

AUSTRALIA / JUDGMENT

Jess (a pseudonym) [2024] NSWCATGD 16

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NSW Civil and Administrative Tribunal

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NSW Civil and Administrative Tribunal

New South Wales

Medium Neutral Citation: Jess (a pseudonym) [2024] NSWCATGD 16

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: Pursuant to s 175(3) of the Children and Young Persons (Care and Protection) Act 1998 (NSW), the Tribunal gives consent to the carrying out of the treatment proposed by Dr 4 for Jess, that is, Stage 2 (oestrogen) treatment.

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 – whether the Tribunal is limited to considering the effect of proposed treatment on the child's fertility up to age 16 – whether Gender Dysphoria is a life-threatening condition – whether proposed treatment is intended to remediate a life-threatening condition

GUARDIANSHIP – discretion to consent to special medical treatment (gender affirming hormone therapy) under s 175(3) of the Children and Young Person (Care and Protection) Act 1998 (NSW) – whether necessary to carry out gender affirming hormone therapy in order to save the child's life or to prevent serious damage to the child's psychological or physical health – factors relevant to exercise of discretion to grant consent to the gender affirming hormone therapy treatment – consent granted

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Children (Care and Protection) Act 1987 (NSW), s 208 (repealed)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: 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)
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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)
Jess (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 Jess (Respondent)
D McMullen (Respondent)
File Number(s): NCAT 2024/00277443
Publication restriction: The publication of the evidence given in these proceedings to the Tribunal is prohibited. This order is made under s 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 s 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 Jess who will turn 16 in eight months. Jess is a transgender female (assigned male at birth) who has been diagnosed with Gender Dysphoria. Since August 2023, Jess has been taking medication, prescribed by an endocrinologist, designed to delay the physical and psychological changes associated with puberty. Jess wishes to commence "gender affirming hormone therapy", which involves taking cross-sex hormone, oestrogen (the proposed treatment). Jess' parents are both supportive of Jess receiving the proposed treatment.
2. Jess lives with her parents. At age 13, Jess told her mother and school friends "I found I'm a girl today". She is enrolled in high school as a female student, wears the female school uniform and accesses a gender-neutral bathroom.
3. 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 Jess. [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).
4. In considering whether we can and should grant consent to the proposed treatment on Jess, the central questions to be decided are:
 1. whether the proposed treatment is special medical treatment; and
 2. if so, whether it is necessary to carry out the proposed treatment on Jess in order to save her life or to prevent serious damage to her psychological or physical health.
1. For the reasons we explain below, we find that the proposed treatment is special medical treatment and that it is necessary to carry out that treatment in order to prevent serious damage to Jess' psychological health. We have decided to exercise the discretion to consent to that treatment.

Procedural background

1. At a hearing on 10 September 2024, we heard the application made under s 175 of Care Act in respect of Jess, 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 (a transgender female) and Child 3 (a transgender male). Many of the same issues are raised in the respective applications made for each child. Parts of these reasons are identical to those given in respect of Child 1 and Child 3.
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 Jess 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 6 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.

Jess is diagnosed with Gender Dysphoria

1. In 2022, Jess was referred by her General Practitioner to a specialist transgender health care facility operated by NSW Health (the Facility).
2. Following three consultations, in April 2023 Dr 7, a clinical psychologist with the Facility, diagnosed Jess with Gender Dysphoria. After meeting with Jess on two occasions, in a report dated 27 May 2024, psychiatrist, Dr 5, confirmed that Jess met the diagnostic criteria for Gender Dysphoria.
3. In a report dated 27 August 2024 and prepared for these proceedings, Dr 7 recorded being told by Jess that she has had occasional thoughts about her gender since 2019. In August 2022, at age 13, Jess told her school friends and mother "I found I'm a girl today". Jess is currently enrolled in High School as a female student, wears the female school uniform and accesses a gender-neutral bathroom.

