to hear an application. Toohey J in *Harris v Caladine* (1991) 172 CLR 84 at 136 defined the term as follows:

> *"Jurisdiction is the authority which a court has to decide the range of matters that can be litigated before it; …"*

145. Section 67ZC of the Act is a grant of jurisdiction. It provides:

> *"(1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.*
>
> *(2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration."*

146. The accompanying Explanatory Memorandum stated that the new provision:

> *"… provides the court with jurisdiction relating to the welfare of children in addition to the jurisdiction that the court has under Part VII in relation to children. This jurisdiction is the parens patriae jurisdiction explained by the High Court in SMB and JWB; Secretary, Department of Health and Community Services* [sic] *(Re Marion) (1992) 175 CLR 218."*

147. Division 10 of the Act, which contains s 68F, provides for how a court determines the best interests of a child or young person. Section 68F(2) is the well known "checklist" of factors to which a Court must have regard.

148. In *Re Marion (No. 2)* (1994) FLC ¶92-448 I proposed a number of particular matters to be considered when the Court is faced with a special medical procedure application, in that case, a sterilisation procedure. These are:

> *"(i) the particular condition of the child which requires the procedure or treatment;*
> *(ii) the nature of the procedure or treatment proposed;*

(iii) the reasons for which it is proposed that the procedure or treatment be carried out;
(iv) the alternative courses of treatment that are available in relation to that condition;
(v) the desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives;
(vi) the physical effects on the child and the psychological and social implications for the child of:
(a) authorising the proposed procedure or treatment
(b) not authorising the proposed procedure or treatment
(vii) the nature and degree of any risk to the child of:
(a) authorising the proposed procedure or treatment
(b) not authorising the proposed procedure or treatment
(viii) the views (if any) expressed by:
(a) the guardian(s) of the child;
(b) a person who is entitled to the custody of the child;
(c) person who is responsible for the daily care and control of the child;
(d) the child;
to the proposed procedure or treatment and to any alternative procedure or treatment."

149. Subsequently in *P and P* (1995) FLC ¶92 615, another sterilisation case, the Full Court said that the matters I suggested "should prove of practical use to those considering problems of this nature" (at 82,151).

150. There are three factual issues which determine the Court's capacity to exercise the welfare jurisdiction granted by s 67ZC of the Act.

Whether the Child or Young Person is Currently under a Care Order

151. As I have mentioned, the Applicant's guardianship responsibility for Alex is immaterial to the Court's jurisdiction due to the written consent of a specified child welfare officer. I would however mention that there is no decided authority on the subject of how s 69ZX may or may not limit the jurisdiction conferred by s 67ZC of the Act. In the circumstances I need not explore whether the Court would have jurisdiction if such written consent had not been given.

152. However, two further issues arise from the High Court of Australia's decision in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (*Marion's* case) which is the relevantly binding Australian authority:

- whether the child or young person is himself competent to consent; and
- whether the subject matter of the application is a "special medical procedure" to which a parent or guardian cannot consent.

153. *Marion's* case involved an application for the sterilisation of a 14-year-old teenager with a severe intellectual disability for the purpose of "preventing pregnancy and menstruation with its psychological and behavioural consequences". The gravamen of the decision was that if a child or young person cannot consent her/himself to a medical procedure, parental consent (which for present purposes may be equated with that of a guardian) is ineffective where the proposed intervention is:

- invasive, permanent and irreversible; and
- not for the purpose of curing a malfunction or disease.

Whether the Child or Young Person Himself Can Consent to the Procedure

154. The welfare jurisdiction is a protective jurisdiction. It is paternalistic and, in modern thinking about children and young people, must be understood with regard to their rights.

155. The circumstances in which a child or young person has the right to make his or her own decisions as to medical treatment are far from precise. There is a significant onus upon the treating professional's assessment of the child or young person. Unless legislation provides otherwise, and it is not applicable in this case, the professional risks liability unless satisfied that the child or young person has "a sufficient understanding and intelligence to enable him or her to understand fully what is imposed" - *Marion's case* at 237-238. A majority of the High Court were there expressly approving a

principle that emerged from House of Lords' decision in *Gillick v West Norfolk and Wisbech Area Health Authority* ("*Gillick's case*") [1986] AC 112. Even though the question of Marion's *Gillick* competency was not, in fact, an issue in that case, given the degree of Marion's disability, the following statement by the High Court majority has been applied by this Court in special medical procedure cases:

> *"This* [Gillick] *approach, though lacking the certainty of a fixed age rule accords with experience and with psychology. It should be followed in this country as part of the common law."* (at 237-238, footnotes omitted; see for example the Full Court's decision in *P and P* (supra) and, in respect of a procedure other than sterilisation the first instance decisions of *Re A (A child)* (supra) and *Re GWW and CMW* (supra)).

156. The majority in *Marion's* case (at 232) described as a "threshold question of consent; whether a child, intellectually disabled or not, is capable, in law or in fact, of consenting to medical treatment on his or her own behalf". As submitted by the Commission, I am therefore required to consider whether Alex is competent in the sense that "competent" is used in *Gillick's* case - whether Alex has achieved "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.". The Commission further submitted this was a threshold matter and the first decision I must make.

157. There is evidence on this matter from Mr T, who prepared the family report and from Professor P, the treating child psychiatrist.

