

AUSTRALIA / JUDGMENT

Charles (a pseudonym) [2024] NSWCATGD 15

COURT

NSW Civil and Administrative Tribunal

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NSW Civil and Administrative Tribunal

New South Wales

Medium Neutral Citation: Charles (a pseudonym) [2024] NSWCATGD 15

Hearing dates: 10 September 2024

Date of orders: 18 September 2024

Decision date: 04 October 2024

Jurisdiction: Guardianship Division

Before: A Britton, Deputy President

Dr B McPhee, Senior Member (Professional)

S Bullock, General Member (Community)

Decision: The treatment proposed by Dr 3 for Charles, that is, Stage 2 (testosterone) treatment is not special medical treatment within the meaning of the definition of "special medical treatment" in s 175(5) of the Children and Young Persons (Care and Protection) Act 1998 (NSW).

The application is dismissed.

Catchwords: GUARDIANSHIP -- application to NCAT under s 175 of the Children and Young Person (Care and Protection) Act 1998 (NSW) in respect of transgender child – whether gender affirming hormone therapy constitutes "special medical treatment" – whether gender affirming hormone therapy treatment is reasonably likely to render child permanently infertile – finding that gender affirming hormone therapy treatment is not reasonably likely to render child permanently infertile and therefore does not constitute special medical treatment – application dismissed

WORDS AND PHRASES — "reasonably likely" — Children and Young Persons (Care and Protection) Act 1998 (NSW), s 175(5)

Legislation Cited: Children and Young Persons (Care and Protection) Act 1998 (NSW), ss 3, 9, 175, 175(1), 175(2)(b), 175(3), 175(5), 175(5)(a), 175(5)(a)(i)-(ii), 175(5)(c)-(d)

Children (Care and Protection) Act 1987 (NSW), s 208 (repealed)

Civil and Administrative Tribunal Act 2013 (NSW), s 45(4)(c)

Cases Cited: Boughey v The Queen (1986) 161 CLR 10; [1986] HCA 29

Department of Agriculture and Rural Affairs v Binnie [1989] VR 836

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112

Project Blue Sky Inc v Australian Broadcasting Authority (1998) 194 CLR 355; [1998] HCA 28

Re Fenwick (2009) 76 NSWLR 22; [2009] NSWSC 530
Re the Will of Bridget [2018] NSWSC 1509
Texts Cited: A Leung, D Sakkas, S Pang, K Thornton, and N Resetkova, "Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine" (2019) 112(5) Fertility and Sterility, 858-865
Children (Care and Protection) Further Amendment Act 1988 (NSW); NSW, Parliamentary Debates, Legislative Council, 13 October 1988, 2202 (Virginia Chadwick, Minister for Family and Community Services)
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
NSW Law Reform Commission, "Young People and Consent to Health Care", Report 119, October 2008
Royal Children's Hospital Melbourne, "Australian Standards of Care and Treatment Guidelines: For Trans and Gender Diverse Children and Adolescents", Version 1.4
World Professional Association for Transgender Health (WPATH), "Standard of Care for the Health of Transgender and Gender Diverse People", Eighth Edition
Category: Principal judgment
Parties: Hunter New England Local Health District (Applicant)
Charles (Respondent)
NSW Ministry of Health (Joined Party)
Representation: Counsel:
G Wright SC (NSW Ministry of Health, Hunter New England Local Health District)

Solicitors: Minter Ellison (NSW Ministry of Health, Hunter New England Local Health District)
Legal Aid NSW, Separate Representative for Charles (Respondent)
D McMullen (Respondent)
File Number(s): NCAT 2024/00286581
Publication restriction: The publication of the evidence given in these proceedings to the Tribunal is prohibited. This order is made under section 64(1)(c) of the Civil and Administrative Tribunal Act 2013 (NSW).
The publication or broadcast of the name of the witness is prohibited. This order is made under section 64(1)(a) of the Civil and Administrative Tribunal Act 2013 (NSW).
Note: A Reference to the name of a person includes a reference to any information, picture or other material that identifies the person or is likely to lead to the identification of the person.

REASONS FOR DECISION

1. This decision is about Charles who will turn 16 in three months. Charles is a transgender male (assigned female at birth) who has been diagnosed with Gender Dysphoria. Since December 2019, Charles has been taking medication, prescribed by an endocrinologist, designed to delay the physical and psychological changes associated with puberty. Charles wishes to commence "gender affirming hormone therapy", which involves taking cross-sex hormone, testosterone (the proposed treatment).