Jess commences puberty suppression medication (Stage 1 treatment)

1. Dr 4 is a senior paediatric endocrinologist with the Facility. Dr 4 first met with then 14-year-old Jess in July 2023. Dr 4 assessed Jess as being "well into puberty" with testosterone levels at 20.7 nmol/L (normal adult range being 10 to 25 nmol/L).
2. Dr 4 explained that if a patient were "well-masculinised, with a deep voice" they would not generally be commenced on puberty suppression medication. However, because Jess' voice pitch and intonation were still in "the female range", Dr 4 considered it was appropriate to commence Jess on puberty suppression medication. According to Dr 4, being able to "pass" as feminine in the wider community is much easier if a person's voice is in the female range and that this "significantly reduces dysphoria and anxiety".
3. On 1 August 2023, Jess commenced puberty suppression medication (Zoladex®), administered by subcutaneous injection every 12 weeks. Dr 4 reported that, after commencing this medication, despite reporting being happy that it had the desired effect of stopping further masculinisation of her body, Jess experienced a significant decrease in her mood. Dr 4 explained that the medication had been very effective in quickly reducing Jess' testosterone levels from the adult level to the female level but that rapid changes in hormones can be associated with mood changes.

4. Dr 4 reported that she had discussed with Jess the option of stopping puberty suppression medication to improve her mood, but Jess was adamant that she wanted to continue. Dr 4 reported that Jess told her that she feared the resultant masculinisation if she were to stop receiving puberty suppression medication, including the deepening of her voice and the development of an Adam's apple and facial hair.
5. In these reasons we refer to the administration of puberty suppression medication as "Stage 1 treatment", and, the administration of hormones, in Jess' case oestrogen, 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, [2] Dr 4 described the proposed Stage 2 treatment as "oral or transdermal oestrogen as part of gender affirming feminising therapy". In oral evidence, Dr 4 explained that if the Tribunal consents to Jess receiving that treatment, she intends to commence Jess on a low dose of oestrogen, administered by way of transdermal patch or oral tablet. For a period after Jess commences Stage 2 treatment, Dr 4 proposes to continue Jess on Stage 1 treatment and to discontinue that treatment once the oestrogen dose being administered is sufficiently high to suppress Jess' endogenous testosterone.
2. Dr 4 explained that she intends to slowly increase the dose of oestrogen given to Jess and to carefully monitor her clinical response. She also explained that the nature of Stage 2 treatment is lifelong and indefinite.
3. Dr 4 said that Stage 2 treatment is not intended to cause permanent infertility but "to bring about the feminisation of [Jess'] body to treat her dysphoria".
4. Dr 4 reported that Jess has consistently said to her that she wishes to commence Stage 2 treatment as soon as possible.

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 Jess, her safety, welfare and well-being are paramount.

Predecessor to s 175 of the Care Act

1. The predecessor to s 175 to 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). [3]
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".

Is the proposed treatment special medical treatment?

1. Whether the proposed treatment is special medical treatment within the meaning of paragraph (a) of the definition of special medical treatment in s 175(5) of the Care Act turns on:
 1. whether the proposed treatment is reasonably likely to have the effect of rendering Jess permanently infertile; and
 2. if so, whether the proposed treatment is intended to remediate a life-threatening condition, and from which the likelihood of permanent infertility, is an unwanted consequence.

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 Jess' 16th birthday?

1. The Separate Representative contends that in deciding whether the proposed treatment is reasonably likely to have the effect of rendering Jess permanently infertile, the Tribunal is limited to considering the effect of that treatment in the period preceding Jess' 16th birthday, that is in about eight 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 Jess 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 Jess' 16th birthday. If Jess commences Stage 2 treatment before she turns 16, as explained by Dr 4, she is not committed to the continuation of that treatment. That treatment can be paused or ceased at any time in accordance with Jess' wishes and the advice of her treating team.
3. NSW Health contends that the 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 their 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 paragraphs (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 Jess 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 Jess permanently infertile. NSW Health acknowledges that the available evidence would not support a finding that it is probable that the proposed treatment will render Jess permanently infertile. However, NSW Health contends that the available evidence supports a finding that there is a real and not remote or speculative chance that the proposed treatment will render Jess infertile.
2. On the other hand, the Separate Representative contends that the available evidence supports a finding that, while it is possible that the proposed treatment might render Jess infertile, it does not support a finding that there is a real and not remote chance that it will render Jess infertile. The Separate Representative says that the significant uncertainty surrounding the effects of Stage 2 treatment on the fertility of trans females cannot be taken to establish that there is a real and not remote chance that the proposed treatment will render Jess infertile. As agreed by the two experts who gave evidence in these proceedings about the effects of the proposed treatment on Jess' fertility, there is no evidence that establishes that the effects of oestrogen on fertility are permanent. Both experts say that there is some evidence which suggests the effects are reversible.