158. The evidence from Mr T was that Alex was able to describe the stages of treatment he is currently undergoing and those that he will be able to undergo in the next few years. Mr T reported:

> *"[Alex] was also able to tell me that he is on stage I of the treatment and that the 'pill medication' he is on now, stops his periods, can cause him to feel like he is having a headache or that he wants to vomit. Furthermore, he indicated that he uses 'the medication to go to school as a boy'. In addition, he reported that the medication stops his breasts growing and 'stops hip shape growing like female shape'."*

[Alex] reported that stage II would involve him taking 'a male hormone and the injection medication' that is similar to the one he is taking for stage I. With the male hormone, he said, 'it won't affect my bones as I am getting older, while I take the injection. If I take the injection medication by itself, it will affect my bones badly as I getting older.' At a later session I asked [Alex] how would the bones be affected and he answered, saying 'Make my bones feel weak, won't be strong like now anymore. Feel sick, could break my bones if I do weight lifting'. [Alex] also reported that the male hormone also makes him have a deeper voice, 'it's kinda scarier, stronger and louder than a woman's voice', 'I'll have hair, bones stronger like a boy, man, muscles begin stronger like normal boys'. [Alex] said he hopes that Stage II could be done when he turns 15 'so I look like a young man, like a normal teenager does'."

159. Mr T's report indicated that Alex appreciated that irreversibility commences with the taking of the testosterone. Mr T also reported:

"In a later session, I asked [Alex] how he got to know the above information, he said from his doctor, from his aunt, from books and from his own thinking. I also asked if anyone had told him how to answer these questions, he said no."

160. Mr T's conclusion was as follows:

"I am of the professional opinion that while [Alex] appears very knowledgeable about, and would seem to have an intellectual understanding of, the treatment process, including the stages of the treatment, some of the intended effects as well as the side-effects of the medications and what the treatment process is form it is not clear whether he understands the full implications of the treatment. I, therefore, concur with [Professor P's] point in his Supplementary Mental Health Report on [Alex] that 'it is not appropriate at age 13 [Alex] should be wholly responsible for the decision to undergo hormone treatment'."

161. The supplementary reports filed by Professor P and Dr N addressed the question of Alex's present and future capacity to consent to the proposed treatment.

162. Professor P stated that Alex has an adequate understanding of sex differences and the human reproductive system. He also reported that Alex appreciates the nature of the proposed treatment and its consequences

better than he would expect other young people his age to understand it, and that Alex has acquired this information over a fairly short space of time.

163. Professor P expressed the view and that Alex demonstrates "good intellectual and cognitive capacity to learn and understand such phenomena". Professor P is not qualified to undertake formal psychometric assessment but he said he believed that Alex's general intellectual capacities are at least average for his age.

164. I would refer to two particular statements of Professor P:

> *"Although [Alex] fully understands at this stage the mechanism of action for the proposed hormone treatment, and side effects and the benefits, I believe that it is not appropriate at age 13 [he] should be wholly responsible for the decision to undergo hormone treatment. This is particularly so since [his] own mother is not currently responsible for his care.*
> *…*
> *I believe that [Alex] is able to make an informed judgment about the procedure and its risk in the foreseeable future but that the urgency of treatment is such that it should begin a soon as possible."*

165. These comments would suggest that Alex may in fact have "Gillick" capacity or may reach that standard soon but that nonetheless it is Professor P's view that the decision should be in the Court's hands in part due to the urgency of the matter. I would also observe that it is unclear to me how Alex being out of his mother's care bears upon the question of Alex's capacity. These matters were not elaborated in oral evidence.

166. Dr. N's supplementary report was also somewhat non-specific on the question of capacity. Her assessment described Alex as "a mature, intelligent 12 year old" who "concurrently has angry and unresolved feelings towards her mother and a strong identification with her deceased father". Dr N's opinion of the significance of these matters was as follows:

> *"The issue here is to what effect these emotional factors impact on [his] capacity to understand the proposed treatments. In my opinion, these factors are important underlying determinants, they per se, should not be*

seen as contraindications to medical intervention or as impairing [Alex's] comprehension."

167. Dr N's report does not provide a final conclusion on the question of Alex's capacity to give effective consent.

168. In my view, the evidence does not establish that Alex has the capacity to decide for himself whether to consent to the proposed treatment. It is one thing for a child or young person to have a general understanding of what is proposed and its effect but it is quite another to conclude that he/she has sufficient maturity to fully understand the grave nature and effects of the proposed treatment.

169. However, in the present case, I have uncontroverted evidence not only that the proposed procedure is entirely consistent with Alex's wishes but also that the expert evidence as to the best interests of Alex accords with those wishes. I therefore take the view that the capacity of Alex to give his own consent would be an academic question unless I were to refuse authorisation. The evidence left me in no doubt that I should make orders authorising at least the continued first stage of the proposed treatment that I had permitted by way of interim orders and, as is discussed subsequently, the second stage of hormonal treatment as well.

170. Before leaving this topic, I would note the following written submissions of the Commission which responded to a request I made in the course of hearing closing argument:

"2.5 The general position in Australia in relation to competent minors refusing medical treatment is unclear. While the right of minors to consent to medical treatment has been judicially recognised, their right to refuse treatment has not been the subject of similar discussion. The position in England following the cases of Re R and Re W is that a "Gillick competent" child is unable to refuse treatment, if such refusal has the effect of overriding consent given by the guardian or the court. It is submitted that this view should not be adopted in Australia. It is submitted that the better view - and the view that is most consistent with Re Marion and the principles of international law outlined above - is that a court has no power to override either the informed consent or informed

refusal of a competent child to medical treatment, or, if it does have such a power, it should not as a matter of discretion exercise that power except, perhaps, in extreme circumstances."