2. In an undated letter to the Tribunal in support of his request to receive the proposed treatment, Charles wrote that "for longer than I can remember I've been a boy". He said he wants to go through puberty with his friends and it is "not fair to be told that something you've been waiting your whole life for... you have to wait longer".
3. Charles lives with his father and one of his two sisters. His parents are separated. He is in regular contact with his mother. Both parents support and have given written consent to Charles receiving the proposed treatment.
4. Charles has been under the care of psychologist, Dr 1 for about the past 10 years. Dr 1 reports that Charles has been presenting and living as a boy since the age of six. Dr 1 is of the opinion that Charles understands the nature of the proposed treatment and is "Gillick competent".¹
5. The Hunter New England Local Health District has applied to the NSW Civil and Administrative Tribunal (NCAT) under s 175 of the Children and Young Persons (Care and Protection) Act 1998 (NSW) (the Care Act) for consent to carry out the proposed treatment on Charles. [1] It is an offence to carry out "special medical treatment" on a child, that is, a person under the age of 16 years otherwise than in accordance with s 175 of the Care Act: Care Act, s 175(1). Special medical treatment includes treatment that is reasonably likely to have the effect of rendering permanently infertile the person on whom it is carried out: Care Act, s 175(5)(a). It is not an offence for a medical practitioner to carry out special medical treatment on a child if NCAT consents to the carrying out of that treatment: Care Act, s 175(2)(b). To give consent to the carrying out of special medical treatment on a child, NCAT must be satisfied that the treatment is necessary to carry out in order to "save the child's life or to prevent serious damage to the child's psychological or physical health": Care Act, s 175(3).
6. For the reasons we explain below, we find that the proposed treatment is not special medical treatment. Therefore, s 175 of the Care Act does not make it unlawful for a medical practitioner to carry out the proposed treatment on Charles.

Procedural background

1. At a hearing on 10 September 2024, we heard the application made under s 175 of Care Act in respect of Charles, together with separate applications made in respect of two other 15-year-old children. To preserve their privacy, in these reasons we will refer to those children as Child 1 and Child 2. Each are transgender female. Many of the same issues are raised in the application made in respect of each child. Parts of these reasons are identical to those given in respect of Child 1 and Child 2.

2. NCAT made orders under s 45(4)(c) of the Civil and Administrative Tribunal Act 2013 (NSW) that each child be separately represented. Legal Aid NSW appointed a separate representative for each child. Solicitor, Ms McMullen, represented each separate representative. For convenience we will refer to submissions made on behalf of Charles as being made by the Separate Representative.
3. The NSW Ministry of Health (NSW Health) was joined as a party to these proceedings. NSW Health and Hunter New England Local Health District were represented in the proceedings by Ms Wright SC.

Gender dysphoria

1. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (the DSM-V) defines Gender Dysphoria in adolescents and adults as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least six months, as manifested by at least two of the following:
 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics);
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender (or some alternative gender different from one's assigned gender);
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender); and
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
1. The DSM-V also provides that to meet the criteria for the diagnosis of Gender Dysphoria, the condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Charles is diagnosed with Gender Dysphoria

1. In 2019, Charles was diagnosed with Gender Dysphoria by psychologist Dr 2. Dr 2's diagnosis is referred to in several reports filed in these proceedings but the material before us does not contain a report or clinical record of Dr 2's diagnosis.

2. In a report dated 25 September 2023, Dr 1 confirmed Dr 2's diagnosis. Dr 1 said that Charles met Criteria A in the definition in the DSM-V of Gender Dysphoria: "a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration". In addition, Charles satisfied Criteria B: "the condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning".