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 Jess, Child 1 and Child 3. 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 Zoladex (Stage 1 treatment) has the effect of suppressing testosterone which, in turn, "prevented full spermatogenesis [sperm production]". Each was of the opinion that the effects of Stage 1 treatment were "fully reversible" and would have no effect on Jess' fertility. However, they differed in their opinion about the effect of Stage 2 treatment on Jess' fertility.

Expert 1 meets with Jess to discuss fertility

1. In May 2024, at the request of Dr 4, Expert 1 met with Jess and her father to "discuss fertility prior to gender affirming treatment". In a letter addressed to Dr 4 dated 16 May 2024, Expert 1 recorded that, during that meeting, Jess was "very clear that she does not wish to pursue a biological family, is aware that these feelings can change over time, and it is difficult to make these predictions at 15 years of age". Expert 1 recorded that Jess and her father understood that there is a "high risk of infertility with oestrogen therapy and increased chance this is irreversible once commenced". Expert 1 recorded that "Jess was very clear in her thoughts ... she does not wish to pursue fertility preservation, is very clear of the future implications and is well supported by her family".

Expert 1's initial report

1. In a report dated 27 August 2024, Expert 1 noted that Jess commenced Stage 1 treatment after the onset of puberty, probably at "Tanner stage 3". 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). [4] In Expert 1's opinion, Jess is likely to have developed sperm production (spermatogenesis) prior to the commencement of that treatment.
2. Expert 1 said that "there is good evidence from available studies to indicate that oestrogen impairs spermatogenesis and causes testicular atrophy whilst it is being taken". In oral evidence, Expert 1 expanded on the effects of oestrogen on trans females:

"It shrinks testicular volume, and it has a direct inhibitory effect on spermatogenesis, that is, the production and maturation of sperm cells. It also decreases ejaculatory function."

1. Expert 1 considered that the proposed treatment presents a "high risk of infertility whilst it is being taken". According to Expert 1, "the risks of infertility are not time or dose dependent ... Having said that, a short exposure to oestrogen (e.g. a couple of months) would not be likely to impact fertility".
2. In 2023, Expert 2 co-authored a report about a study of nine transgender females, each of whom commenced Stage 2 treatment after full pubertal maturation and later ceased treatment (the Expert 2 report). [5] The participants had used oestrogen treatment for varying periods, with the longest period being five to six years. The study found that: spermatogenesis was fully restored in each of the nine participants; four participants had at least one normal semen analysis; five participants had a lower quality of sperm; and, the length of the treatment had no bearing on fertility outcomes.

3. Commenting on the study the subject of the Expert 2 report, Expert 1 said that it is too limited to be generalised to all patients who commence Stage 2 treatment with oestrogen after onset of full pubertal maturation. Expert 1 noted that while Jess was found to have adult testosterone levels when she commenced Stage 1 treatment, unlike the patients in the studies, she had not reached full pubertal maturation. In Expert 1's view, the evidence of that study cannot be generalised to Jess' circumstances.
4. In her report, Expert 1 noted that she has treated a trans female patient who commenced Stage 2 treatment after full pubertal maturation. That patient returned to normal male fertility about five months after ceasing treatment.