171. I would interpose here that the Commission had referred to The Convention on the Rights of the Child which specifically concerns under 18 year olds and provides in Article 12 that they shall be provided the opportunity to be heard in any legal proceedings affecting them, and their views given due weight in accordance with their age and maturity. It was submitted that the Convention therefore "promotes the right of children to make an informed decision; attempts to ensure that appropriate information is provided to enable this decision to be made; and requires that state parties respect these views and the reasons for their formation."

172. The Commission's submission as to competency continued:

"2.6 Accordingly, it is possible that, on the facts of a particular case, a Court may find that a child is competent to refuse treatment but lacks competency to consent to treatment (or vice versa). This may occur where the treatment issues involved in having the treatment are more complex than the treatment issues involved in refusing it (or vice versa). It is submitted that, on principle, there is no reason why a distinction of this sort cannot be drawn on the facts of a particular case.

2.7 In short, no presumptions should be drawn as to the issue of whether any individual child of any particular age can give informed consent to receive or refuse medical treatment and in each case the issue will depend on the complexity of the treatment issues involved and "on the rate of development of each individual."

2.8 It is submitted that if this Court finds that the child has achieved "a sufficient understanding and intelligence" to enable the child "to understand fully what is proposed", then this Court has no further role in this matter."

173. I have doubts about the correctness of the proposition set out in the last sentence of par 2.5 of the Commission's submissions and the proposition set out in par 2.8. In the circumstances of the present case it is unnecessary to decide these issues. Much will depend upon what it is that is proposed in each individual case. It seems to me that there is a considerable difference between a child or young person deciding to use contraceptives as in *Gillick* and a child or young person determining upon a course that will "change"

his/her sex. It is highly questionable whether a 13 year old could ever be regarded as having the capacity for the latter, and this situation may well continue until the young person reaches maturity.

The Subject Matter of the Application

174. The second issue I must consider is whether the nature of the proposed procedure is one that requires the consent of the Court. Otherwise, it is a procedure to which the Applicant may consent as guardian.

175. While it is the most common type of special medical procedure application, the requirement of court authorisation has not been limited to sterilisation cases. The Family Court of Australia has been called upon to decide applications concerning:

- the surgical gender reassignment of a 14-year-old with a congenital disorder – *Re A* (1993) FLC ¶92-402;
- the performance of cardiac surgery on an 11-year-old boy where parental consent was refused – *Re Michael* (1994) FLC ¶92-471; *Re Michael (No 2)* (1994) FLC ¶92-486; and
- the harvest of bone marrow blood cells from a physically and intellectually healthy 10-year-old boy for transplant to the child's aunt who was suffering from leukemia – *Re GWW and CMW*. (1997) FLC ¶92-748.

176. In *Re GWW and CMW* (supra), Hannon J was faced with a challenge to the Court's jurisdiction and made the following comments at 84,108:

> *"…it is necessary to consider whether this is a special case outside the scope of a parent's power to consent to on behalf of his or her child (Re Marion FLC at 79,171-79,172; CLR at 232). In Re Marion the majority stated that there are features involved in a decision to authorise sterilisation which indicate that in order to ensure the best protection of the interests of a child, such a decision should not come within the ordinary scope of parental power to consent to medical treatment. "Court authorisation is necessary, and is, in essence a procedural safeguard".* ***The court went on to state that court authorisation is required***

firstly because of the significant risk of making the wrong decision and secondly because the consequences of a wrong decision are particularly grave. *Their Honours constituting the majority of the court, noted in some detail the factors which may contribute to the risk of a wrong decision being made and the gravity of the consequences if that were to occur.*

Although their Honours were there dealing with a case involving sterilisation which they referred to as being "invasive, irreversible and major surgery", there are passages in the judgment which indicate that it is not only sterilisation which constitutes a special case and therefore is outside the ordinary scope of parental power to consent. *The majority cited with approval a passage from the judgment of Nicholson CJ in Re Jane (1989) FLC ¶92-007 where at page 77,256 his Honour said:*

> *" The consequences of a finding that the Court's consent is unnecessary are far reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious or quasi-cultural reasons, or the sterilisation of a perfectly healthy girl for misguided, albeit sincere, reasons. Other possibilities might include parental consent to the donation of healthy organs such as a kidney from one sibling to another."*

Such procedures involve the invasive, irreversible and major surgery to which the court adverted in Re Marion whereas the procedure of harvesting of stem cells sought to be authorised in the present application, although invasive is not irreversible in that the stems regenerate and the blood is reinfused into the donor. " (emphasis added)

177. I find the passages of his Honour's comments as to principle which I have underlined to be of assistance in the present matter.

178. Like Hannon J, I do not read their Honours in *Marion's* case to be confining the reasons for authorisation to surgical interventions only. It was a factual element of the case - the sterilisation method proposed for Marion. It is hard to imagine that the principled considerations that I have emphasised in par 176 would be inapplicable if authorisation had been sought for an alternative intervention of similarly irreversible effect for the same purpose, for example the use of radiation or pharmaceuticals.

179. Returning to *Re GWW and CMW*, Hannon J held that the Court did have jurisdiction, saying at 84,108-9:

"Neither counsel nor I have been able to find any authorities in the United Kingdom or in this country where authorisation from a court has been sought for this procedure although there are a number of cases in the United States of America where this has occurred (Propriety of Surgically Invading Incompetent or Minor for Benefit of Third Party — Gregory). The foundation for the intervention of the court has been stated to lie in the fact that the state has an interest in protecting the rights of minor children under its parens patriae power, the doctrine that all orphans, dependent children and incompetent persons are within the special protection and under the control of the state. Similarly although a guardian may be statutorily authorised to act on behalf of an incompetent in some matters, an intrusion into the body of an incompetent to benefit another requires judicial approval. An important factor emphasised by the courts has been that the operation was not for the child's own benefit but for the benefit of the third party. In my opinion that is an important factor to take into account when the proposed procedure is invasive to the bodily integrity of a child of tender years and involves a surgical procedure although that procedure may be of less gravity than is involved in a sterilisation or an organ transplant.