Charles commences puberty suppression medication (Stage 1 treatment)

1. In December 2019, a paediatric endocrinologist prescribed Charles puberty suppression medication (Lucrin®). Soon after Charles commenced taking that medication. He continues to take puberty suppression medication.
2. In December 2021, Charles was transferred to a specialist transgender health care facility operated by NSW Health (the Facility). Charles initially continued on Lucrin but was later swapped to another puberty suppressant, Zoladex®.
3. Dr 3 is a paediatric endocrinologist with the Facility and the original applicant in these proceedings. [2] In a letter dated 27 August 2024, in support of that application, Dr 3 wrote that she understands that when Charles commenced puberty suppression medication he was in "Tanner Stage 2 (early puberty)". [3] Dr 3 explained that the Tanner stages are used to describe the progression of puberty from Stage 1 to Stage 5. For natal females, the commencement of true puberty is signalled by breast bud development. Tanner Stage 2 is described as "breast bud palpable under the areola".
4. In these reasons we refer to the administration of puberty suppression medication as "Stage 1 treatment", and, the administration of hormones, in Charles' case testosterone, as "Stage 2 treatment". The experts who gave evidence in these proceedings used various terms to describe Stage 2 treatment, including "gender affirming feminising therapy" and "feminising treatment". Those terms mean one and the same thing.

The proposed treatment (Stage 2)

1. In the initiating application made to NCAT, Dr 3 described the proposed Stage 2 treatment the subject of that application as "gender affirming treatment (testosterone)". In the supporting letter dated 27 August 2024, Dr 3 explained that it was proposed that testosterone would be administered by topical gel applied by Charles at home, or by injection given by a health practitioner. Charles would be commenced on a low dose of testosterone which would be increased over one to two years. When Charles commences Stage 2 treatment, he would continue to receive Zoladex and this would continue until his testosterone levels were considered adequate to suppress female puberty and possibly menstruation.
2. Dr 3 said that Stage 2 treatment is not intended to cause permanent infertility but "to bring about the masculinisation of [Charles'] body".

3. According to Dr 3 if Stage 2 treatment were to be delayed until Charles reaches 16, that would not have any significant impact on his medical (physical) outcome in the long term. However, starting now may improve Charles' psychological health.

Statutory framework

1. The central provision in these proceedings is s 175 of the Care Act which relevantly states:

175 Special medical treatment

- (1) A person must not carry out special medical treatment on a child otherwise than in accordance with this section.

Penalty on indictment: imprisonment for 7 years.

Note—

An offence against subsection (1) committed by a corporation is an executive liability offence attracting executive liability for a director or other person involved in the management of the corporation--see section 258.

- (2) A medical practitioner may carry out special medical treatment on a child if—
 - (a) the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health, or
 - (b) the Civil and Administrative Tribunal, in the case of special medical treatment described in paragraph (a), (b) or (c) of the definition of "special medical treatment" in subsection (5), consents to the carrying out of the treatment, or
- ...
- (3) Consent to the carrying out of special medical treatment on a child must not be given by the Civil and Administrative Tribunal unless the Civil and Administrative Tribunal is satisfied that it is necessary to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's psychological or physical health.
- ...

- (5) In this section—

"medical treatment" includes—

- (a) any medical procedure, operation or examination, and
- (b) any treatment, procedure, operation or examination that is declared by the regulations to be medical treatment for the purposes of this section.

"special medical treatment" means—

- (a) any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, not being medical treatment—
- (i) that is intended to remediate a life-threatening condition, and
- (ii) from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence, or
- ...
- 1. In the Care Act, a "child" is defined to mean a person who is under the age of 16 years: s 3.
- 2. Section 9 of the Care Act instructs that in any decision we make concerning Charles, his safety, welfare and wellbeing are paramount.

Predecessor to s 175 of the Care Act

1. The predecessor to s 175 of the Care Act is s 208 of the former Children (Care and Protection) Act 1987 (NSW) (the 1987 Care Act). There is no material difference between the definition of "special medical treatment" in s 208 of the 1987 Care Act and that contained in s 175(5)(a) of the Care Act.
2. Section 208 of the 1987 Care Act originally provided that special medical treatment could be carried out on a person under 16 years only if a medical practitioner thought it necessary as a matter of urgency in order to save the patient's life or prevent serious damage to health, or with the Supreme Court's consent. A subsequent amendment "[strengthened] ... the protective effect" of the 1987 Care Act "by ensuring that the Supreme Court consents to the carrying out of any treatment that is likely to result in a child being rendered infertile only if the court is satisfied that the treatment is necessary to save the child's life or to prevent serious damage to the child's health" (emphasis added). [4]
3. In a report published in 2008, "Young people and consent to health care", the NSW Law Reform Commission (the NSWLRC) commented at [8.23]:

"The evolution of the NSW legislation would seem to indicate that the concept of special medical treatment was introduced principally to prevent young people from being subjected to sterilisation undertaken without independent scrutiny. Other types of treatment were added soon after. During Parliamentary debate it was stated that the principal purpose of the above definition of "special medical treatment" was:

to make it unlawful to carry out sterilization, except in a case where it is necessary to save the life of the patient or to prevent serious damage to the patient's health, or unless the Guardianship Board has held a hearing concerning the matter and has given its consent. There have been allegations over a number of years that intellectually disabled people in particular have been improperly sterilized as a means of social control and this practice was condemned by the Anti-Discrimination Board in a report which it produced in 1981. There would be few people in a

civilized community who would condone such a thing and it is a principal purpose of this bill to outlaw the practice." (Footnotes omitted)

1. The NSWLRC recommended that s 175 be retained and said at [8.26] that "[t]he provision should contain a definition of special medical treatment that accords with the present definition contained in s 175(5)(a), (c) and (d), and which refer to treatments affecting reproductive capacity and any others declared special medical treatments by the regulations".

Reasonably likely

1. In construing the expression "reasonably likely" in the definition of special medical treatment in s 175(5) of the Care Act, the text, context and the purpose of the Care Act are relevant: *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355; [1998] HCA 28 at [78].
2. As a general principle of statutory construction, where words are not defined, they are to be given their ordinary meaning.
3. What does the expression "reasonably likely" mean in the context of s 175(5) of the Care Act? It is well-established that the meaning of the word "likely" may vary according to its context. Generally, it is accepted that an event is "likely" if there is a real rather than a remote chance of it happening. If something is likely to happen, there is a good chance that it will happen: *Bouhey v The Queen* (1986) 161 CLR 10; [1986] HCA 29 at 15.
4. The adverb "reasonably" in the expression "reasonably likely" conveys a sense that the likelihood of an event occurring is relatively less than it is "likely". The qualifying adverb diminishes the phrase's weight or intensity compared with the power of the adjective "likely" standing by itself. It conveys a sense that there is "a fairly good chance" that the potential event will occur: see *Re Fenwick* (2009) 76 NSWLR 22; [2009] NSWSC 530 at [150]-[152] (Palmer J); see also *Department of Agriculture and Rural Affairs v Binnie* [1989] VR 836. The "likely" event is not one which is more likely than not to occur, that is "odds on", or necessarily probable but must be more than a mere possibility: *Re the Will of Bridget* [2018] NSWSC 1509 at [106]-[108] (Hallen J).
5. In the context of s 175(5) of the Care Act, the phrase 'reasonably likely' carries a cautionary connotation because the consequences of a proposed treatment may be irreversible and, if so, for many people, undesirable. Medical treatment that is reasonably likely to have the effect of rendering a person permanently infertile, in our view, is treatment that creates a real, not speculative or remote, but not probable risk of permanent infertility for the treated person. The apprehended risk is above speculation, conjecture or mere possibility.

Is the Tribunal limited to considering the effect of that treatment in the period up to Charles' 16th birthday?

1. The Separate Representative contends that in deciding whether the proposed treatment is reasonably likely to have the effect of rendering Charles permanently infertile, the Tribunal is limited to considering the effect of that treatment in the period preceding Charles' 16th birthday, that is in about three months. She argues that s 175 of the Care Act is only concerned to restrict the carrying out of special medical treatment on children under the age of 16 years and that any treatment carried out after that time is not the subject of intervention pursuant to s 175. She points out that if Charles or any child were to commence treatment on their 16th birthday, the Tribunal would have no jurisdiction. It would be inconsistent with the purpose and objects of the Care Act to give the Tribunal power to consent to treatment given to a person over the age of 16 years.
2. The Separate Representative points out that in contrast to a form of one-off treatment, such as a hysterectomy, here the proposed treatment is a course of indefinite treatment which will extend beyond Charles' 16th birthday. If Charles commences Stage 2 treatment before he turns 16, as explained by Dr 4, he is not committed to the continuation of that treatment. That treatment can be paused or ceased at any time in accordance with Charles' wishes and the advice of his treating team.
3. NSW Health contends that the Care Act requires the Tribunal to make a realistic and holistic assessment of the effect of the proposed treatment, not on a dose-by-dose assessment. The word "permanent" in s 175(5)(a) requires the Tribunal to consider the effect of all of the treatment that is proposed to be commenced and its effect on the person's fertility, not only the effect of treatment on the person's fertility until they reach age 16.