Expert 2's initial report

1. In a report dated 29 August 2024, Expert 2 said that "there is probably not a real chance" of Jess becoming "permanently infertile if [she] undergoes Stage 2 treatment". Expert 2 acknowledged that the evidence on "fertility outcomes of trans-feminine individuals is sparse". She said that in preparing the Expert 2 report, the authors completed a systematic literature review and found no studies in relation to the fertility outcome of "trans-feminine minors with years of puberty suppression". Expert 2 said that oestrogen treatment "will in the majority of transfeminine patients lead to reduced sperm quality, however data [is] from adult patients and were always combined with a testosterone blocker".
2. Expert 2 said that currently there was no evidence to prove that the effects of oestrogen on fertility are "irreversible or permanent". Referring to the Expert 2 report, Expert 2 said that there is some data to suggest that the effects of oestrogen in trans-female patients may be reversible.
3. Commenting on Child 1, Expert 2 hypothesised that if she were to commence and later cease Stage 1 treatment, she "could have a return of testosterone and fertility with [a] reasonable amount of uncertainty". Expert 2 considered the fertility implications for Jess would be similar.
4. Expert 2 emphasised that there is always a chance that a person will be infertile and there is no guarantee that a person will be able to parent a biological child.

Joint expert report

1. At the request of the Tribunal, NSW Health requested Experts 1 and 2 to prepare a joint report. Expert 1 and Expert 2 were asked to answer a series of questions jointly formulated by NSW Health and the Separate Representative about Jess, Child 1 and Child 3.

2. In the joint report dated 9 September 2024, in answer to the question, "Is there a real and not remote chance that Stage 2 (oestrogen) treatment would have the effect of rendering [Jess] permanently infertile?", Expert 1 wrote that she is "unable to confidently state that stage 2 treatment in the form of oestrogen will not result in a real and not remote chance of permanent infertility". However, Expert 1 emphasised that "there is no evidence strongly suggesting that [Stage 2 treatment] does cause infertility".
3. Expert 2 did not directly address this question, and wrote: "I fully agree, the difference between real and remote is hard to establish due to the lack of evidence on the effect of [o]estrogens only". She went on to comment that "cisgender boys treated with [Gonadotropin Releasing Hormone Agonists] for precocious puberty ... showed normal sperm analysis 0.7-3 years after the determination of GnRHa therapy".
4. In her initial report Expert 2 wrote "[t]he data on fertility outcomes of transfeminine individuals is sparse" and "[w]hile there is no data relevant to [Jess], based on what is presently known, I would expect that if the minor were to commence on oestrogen, the effects would not be different from the current situation with Zoladex only and, if hormone therapy was ceased, the minor could have a return of testosterone and fertility with a reasonable amount of uncertainty. This opinion is based on the case study [in the Expert 2 report] and some examples from clinical practice" (emphasis added).
5. In answering what she meant by the phrase "a reasonable amount of uncertainty" in the above passage, Expert 2 wrote:

"There is no [proof] of fertility other than birth of a healthy infant, there is always a reasonable amount of uncertainty in fertility. There is only evidence of the reversibility of subfertility in transgender adults. And we don't know what the outcome in (sub)fertility would have been without this treatment (background risk of infertility due to other non transgender related causes)."

1. In response to the request that she expand on her opinion that she would expect that the minor could have a return of testosterone and fertility, in the absence of data on fertility relevant to Jess or Child 1, Expert 2 wrote:

"From cisgender boys treated with GnRHa for precocious puberty we know that they showed normal sperm analysis 0.7-3 years after the determination of GnRHa [gonadotopintherapy] [6] ... Together with the case report in adults, all we know is reassuring. So I think it very well possible that fertility returns after cessation of GAHT [Gender affirming hormone therapy]."