In summary I accept the submission on behalf of the Attorney-General of the Commonwealth that the circumstances of the present case constitute a "special case" namely that the purpose is to donate tissue to a third party without any physical benefit to the donor, and it involves general anaesthetic and possibly the injections of a drug. Hence it is a non- therapeutic procedure which at the very least will have an immediate adverse effect upon the child regardless of it not being carried out to promote his physical welfare. The responsibility of the court to protect the welfare of children justifies an intervention."

180. The application before me would seem a novel one and I was not referred to any Australian or overseas authority with similar fact characteristics.

181. It is distinguishable from *Re GWW and CMW* (supra) in that the proposed procedures are for the benefit of Alex and not another person and it is not a feature of the proposed treatment that Alex would undergo surgery or a general anaesthetic. The use of injections to administer hormonal treatment is however an option. Alex's case is also distinguishable because the second stage will have irreversible consequences.

182. *Re A* (supra) was also a significantly different case. A had been born a genetic female with an extreme degree of masculinisation due to an abnormality in the adrenal gland. A had genital reconstruction in her early years to give her a feminine appearance and was placed on a continuous regime of hormone treatment to prevent the production of any further male hormones by the adrenal gland. During her childhood, however, the recommended level of hormone treatment she received was inadequate as it was not pursued thoroughly by the parents. This led to the further production of male hormones and masculinisation of the external genitalia. At the time of the application to the Court, A was 14 years of age. A felt and the experts agreed, that she would be better as a male and that male gender re-assignment including by way of surgery would be more appropriate.

183. In the present case, Alex is a physically unambiguous young person who has been diagnosed with a male self image and a clinically recognised psychological urge to become physically male and where the proposed procedure is hormonal treatment, only the second stage of which has irreversible consequences.

184. Having regard to the original form of the orders sought by the Applicant (see par 19 above), I raised with the parties at an early stage of the hearing process whether the Court's authorisation was presently required. I did so because the evidence of the experts indicated that par (a), namely "that the child be administered a combination of oestrogen and progestogen on a continuous basis until the child turns 16" was uniformly identified as a reversible medical treatment. In contrast, the treatment in par (c), namely, "the child being treated with an LHRH analogue and testosterone administered either in oral form, by monthly injection or by 6 monthly subcutaneous implant" would have, on the expert evidence, irreversible consequences, but I was not being asked by the application as originally filed, to make orders in the present proceedings for the treatment set out in par (c).

185. I heard submissions on this topic from Senior Counsel for the Applicant and from the Child Representative. I was asked not to view the reversible first stage in isolation from the second stage of hormonal therapy which would have irreversible consequences and may involve injections or an implant.

186. It seemed to me to be common ground that what may be termed a staged clinical program for Alex should be seen as part of a single package. It was submitted that the evidence showed he was eager for the treatment to commence and that if treatment were to commence, he both perceived and wished it would progress through to the irreversible hormonal treatment contemplated by the application, unless of course Alex elects to cease the treatment or clinical contraindications arise. It was also put on the basis of the expert evidence that to authorise the first stage of treatment but leave the subsequent stages for future application and determination by this Court would be destructive and anxiety-provoking for him.

187. Submissions by both Senior Counsel for the Applicant and the Child Representative as to the form of orders I should finally make proceeded on the basis that my orders would authorise both stages of treatment.

188. I accept the argument that I should treat the stages of treatment as a single treatment plan. It is respectful of the assessment of Alex that emerges from the expert evidence and my own interview with him. He is adamant in his deep and long held desire to suppress his biological development as a female and to induce the presence of male characteristics. Compartmentalising the stages of treatment for the purposes of these proceedings would have an air of unreality about it.

189. In my view, It was proper for the Applicant to make the present application and to then alter the form of orders sought to reflect this characterisation. Doing so was sensitive to the limits of the Applicant's guardianship authority and the risk of commencing a course of treatment which may have raised false expectations for Alex. I think it would have

been detrimental to Alex's best interests for the Applicant to have viewed the reversible treatment as within its authority as a guardian and only approached the Court when the second stage was imminent.

190. It seems to me that there is a further question that I must address as a component of the definition of a special medical procedure that requires court authorisation. That is whether or not the proposed treatment for Alex is, to use the language of the majority decision in *Marion's* case (at 253), "to cure a disease or correct some malfunction"?

191. On reviewing the evidence, I am in no way critical that there were no specific submissions before me in this regard. The High Court majority's definition was framed and expressed in a particular context – an application for the sterilisation of a girl for reasons that were not, in a strict sense, medically required.

192. The aetiology of a compelling desire to make the transition to become the opposite sex has not been definitively established: see *In re Kevin (Validity of marriage of transsexual)* (2001) FLC ¶93-087 per Chisholm J upheld on appeal to the Full Court in *In Re Kevin (Validity of marriage of transsexual) (No 2)* (2003) FLC ¶93-127. The Full Court commented at par 56:

> *"… the weight of medical opinion generally agrees that in the instance of a transsexual person, that individual is born with a brain that recognises him or herself as a member of the sex opposite to that whose physiological indicia he or she bears. The expert evidence before his Honour, which he accepted, was that this was probably of biological origin within the brain."*

193. I asked the medical experts in this case their views on the research which underpinned the view that there is a physiological basis to transsexualism. Professor W said that he had attended a seminar where a leading proponent of that opinion presented the supporting evidence. He said he did not find there was convincing proof of any biological disorder but went on to say:

"I believe it myself that it is a biological disorder because it can be detected so early in life, you know. It's quite usual now for a transsexual to be diagnosed at the age of five or six. It just makes me believe that it's going to turn out to be biological, but there is no direct evidence, as I understand it."