Consideration

1. This argument advanced by the Separate Representative, in our view, is misconceived. Section 175 of the Care Act gives the Tribunal jurisdiction in respect of children under the age of 16 years in relation to medical treatment that falls within paras (a), (b) or (c) of the definition of special medical treatment in s 175(5) of the Care Act. Section 175 imposes a decision-making responsibility on the Tribunal. The obligation to exercise that jurisdiction according to law is not concerned with the course or length of the proposed treatment but with the protection of children from harm that may be caused by the subject treatment. If a person is under the age of 16 and an application is made for the Tribunal to consent to the proposed special medical treatment under s 175(3), the Tribunal must consider the evidence and make a decision according to the principles outlined in the Care Act. The Tribunal must consider the evidence concerning the proposed treatment and its potential effects.
2. Section 175 is both present-oriented and forward-looking. It requires the Tribunal to anticipate, as best it can, what may follow from a treatment of a child who is, at the time of the application, under the age of 16. In our view, it would be a failure of jurisdiction, and potentially lead to absurd results, if the Tribunal were to consider only the potential effects of a treatment up to the 16th birthday of a child. Where a "special medical treatment" in the form of an operation were commenced five minutes prior to a child's 16th birthday, such a

stance would require NCAT to ignore the possible effects occurring after the conclusion of the operation, as the child would be 16 by that time. In our view, once seized with jurisdiction, the Tribunal must consider whether the treatment over its course is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is proposed to be carried out. The fact that a treatment may extend beyond the child's 16th birthday, in our view, has no bearing on the Tribunal's jurisdiction at the time of the application. Otherwise, the Tribunal would not be able to exercise jurisdiction at all if the course of treatment continued beyond the child's 16th birthday.

Is the proposed treatment reasonably likely to have the effect of rendering Charles permanently infertile?

1. NSW Health contends that it is open to the Tribunal to find on the available evidence that the proposed treatment is reasonably likely to have the effect of rendering Charles permanently infertile. NSW Health acknowledges that the available evidence would not support a finding that it is probable that the proposed treatment will render Charles permanently infertile.
2. On the other hand, the Separate Representative contends that the available evidence does not support a finding that there is a real and not remote chance that Stage 2 treatment will render Charles infertile. The Separate Representative points out that none of the experts who gave evidence in these proceedings about the effects of the proposed treatment on Charles' fertility, expressed the opinion that it is reasonably likely that the proposed treatment would render Charles permanently infertile.

Expert evidence

1. At the request of NSW Health, obstetricians and gynaecologists, Experts 1 and 2, gave evidence in these proceedings about the effects of Stage 2 treatment on the fertility of Charles, Child 1 and Child 2. Experts 1 and 2 each prepared individual reports and, at the request of the Tribunal, a joint report. In addition, Expert 1 gave oral evidence. Expert 2 lives overseas and was not available to give oral evidence.
2. Experts 1 and 2 agree that Stage 1 treatment has the effect of suppressing pubertal development, including suppressing ovulation. In addition, they agree that Stage 1 treatment is "fully reversible" and would have no effect on Charles' fertility. Further, they are in general agreement that it is not reasonably likely that Stage 2 treatment will render Charles permanently infertile.

Expert 1 meets with Charles to discuss fertility

1. Expert 1 met with Charles in March 2024 to discuss "fertility impacts of gender affirming treatment". In a letter addressed to Charles' GP dated 14 March 2024, Expert 1 wrote that Charles "does not want to carry a pregnancy ... and does not feel that genetics are important for family". Expert 1 recorded that during that consultation she discussed with Charles:

1. That there is limited data about the long-term impact of testosterone on ovarian follicles and almost none in patients who have commenced testosterone in a pre-pubertal state;
2. Studies have confirmed successful pregnancies after testosterone has ceased; and
3. While some evidence that testosterone can impact ovarian histology, it does not deplete the primordial follicle pool.