Expert 1's oral evidence

1. In Expert 1's opinion, the World Professional Association for Transgender Health (WPATH) "Standard of Care for the Health of Transgender and Gender Diverse People", Eighth Edition (the WPATH Guidelines) and the Royal Children's Hospital Melbourne "Australian Standards of Care and Treatment Guidelines: For Trans and Gender Diverse Children and Adolescents",

Version 1.4 (the AusPATH Guidelines) represent best practice for transgender health in Australia. According to Expert 1, fertility preservation should form part of gender care. Expert 1 agreed with this statement contained in the AusPATH Guidelines at p 14: "the degree to which testosterone may reduce one's reproductive potential when taken in adolescence and early adulthood is unknown".

2. In oral evidence, Expert 1 agreed with the proposition that there is evidence that oestrogen impairs sperm production and that it is unknown whether those effects are permanent. Expert 1 said that she could not say there is not a real possibility of permanent infertility flowing from stage 2 treatment for Jess. However, she clarified that this was an opinion and there is no evidence to guide her. Expert 1 speculated that Jess may be less at risk of permanent infertility than Child 1 who commenced treatment at an earlier stage of pubertal development.

Consideration

1. It is uncontroversial that Stage 2 treatment affects sperm production and causes testicular atrophy throughout the period it is being received. We find that Jess is likely to be at high risk of infertility while she is undergoing Stage 2 treatment.
2. The more difficult question is whether Stage 2 treatment is reasonably likely to render Jess permanently infertile if she were to stop that treatment. Each expert considered that the question was attended by considerable doubt, largely because of the dearth of evidence about the effect of oestrogen treatment on transgender females in general, and, in particular, transgender girls who, like Jess, had not gone through full natal puberty (that is, the process of puberty as their sex assigned at birth).
3. Of the experts, Expert 2 had a greater degree of confidence that Stage 2 treatment was unlikely to render Jess permanently infertile. Nonetheless, the opinion she expressed in the joint report was more equivocal than that expressed in her initial report, namely that "there is probably not a real chance that [Jess] will become permanently infertile if [she] undergo[es] Stage 2 treatment
4. Of the two experts, we consider the opinion expressed by Expert 1 to be more persuasive. Expert 1 said that she was unable to characterise the risk of Jess becoming permanently infertile as remote. She gave a reasoned explanation for that opinion. We are mindful that we have had the advantage of hearing in oral evidence Expert 1's expanded explanation for that opinion. In contrast, we did not have the advantage of hearing from Expert 2 and in particular on her explanation for the apparent discrepancy between the opinion she expressed in her initial report and the joint report.

5. Although the evidence as to the likelihood of the treatment causing permanent infertility is sparse, it cannot be said either to be so remote as to be an inconsequential consideration or improbable. We are of the view that there is a real but immeasurable chance that permanent infertility may be the effect of the treatment. In that sense, we find that the Stage 2 treatment sought for Jess meets the statutory test of being reasonably likely to have the effect of rendering Jess permanently infertile.

Is the proposed treatment intended to remediate a life-threatening condition?

1. Medical treatment that is "intended to remediate a life-threatening condition and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence" falls outside the definition of "special medical treatment". Sub-paragraphs (i) and (ii) in par (a) of s 175(5) of the Care Act operate to carve out from the definition of special medical treatment, medical treatment that is "intended to remediate a life-threatening condition, and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence". For convenience in these reasons, we will refer to sub-paragraphs (i) and (ii) of par (a) of s 175(5) of the Care Act as the 'carve out from the definition of special medical treatment'.
2. The Separate Representative contends that the proposed treatment is intended to remediate a life-threatening condition, namely Gender Dysphoria and therefore falls outside the definition of special medical treatment. The Separate Representative submits that the evidence of Jess' treating practitioners establishes that Jess is actively suicidal and deeply distressed at the prospect that she may not receive Stage 2 treatment or that the treatment may be delayed. The Separate Representative concedes that the evidence indicates that Jess' depression and suicidality are related to Stage 1 treatment. However, she argues that Jess' depression and suicidality are nonetheless fundamentally part of her experience of gender dysphoria. Citing the opinion expressed by Dr 5 and Dr 7, the Separate Representative contends that Jess' gender dysphoria has manifested itself as a life-threatening condition.
3. NSW Health disagrees and contends that Gender Dysphoria is not a life-threatening condition either at large or in Jess' case. NSW Health says that while not seeking to diminish or minimise the distressing impact of Gender Dysphoria on Jess, the evidence does not support a finding that that condition is life-threatening. The expert evidence reveals that the cause of Jess' distress and suicidality is multi-factorial.