194. Dr C commented as follows:

"[The] research which was done in the Netherlands which was for a small group of transsexual people who actually - was on a post-mortem. They found there was one nucleus of (indistinct) which in this male to female transsexual was of the same size in the female population and only in one case of a female to male. It was shown that the size of this nucleus in this female to male transsexual was the same size than it is in the men population. That is what - this study has not been replicated yet. So this is the first point. The second point is that if one looks at gender identity disorder in children and adolescence one is dealing with a wider population because even starting early childhood the children have a gender identity disorder only a minority will progress towards transsexualism later on in life. If one looks at teenagers who present with gender identity disorder of course the proportion of teenagers who have a gender identity disorder who progress towards transsexualism is much higher. But still there is a number of teenagers who present with a gender identity disorder at the age of say 13 or 14 who by the age of 18, 19 no longer wish to pursue gender reassignment. Some of the feature[s] of the gender identity disorder might have disappeared. So this shows that it is much more complex exactly in what might be the causation. The view which I take is that probably it's a combination of biological predisposition or biological factors in association with psychological or social factors. The combination of the three I think is what leads to the disorder which might have from childhood onward various outcome[s]."

195. The current state of knowledge would not, in my view, enable a finding that the treatment would clearly be for a "malfunction" or "disease" and thereby not within the jurisdiction of this Court as explained by the majority in *Marion's* case. To my mind, their Honours were seeking in that case to distinguish medical treatment which seeks to address disease in or malfunctioning of organs. In the context of sterilisation for example, they would seem to have had in mind a malignant cancer of the reproductive system which required an intervention that was medically indicated for

directly referable health reasons. The present case does not lend itself to such a comparison.

196. In light of my analysis in this section, I am therefore satisfied that the treatment plan in the present case falls within the category of cases that require court authorisation. There are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery. Also, it cannot be said on the evidence that the treatment is to cure a disease or correct some malfunction.

197. Having reached that view, I would add that I can imagine that Alex and other people who have longed for transition to the opposite sex may find it offensive to find the incompatibility between their sense of self and the sex of their body being categorised as a "disease" or a "malfunction". It is perhaps relevant that the diagnoses of Professor P and Dr N do not use this language.

198. The categories of cases in which the welfare jurisdiction properly ought to be invoked are not closed. As La Forest J said of the *parens patriae* jurisdiction in *Re Eve* [1986] 2 SCR 407 at 410 "Its limits (or scope) have not, and cannot, be defined." This observation is especially apt as the march of science overtakes the perimeters of the settled law. No type of special medical procedure concerning children or young people has been presented for decision by the High Court save for *Marion's* case.

199. As different fact situations emerge and applications are brought under s 67ZC, each case must be measured against the principled guidance I have set out above.

200. Speaking more generally, it seems to me that where a reversible treatment in respect of a child or young person is in specific anticipation of an irreversible special medical treatment that requires authorisation by this

Court, it would usually be prudent for an application to be made under s 67ZC of the Act at the outset of the clinical intervention. In saying this I am not, however, referring to the assessment and diagnostic procedures that may precede a form of intervention unless such procedures themselves have the qualities of a special medical treatment to them.

Specific Additional Findings

201. In addition to the findings I have expressed earlier in this judgment, I will summarise my findings of the specific matters that ought to be considered in special medical procedures cases and then turn to the factors set out in s68F(2) of the Act.

The Re Marion (No. 2) Matters

(i) The particular condition of the child or young person which requires the procedure or treatment

202. It is common ground that Alex has a gender identity dysphoria which compels him to want to present as a male. That desire is longstanding and most unlikely to change. It has its most likely origins in Alex's biological and psychosocial developmental features.

(ii) The nature of the procedure or treatment proposed

203. It was submitted, and I accept, that I should view the present application as the question of authorising a single package of reversible and irreversible treatment which Alex can elect to cease at any time.

204. The two stages of hormonal intervention as contemplated by the initiating application or with a period of the analogue alone will be a matter for clinical advice by the treating physicians for so long as Alex wishes to pursue his transition. The hormonal treatment will be accompanied by

on-going psychological and psychiatric support to Alex, in the context of the guardianship and educational supports I have described above.

(iii) The reasons for which it is proposed that the procedure or treatment be carried out

205. The evidence speaks with one voice as to the distress that Alex is genuinely suffering in a body which feels alien to him and disgusts him, particularly due to menstruation. It is also consistent as to his unwavering and profound wish to present as the male he feels himself to be. The possibility that Alex is an emerging lesbian has been considered but not accepted by the two expert psychiatric witnesses who have assessed him.

(iv) The alternative courses of treatment that are available in relation to that condition

206. The prognosis for behavioural intervention to change Alex's self-image and behaviour is poor. Hormonal intervention is the agreed expert view and the option of the use of analogue treatment alone at the age of approximately 16 is to be permitted by my order but subject to clinical monitoring and decision-making.

(v) The desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives

207. The proposed treatment is uniformly recommended by the expert witnesses. It is in keeping with Alex's wishes and will facilitate his socialisation into his chosen identity from the outset of his secondary schooling. In the past, Alex has been depressed and self-harming when he has thought that his deep wish to present as male has not been taken seriously. Those who know him well are supportive of the treatment that is proposed and concerned about self-harming conduct if he is unable to embark on the proposed treatment.