1. In a report dated 27 August 2024, Expert 1 explained that natal females are born with all the oocytes (eggs) they will use throughout their life. They do not make any more.
2. Expert 1 noted that Charles commenced Stage 1 treatment before the onset of pubertal maturation and, as a consequence, is unlikely to have commenced ovulation when that treatment commenced. Expert 1 explained that Stage 1 treatment has the effect of suppressing the progression of puberty, including suppressing ovulation. In her opinion, if Charles were to cease Stage 1 treatment, and to commence Stage 2 treatment, ovulation would continue to be suppressed. Expert 1 pointed out that there is limited evidence about the long-term impact of Stage 2 treatment (testosterone) on ovarian follicles and almost none in natal females who, like Charles, commenced testosterone in a "pre-pubertal gonad state". The little available data is limited to studies involving mice. None of those studies involve humans.
3. Expert 1 said there was some evidence that Stage 2 treatment (testosterone) "can impact ovarian histology (tissue as it is viewed under a microscope), with tissue changes in the ovarian stroma (tissue of the outer layer of the ovary)". However, the current evidence was conflicting, with early studies showing that when exposed to testosterone the ovary takes on the appearance of a polycystic ovary; later studies showed this impact was completely reversible and had been overstated.

4. Expert 1 went on to say:

"However, there is limited evidence in general about the long-term use of Stage 2 treatment with testosterone (over the course of >5-10 years) on ovarian follicles and almost none in natal females who have commenced testosterone in a pre-pubertal gonad state (as is [Charles'] case). There are no reports in relation to humans in this setting, and the available data is limited to that attained in mouse models. It should be noted that there is no evidence to suggest that testosterone causes irreversible infertility."

1. Expert 1 referred to studies involving transgender males who had successful pregnancies after cessation of Stage 2 treatment with testosterone. Those studies involved transgender males where treatment had commenced after full female pubertal maturation, and ovarian stimulation was used in assisted reproductive technology. According to Expert 1 the results of those studies were in keeping with the "expected response in cis gendered women". [5] Nonetheless, she said:

"In view of the state of the evidence, particularly relating to natal females who commence Stage 2 treatment by way of testosterone before full pubertal maturation, there remains uncertainty as to whether infertility in this setting is likely to be permanent." (Emphasis added).

Expert 2's initial report

1. In a report dated 29 August 2024, Expert 2 noted that in contrast to those studies involving fertility outcomes on transgender females there is more data involving transgender males. She said the available data confirms that oocyte reserves and quality are "not harmed by testosterone" and that there are many examples of trans males carrying pregnancies after using testosterone for years. However, she acknowledged that "it is not certain if and how long-term testosterone treatment is related to oocyte quality since studies report a range of 3-6 years exposure".
2. In Expert 2's opinion "there is not a real chance that [Charles] will be permanently infertile if [he] undergo[es] Stage 2 testosterone treatment". Nonetheless she recommended consideration of oocyte retrieval and cryopreservation when Charles is older.

Joint expert report

1. At the request of the Tribunal, NSW Health requested Experts 1 and 2 to prepare a joint report. Experts 1 and 2 were asked to answer a series of questions jointly formulated by NSW Health and the Separate Representative about Charles, Child 1 and Child 2.
2. Experts 1 and 2 were asked "is there a real and not remote chance that Stage 2 (testosterone) treatment would have the effect of rendering [Charles] permanently infertile?". In answering that question the experts were asked to:

1. consider each other's previous report relating to Charles and confer in relation to:

* Expert 1's opinion that "in view of the state of the evidence, particularly relating to natal females who commence Stage 2 treatment by way of testosterone before full pubertal maturation, there remains uncertainty as to whether infertility in this setting is likely to be permanent."

* Expert 2's opinion that "there is not a real chance that [Charles] will be permanently infertile if they undergo Stage 2 testosterone treatment".

1. address whether you each maintain your respective opinions; and
 2. provide any further comment or explanation in relation to Charles.
1. In answer to that question, Expert 1 wrote:

"I refer to my comments: I still feel that there remains no evidence looking specifically at prepubertal girls receiving testosterone after early puberty blockade in the form of zoladex. I also feel that we are unlikely to ever have large scale, good quality studies as the likelihood that these patients will wish to cease testosterone and undergo a natal puberty is remote.

However, based on my review of the available literature and drawing on evidence from other disease processes such as congenital adrenal hyperplasia (where natal females are exposed to high doses of androgens in childhood), it is my opinion that the chance that testosterone would render the young person infertile is remote. We now have an increasing body of evidence that individuals on testosterone are able to fall pregnant spontaneously and that pregnancies or IVF procedures are successful after ceasing testosterone and even whilst testosterone continues." (Emphasis added).