Medical evidence

1. Before considering the submissions made by the parties it is necessary to examine the evidence about Jess' current mental health.
2. Dr 7, Jess' treating clinical psychologist, reported a deterioration in her mental health since January this year. In her opinion, this resulted from the side effects of her puberty suppression medication and increased dysphoria. Dr 7 takes a cautious view of Jess' mental health prognosis.

3. Dr 7 outlined the complex interaction between Jess' Gender Dysphoria and the life-threatening mental conditions she has developed since beginning Stage 1 treatment:

"From a psychological perspective, it is proposed that the treatment will be given in the hope that it will ameliorate [Jess'] mental health symptoms. While I defer to the endocrinologists regarding the specific action of the hormone therapy proposed (oestrogen), it is my expectation that the psychological therapeutic benefit of oestrogen therapy may take some time. This is because it is not expected that oestrogen in and of itself will improve [Jess'] mental health, but rather the progression towards a feminised state as a result of oestrogen therapy, over time, is expected to reduce [Jess'] symptoms of gender dysphoria, and thereby improve her mental health state. It is hoped that this will give [Jess] the mental space to manage her depression and get back to school and on with her life.

[Jess] has clearly articulated to me that if she is unable to access feminising gender affirming medical treatment until the age of 16, she will take action to end her life due to distress, ongoing gender dysphoria and depression. For example, on 31 January 2024 [Jess] expressed that she 'cannot wait' until she is 16 years old to access oestrogen treatment. In February 2024, [Jess] completed written documentation stating delayed access to oestrogen will cause 'a deeper downward spiral the longer I don't have it'. On the 6 August 2024, [Jess] stated, 'I will kill myself if I can't access oestrogen'.

It is my impression that Jess is at high risk of suicide. Although this is currently mitigated by assertive support, it will, however, be difficult to mitigate her risk of suicide if the hope of imminent access to treatment is removed.

Overall, I hold significant concerns for [Jess'] mental health and suicide risk should her access to gender affirming hormone treatment be further delayed."

1. In oral evidence, Dr 7 said that Jess' mental health has stabilised but she continues to experience symptoms of depression and suicidal ideation. Currently Jess is "very socially isolated"; has dropped out of school; is struggling to leave the house; and is unable to engage in normal activities. According to Dr 7, Jess is "not functioning very well at all".
2. On 27 August 2024, Dr 7 conducted a structured risk assessment and found Jess to be at high risk of suicide. Dr 7 has developed a plan to mitigate that risk. In her opinion, if the proposed treatment is delayed until Jess reaches 16, she will remain at high risk of suicide. She is not confident that the mitigation plan developed for Jess will be sufficient to ameliorate that risk if the treatment is delayed.
3. Dr 5 shares Dr 7's opinion. According to Dr 5, "whatever scaffolding is put in place", if Jess were to progress through male puberty, the psychological effects are likely to be catastrophic. Dr 5 described a delay of eight months in commencing the proposed treatment until Jess reaches 16 years of age as "psychologically and functionally significant". In oral evidence, Dr 5 said that in Jess' case the proposed treatment is a "lifesaving intervention".

4. Dr 4 explained that rapid changes in hormone levels which, in Jess' case have resulted from the administration of Zoladex, can result in mood changes. Jess fears that her voice will deepen and other masculine developments that come with puberty will develop if she ceases Stage 1 treatment. In August this year, Jess told Dr 4 that unless she could begin Stage 2 treatment, she "would not be here" – a statement that Dr 4 interpreted as suicidal ideation and possible planning.
5. Jess' GP has also reported that Jess has engaged in self-harming behaviours, such as cutting and scratching herself, and suicidal ideation. The GP's opinion is that "the early initiation of gender-affirming hormone therapy is important to both preserve life and prevent further physical and mental injury" to Jess.