(vi) The physical effects on the child or young person and the psychological and social implications for the child or young person of authorising the proposed procedure or treatment or not authorising the proposed procedure or treatment

208. I have canvassed above the physical consequences arising from each stage of treatment and I am satisfied that Alex has the capacity and indeed does in fact know the side effects that may arise and further that he wishes the proposed treatment with knowledge of such risks. The social implications of the proposed treatment are that Alex will face challenges in his chosen identity in respect of peer relationships, possible bullying and ostracism, but I am satisfied that impressive steps have been taken to anticipate such risks.

209. On the other side of the balance, if treatment is not permitted there is consistent concern that Alex will revert to unhappiness, behavioural difficulties at home and self-harming behaviour. Socially, he will be significantly ill at ease with body and self-image during his period of adolescent development until he is competent to make his own treatment decision. Transition into a male public identity will be more difficult than if it occurs at the commencement of secondary school.

(vii) The nature and degree of any risk to the child or young person of authorising the proposed procedure or treatment or not authorising the proposed procedure or treatment

210. I refer to the risks I explained in the previous paragraph and elsewhere in this judgment. Apart from these immediate and direct consequences, I would also be concerned that his education and residential arrangements and his developmental socialisation would be jeopardised to his long term detriment if authorisation of the proposed treatment were refused.

211. One important risk that Alex himself understands is that he will need to continue the hormonal treatment and may as an adult wish to have further interventions, all of which will require payment. The evidence persuades me that appropriate arrangements are in place for any transfer of the

medical management of his case, and that Alex will have access to the caregiver payments which his aunt has set aside for him to meet the costs of continued treatment after the Applicant's guardianship comes to an end.

(viii) The views (if any) expressed by the guardian(s) of the child or young person, a person who is entitled to the custody of the child or young person , a person who is responsible for the daily care and control of the child or young person, and the child or young person himself, to the proposed procedure or treatment and to any alternative procedure or treatment.

212. Alex, his aunt, his cousin and the Applicant as guardian all support the proposed treatment and I have referred previously to the evidence that contra-indicates an attempt to change Alex's self-image and behaviour

213. The views of his mother are not known but in the circumstances, even if she were opposed to the staged hormonal treatment, I would give such views little weight given the strength of the evidence in favour of authorisation and her withdrawal from a parental role in Alex's life.

Section 68F(2) Factors

214. The Child Representative submitted, and I agree, that I should place considerable weight on the realistic wishes expressed by Alex and the professional concern about the risk to Alex that may occur if the treatment was not authorised. He also submitted, and I agree, that the treating physicians, his schools, his aunt and the Applicant as guardian are providing well for Alex's needs, including emotional and intellectual needs and that I should give considerable weight also to the expectation that those relationships are expected to be ongoing. The submissions of the Applicant and the Commission were to similar effect.

215. Paragraph (k) of section 68F(2) of the Act requires me to consider whether to make an order which would be least likely to lead to the institution of further proceedings. Both Senior Counsel for the Applicant and

the Child Representative addressed me on the issue of the form of order I should make.

216. The nub of the Applicant's submissions was that it would benefit Alex to have closure of the court proceedings and confidence that there was a treatment plan in place covering both the reversible and irreversible hormonal treatments until he was at least 18 years of age. He said this would have an empowering effect for Alex and provide him with the comfort of an expectation of continued treatment which would be in his best interests. He also advocated the inclusion of liberty to apply provisions in the orders for authorisation he urged me to make.

217. The Child Representative did not disagree but said the benefit of finality in the proceedings needed to be balanced with an order which would best safeguard Alex's rights through the continued involvement of the Child Representative. To this end, he suggested that the proceedings remain on foot but adjourned for a period so that the appointment of the Child Representative was procedurally maintained so that Alex could call upon him.

218. I find these suggestions helpful and I note that Counsel for the Commission indicated that to make orders according with these submissions would not infringe Alex's human rights and she was supportive the Child Representative's continued involvement as a safeguard.

219. I would note here too that it was also conceded by Senior Counsel for the Applicant that notwithstanding the fact of its guardianship of Alex, if he attains *"Gillick"* competency for the purpose of the proposed treatment, the fact of a guardianship order would put Alex in no different a position than any other child in making his own treatment decisions.

220. The final matter that I would mention concerning the submissions is one that was raised by the Commission. I think it is appropriately characterised

as "any other fact or circumstances that the court thinks is relevant: " section 68F(2)(l) of the Act. In its written submissions, the Commission said:

> *"3.8 …fundamental human rights are denied when lesbians, gay men and transgender people are not given equal protection without discrimination by the law, or are unable to express their identity through means such as identifying themselves to friends or neighbours, socialising together in public social venues, or openly cohabiting with a partner.*
>
> *3.9 Article 8(1) of the [Convention on the Rights of the Child] also provides children with the right to preserve their "identity". The concept of "identity" is not defined in the [Convention], although three elements of identity are listed by way of example - nationality, name and family relations. Sexual identity and gender identity are arguably within the scope of Article 8(1)…"* (footnotes omitted)

221. The Commission then observed that there is no single definition of "transgender identity" but, referring to s 38A of the *Anti-Discrimination Act* 1977 (NSW), noted that the definition of transgender person there included a person "who identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex". The Commission described this definition as 'inclusive' in the sense that it is not restricted to persons who have undergone or wish to undergo medical or surgical treatment to reassign their gender. It was submitted that an 'inclusive' definition is to be preferred to a definition that draws a distinction between transgender persons who have undergone medical or surgical treatment and those who have not, and that this definitional approach "is in keeping with the sentiment" expressed by the Full Court in *Re Kevin (Validity of marriage of transsexual) (No 2)* (supra) at pars 382 – 384. The Full Court there posed what it termed the "rhetorical question" of why surgery should be a pre-requisite to establish the fact of a change of sex.