1. Expert 2 agreed with that opinion and added:

"From GnRHa [gonadotropin-releasing hormone analogues] we know the reversibility, also from treatment of endometriosis and other fertility treatments. From testosterone all evidence so far is reassuring in term[s] of reversibility. As is stated in [Child 1 and Child 2] there will not be an absolute certainty, because there [are] no exact studies with alike situations as [Charles]. And we will not know the background risk of sub of infertility in these clients life."

1. In addition, the experts were asked given the comments in their respective reports about fertility counselling and fertility preservation measures, to comment on why such counselling is recommended to transgender adolescents prior to commencing gender affirming hormone therapy, and whether the reasons include the real possibility of permanent infertility as a result of the treatment.

2. Expert 1 wrote:

"Every Australian and world-wide guideline on transgender care (including the specific guidance for trans and gender diverse children and adolescence) suggests that fertility preservation should form part of gender care when gender affirming medical and surgical treatment is being considered. We used these documents to guide our practice. Both of the below guidelines [the World Professional Association for Transgender Health Guidelines (WPATH Guidelines) [6] and the guidelines for gender affirming care used by Royal Children's Hospital Melbourne [7]] reference the lack of prospective evidence in this space as rationale for the counselling rather than evidence of permanent infertility. They acknowledge that the emerging evidence is promising."

Expert 1's oral evidence

1. In oral evidence Expert 1 was asked to explain the reason for the apparent shift in the opinion she expressed in the initial report and the more optimistic view she expressed in the joint report about the risk that Stage 2 treatment would render Charles permanently infertile. In the former Expert 1 said on "the state of the evidence ... there remains

uncertainty as to whether infertility in this setting is likely to be permanent". In the later, Expert 1 said that the chance that testosterone would render Charles permanently infertility is remote.

2. Expert 1 said that the reason for the apparent shift in her opinion was because it was not until the initial Tribunal hearing, that she was given clarification that the question she was being asked to address was whether there was a real and not remote chance that the proposed treatment would render Charles permanently infertile. That hearing was held after Expert 1 prepared the initial report and before she prepared the joint report with Expert 2.
3. Expert 1 explained that a further factor that caused her to change her opinion was her consideration about other disease processes, such as congenital adrenal hyperplasia (CAH), a disease associated with infertility. She explained that in a person with CAH, the endogenous secretions of adrenal androgen hormones are enough to suppress the ovaries. Similarly, in a person undergoing Stage 2 treatment, the administration of testosterone suppresses the ovaries. She explained that androgens are a group of hormones that perform similar functions to testosterone throughout the body. According to Expert 1 while the doses of hormones that occur naturally as a result of CAH, may not be the same as the dose of testosterone in Stage 2 treatment, the impact on ovarian suppression is similar. A female with CAH who is not treated will be infertile while exposed to high levels of androgens. However, fertility returns once the CAH is "brought well under control" and the person is no longer exposed to high levels of androgens. Similarly, with a person undergoing Stage 2 treatment once testosterone treatment stops, fertility returns. Expert 1 said that she counsels patients with CAH that when that the disease process is corrected, they should expect "good fertility outcomes".
4. The Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents (the AusPATH Guidelines) are endorsed by the Australian Professional Association for Trans Health (AusPATH). [8] In oral evidence, Expert 1 agreed with the proposition that those Guidelines represent best practice health care for transgender and gender diverse people in Australia. Expert 1 said that she agreed with the statement contained in those guidelines that the degree to which testosterone may reduce reproductive potential in trans males when taken in adolescence and early adulthood is unknown.

Consideration

1. Both experts expressed the opinion that there is not reasonably likely that Stage 2 (testosterone) treatment would have the effect of rendering Charles permanently infertile.