222. The Commission's submission continued:

> *"3.12 On the basis of the above, it is submitted that:*

(a) *A child has a right to live with a transgender identity, free from discrimination, under international human rights law;*
(b) *It is in the child's 'best interests' to have that right respected;*
(c) *A child's right to live with a transgender identity should not be limited by a narrow definition of 'transgender identity' that relies on medical or surgical intervention. There is a right to choose how that identity is expressed;*
(d) *It follows that respecting a child's right to live with a transgender identity does not, of itself, decide the issue, one way or the other, of whether the authorisation of a medical procedure is in the child's best interests. The latter is a separate yet contextually related question to be decided by the Court, based on its assessment of the child's best interests, and taking into account the right of a child to express their wishes and to be heard..."*

223. I agree with the submission as a matter of general principle, and in the present case, it weighs in favour of authorisation as being in his best interests.

224. I would however, add the following caveat to Commission's submission - that it is necessary in each case where the wishes of a child or young person are seen to be significant, and not just medical procedure cases, to give careful consideration to the evidence and opinions concerning the bases for such wishes and the weight they should be accorded: see the discussions by the Full Court in *R and R : Children's Wishes* (2000) FLC ¶93-000 and *R v R (Children's Wishes)* 2002 FLC ¶93-108.

Birth Certificates – The Recorded Sex

225. The orders proposed by the Child Representative in respect of Alex's birth certificate seek that the Applicant be authorised to apply to register a change of his recorded name which would reflect the name he is currently using. No change is sought in respect of the record of Alex's sex however paragraph 3.12 of the Commission's submission invites attention to the laws which govern the issue of a birth certificate which shows a sex that reflects the chosen gender identity of a person.

226. A helpful collation of Australian law is contained in the September 2003 *Discussion Paper: Changes to Birth Certificates for Transsexual People* by

the Victorian Attorney-General's Advisory Committee on Gay, Lesbian, Transgender and Intersex Issues. It provided a consultation mechanism to assist the Attorney consider "legislative reforms to enable transsexual people to have the recorded sex on their birth certificate amended to reflect their affirmed sex."(at 2). The Discussion Paper informs that:

> *"All Australian States and Territories (except Victoria) enacted legislation between 1988 - 2002 to provide a legislative mechanism by which an individual who has undergone "sexual reassignment surgery or procedures", is unmarried and meets the jurisdictional requirements, may apply to have their legal sex (as recorded in the Registry of Births Deaths and Marriages) amended to reflect their affirmed sex. New South Wales, the Northern Territory, the Australian Capital Territory, Tasmania and Queensland have included transsexual recognition provisions in their Births Deaths and Marriages Registration legislation.* (at 5)

227. The Discussion Paper then identifies the following statutes: *Births Deaths and Marriages Registration Act* 1995 (NSW); *Births Deaths and Marriages Registration Act* 1997 (Northern Territory); *Births Deaths and Marriages Registration Act* 1997 (Australian Capital Territory); *Births Deaths and Marriages Registration Act* 1999 (Tasmania) and *Registration of Births Deaths and Marriages Act* 1962 (Queensland). The Discussion Paper says of these jurisdictions:

> *"Applications under this model are limited to those who have their birth registered in the jurisdiction. Applications are determined by the Registrar on the basis of whether or not the person complies with the mandatory criteria, namely, that the applicant has undergone sexual reassignment surgery, is unmarried and has birth records registered in that jurisdiction."* (at 5)

228. The Discussion Paper then observes that the *Sexual Reassignment Act* 1988 (South Australia) and the *Gender Reassignment Act* 2000 (Western Australia):

> *"… require a Magistrate (SA) or a Gender Reassignment Board (WA) to be satisfied that the person believes that his or her true sex is the sex to which the person has been reassigned and has adopted the lifestyle and has the sexual characteristics of a person of the sex to which the person has been reassigned, and has received proper counselling in relation to*

his or her sexual identity. In addition, in WA and SA, a copy of the application must be served on the Minister and any other person who should in the Board or Magistrate's opinion be served with notice of the application. If the applicant does satisfy the Magistrate (SA) or Gender Reassignment Board (WA), a "recognition certificate" is issued. Such a certificate can be taken to other recognising states or to that state's registry of Births Deaths and Marriages for the record to be amended." (at 5)

229. The Discussion Paper explains that surgery is not required in Western Australia or South Australia. Since in the former, an authorised Magistrate, and in the latter, the Gender Reassignment Board decides:

"… whether the person has completed transition based on a range of evidence, the medical treatment criteria does not need to be too prescriptive. These jurisdictions do not require that an applicant for a change of birth certificate has had 'sexual reassignment surgery' as other Australian jurisdictions do. Rather, they require that the applicant 'has the sexual characteristics of a person of the sex to which they have been reassigned'. This factor will then be assessed by the Court or [Gender Reassignment Board of Western Australia] based on the evidence presented." (at 10)

230. For example, s 3 of the *Sexual Reassignment Act* 1988 (SA) provides the following definitions and are consistent with the definitions of "reassignment procedure" and "gender characteristics" found in s 3 of the *Gender Reassignment Act* 2000 (WA):

*""reassignment procedure" means a medical **or** surgical procedure (or a combination of such procedures) to alter the genitals and other sexual characteristics of a person, identified by birth certificate as male or female, so that the person will be identified as a person of the opposite sex and includes, in relation to a child, any such procedure (or combination of procedures) to correct or eliminate ambiguities in the child's sexual characteristics;*

"sexual characteristics" means the physical characteristics by virtue of which a person is identified as male or female" (emphasis added)

231. The Discussion Paper gives consideration to the law concerning people under the age of 18 years and notes that "most other jurisdictions provide that a parent or the child's guardian may apply for amendment to the recorded sex on their child's birth certificate."(at 7).

232. Again, to use the *Sexual Reassignment Act* 1988 (SA) as an example, in respect of a child under the age of 18 years, s 7(3) provides:

> *"An application may be made under this section--*
> *(a) by the person to whom it relates; or*
> *(b) if that person is a child--by the child's guardian."*

233. Section 14 (2) *Gender Reassignment Act* 2000 (WA) is to the same effect.

234. I consider it is a matter of regret that a number of Australian jurisdictions require surgery as a pre-requisite to the alteration of a transsexual person's birth certificate in order for the record to align a person's sex with his/her chosen gender identity. This is of little help to someone who is unable to undertake such surgery. The reasons may differ but for example in the present case, a young person such as Alex, on the evidence, would not be eligible for surgical intervention until at least the age of 18 years. Thus, for the many purposes for which a birth certificate is required (such as an application for a passport), a person such as Alex in those jurisdictions is required to produce a birth certificate that describes him as a female in circumstances where in all other respects he is living his life as a male.

235. The Discussion Paper to which I have referred contains illustrations of the hardships that are experienced when the sex recorded on the birth certificate is incongruent with their chosen gender identity. It rightly appreciates that people in these circumstances:

> *"… have to endure the embarrassment of explaining their personal history. Naturally, this will be the source of a great deal of distress and embarrassment for the person as well as increasing the risk of being unfairly discriminated against."* (at 3)

236. Reflecting upon the particular circumstances of this case leaves me anxious about the detrimental consequences that a young person such as

Alex would suffer from having to present a birth certificate that is antithetical to his self-image.

237. A requirement of surgery seems to me to be a cruel and unnecessary restriction upon a person's right to be legally recognised in a sex which reflects the chosen gender identity and would appear to have little justification on grounds of principle.

238. The requirement of prior surgery in order to establish the fact that a person is a man for the purposes of a valid marriage was questioned in the *Re Kevin* cases (supra): see particularly *In Re Kevin (Validity of marriage of transsexual) (No 2)* (supra) at pars 382-388. The Full Court there also noted (at par 386) the submission of the Commission that the efficacy of surgical intervention is more problematic where the transition is from female to male. Senior Counsel for the Commission in that case said:

> *"…in the circumstances of this case, it is worth accepting that surgical intervention in relation to the removal of gonads maybe relatively straight forward, surgical intervention for a male to female transsexual person in relation to the construction of a vagina may be common place, surgical intervention which requires the construction of a penis is much more problematic and even where it takes place may or may not give rise to something which would be readily accepted as a penis of a sexual kind which has a particular sexual function."*

239. If one accepts such a submission, a requirement of surgery is not only generally inconsistent with human rights. The requirement is more disadvantageous and burdensome for people seeking legal recognition of their transition from female to male than male to female. Expressed in this way, there is an additional objection to surgery as a pre-requisite; the requirement of surgery is a form of indirect discrimination.

240. I would urge the various State and Territory Legislatures that make surgery a pre-requisite for a change in birth certificates to reconsider their position.

241. A scheme for the change of birth certificates which requires a Magistrate or a Board to make a finding of fact but does not make surgery a pre-requisite is, in my view, more consistent with human rights and therefore preferable in comparison with an administrative scheme wherein the applicant must have had surgery to be eligible for the changed birth certificate.

Authorisation and Other Orders

242. In the result and for the reasons contained in this judgment, I am satisfied to the *Briginshaw* standard by the evidence and by the submissions that I should make a declaration authorising the administration of hormonal treatment as determined from time to time by the attending physicians without specifying the timing and nature of the treatment. My authorisation will extend to both of the interventions sought in the application and I make it clear that when Alex is older, the question of whether the analogue is administered alone or in combination with testosterone is a matter for the treating clinicians and, of course, Alex.

243. I will make certain ancillary orders in respect of Alex's public identity, the explanation of my orders and permission to provide copies of my orders to persons and organisations relevant to his best interests as proposed by the Child Representative.

244. I will give liberty to apply any party and to Alex to relist the matter on reasonable notice.

245. I will make orders adjourning the matter to the Chief Justice of the Court, for the purpose of the appointment of a Judge case manager should any further application be made.

246. I will preserve the continued appointment of the Child Representative in the matter on the expectation that this will not involve an active ongoing role but rather, provides a continuing contact point for Alex as the course of treatment progresses, in case there is a need to seek any further order from the Court.

247. I will direct that a copy of my reasons for judgment and my orders are translated into the native language of Alex's aunt, such translation to be arranged and paid for by the Court

248. My orders will certify for solicitor acting as counsel.

249. I will direct the return of the exhibits and further make directions for the file to be sealed and held by the Registry Manager and only to be produced on order of a Judge of this Court.

250. I will hear the parties as to the specific form of the orders including any matters as to costs.

I certify that the preceding **250** paragraphs is a true copy of the reasons for judgment delivered by the Honourable Chief Justice

Danny Sandor
Senior Legal Associate to the Chief Justice