2. Expert 1 gave a plausible explanation for the shift in her opinion she expressed about the likelihood of Stage 2 treatment rendering Charles permanently infertile. We find that the opinion she expressed in the joint report — that the risk that Stage 2 treatment will render Charles permanently infertile is remote — is genuinely held. Neither party suggested otherwise.
3. In reaching that opinion, Expert 1 took into account the absence of studies of trans males who had undergone Stage 2 treatment after early suppression of puberty. She acknowledged that this made the assessment of the likelihood of Stage 2 treatment rendering Charles permanently infertile difficult. Ultimately, however, Expert 1 concluded that there was sufficient evidence to conclude that that risk was remote. That evidence included the "increasing body of evidence" of trans males falling pregnant after ceasing Stage 2 treatment, together with the evidence about the resumption of fertility in patients with CAH once that condition was treated.
4. As pointed out by NSW Health, the AusPATH Guidelines and their international equivalents, recommend that transgender people be encouraged to undergo fertility counselling and to consider fertility preservation options before commencing gender affirming treatment. However, that recommendation could not be said to establish that it is reasonably likely that Stage 2 treatment will render trans males in Charles' position permanently infertile. At best, consistent with the available evidence, the guidelines acknowledge that Stage 2 treatment brings with it a risk of permanent infertility, a proposition not disputed by either Expert 1 or Expert 2.
5. There is uncertainty surrounding the effect of Stage 2 treatment on transgender males. Both parties agree that this an emerging area of medicine. Nonetheless, while possible, we are not satisfied that the proposed treatment is reasonably likely to have the effect of rendering Charles permanently infertile.
6. It follows that the proposed treatment is not special medical treatment within the meaning of s 175(5) of the Care Act.

ADDENDUM 4 October 2024

On 4 October 2024 the parties were given a copy of the statement of reasons for this decision, which included the names of the individuals referred to in that statement, including the young person the subject of the application to NCAT made by the Hunter New England Local Health District under s 175 of the Children and Young Persons (Care and Protection) Act 1998 (NSW). In the version of the statement of reasons published on CASELAW the Tribunal decided to anonymise the names of the individuals mentioned in that statement.

Annexure A

Pseudonym Description

Dr 1 Psychologist with care of Charles for past 10 years

Dr 2 Psychologist who diagnosed Charles with gender dysphoria

Dr 3 Paediatric endocrinologist with the Facility and the original applicant in the proceedings

Dr 4 Senior paediatric endocrinologist with the Facility

Expert 1 Australian obstetrician and gynaecologist, who gave evidence in these proceedings at the request of NSW Health

Expert 2 Overseas obstetrician and gynaecologist, who gave evidence in these proceedings at the request of NSW Health

Endnotes

1. The expression "Gillick competent" is used to describe a person who is found to sufficient maturity and understanding to give valid consent to proposed medical treatment. See, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, at 88-90.
2. Lodged with NCAT on 4 July 2024, the application was initially made by Charles' treating endocrinologist, Dr 3. After the commencement of the proceedings, at the request of the Hunter New England Local Health District and Dr 3, NCAT ordered that the Hunter New England Local Health District be made the applicant in place of Dr 3. The NSW Ministry of Health was joined as a party to the proceedings.
3. See end note 2 above.
4. The Tanner stages refer to the five stages of pubertal development, ranging from Tanner stage 1 (pre-pubertal) to Tanner stage 5 (full adult sexual maturity). Each Tanner stage is identified by physical changes to the body, including breast development in female puberty, the growth of the penis and testicular volume in male puberty, and pubic hair development in both genders. See, World Professional Association for Transgender Health, *Standards of Care for the Health of Transgender and Gender Diverse People*, Eighth Edition (Report, 2022), S64 [6.12.f] citing W A Marshall & J M Tanner (1969), "Variations in pattern of pubertal changes in girls", *Archives of Disease in Childhood*, 44(235), 291-303.
5. *Children (Care and Protection) Further Amendment Act 1988 (NSW)*; NSW, Parliamentary Debates, Legislative Council, 13 October 1988, 2202 (Virginia Chadwick, Minister for Family and Community Services).
6. A Leung, D Sakkas, S Pang, K Thornton, and N Resetkova, "Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine" (2019) 112(5) *Fertility and Sterility*, 858-865.

7. World Professional Association for Transgender Health (WPATH), "Standards of Care for the Health of Transgender and Gender Diverse People", Eighth Edition.
8. Royal Children's Hospital Melbourne "Australian Standards of Care and Treatment Guidelines: For Trans and Gender Diverse Children and Adolescents", Version 1.4 (endorsed by the Australian Professional Association for Trans Health).

I hereby certify that this is a true and accurate record of the reasons for decision of the Civil and Administrative Tribunal of New South Wales.

Registrar

Amendments

18 December 2024 - Amended pseudonyms - see annexure.

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Decision last updated: 18 December 2024

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