Relationship between Gender Dysphoria and Jess' psychological health

1. Dr 5 agreed with the proposition that Gender Dysphoria is not a life-threatening condition. However, in Jess' case: "the Gender Dysphoria is the foundation; the depression is the house". Dr 5 also agreed that the cause of Jess' depression was "multi-factorial" and not solely related to Gender Dysphoria.
2. Dr 5 considered the WPATH Guidelines [7] to be authoritative and agreed with the following statements contained in those Guidelines (at S126):
 1. Several mental health disparities have been documented in the transgender population including depression, suicidality, anxiety, decreased self-esteem, and post-traumatic stress disorder.
 2. Hormone therapy has been found to positively affect the mental health and quality of life of transgender and gender diverse youth and adults who embark on this treatment.
 3. In many cases, hormone therapy is a life-saving intervention.

Consideration

1. As we explain below, we are satisfied that it is necessary to carry out the proposed treatment to prevent serious damage to Jess' psychological health. However, that does not dispose of the question posed by the definition of special medical treatment, whether the proposed treatment "is intended to remediate a life-threatening condition".
2. Section 175(3) requires the Tribunal to consider whether "it is necessary to carry out the [subject special medical 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". On the other hand, the carve out to the definition of special medical treatment requires the Tribunal to consider whether the subject medical treatment is intended to "remediate a life-threatening condition". That task requires consideration of the intention of the person or persons who recommended the proposed treatment. Read in the context of s 175 as a whole, that person (or persons), in our view, can only be the medical practitioner who proposes to carry out, or seeks the consent of

NCAT to carry out, the subject medical treatment. In Jess' case, Dr 4 proposes, subject to the consent to the Tribunal, to prescribe oestrogen to Jess as part of the Stage 2 treatment.

3. In her report dated 28 August 2024, Dr 4 said that the proposed Stage 2 treatment for Jess:

"[I]s not intended to cause permanent infertility. It is intended to bring about the feminisation of her body to treat her dysphoria" (emphasis added).

1. Dr 4 does not claim that when she first recommended Jess commence Stage 2 treatment, or at any subsequent time, that that treatment was intended to "remediate a life-threatening condition". While acutely aware of the deterioration in Jess' mental health since commencing Stage 1 treatment and more recently the reports of suicidal ideation, Dr 4 has not expressed the opinion that Jess' Gender Dysphoria is a life-threatening condition. Indeed, in her report dated 28 August 2024, Dr 4 expressly deferred to Jess' mental health team on the question of whether Stage 2 treatment "is necessary to save [Jess'] life or prevent serious damage to her psychological health". [8] According to Dr 4, the proposed treatment was and is intended to "bring about the feminisation of [Jess'] body to treat her dysphoria", or as she put in in her report dated 28 August 2024, to enable Jess to "'pass' as feminine in the wider community".
2. We are not satisfied that, in Jess' case, the proposed treatment is intended to remediate a life-threatening condition, and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence.

Conclusion

1. The proposed treatment constitutes special medical treatment within the meaning the definition of special medical treatment in par (a) of s 175(5) of the Care Act.

Is it necessary to carry out the proposed treatment in order to save Jess' life or to prevent serious damage to her psychological health?

1. The evidence demonstrates that Jess is exceptionally vulnerable to self-harm, that a variety of factors are contributing to her current state of mind, and that she needs treatment to remediate her life-threatening condition, namely acute suicidal ideation. Her Gender Dysphoria underpins all other aspects of her vulnerability to the mental condition that threatens her life. The weight of evidence persuades us that it cannot be successfully treated except by simultaneously addressing her Gender Dysphoria.
2. In reaching that conclusion we note, as explained by Dr 7, that commencement of Stage 2 treatment would not, of itself, alleviate Jess' depression and the comorbidities which are contributing to suicidal ideation. Oestrogen is not an antidepressant. Jess will continue to require anti-depressants to treat her depression. However, according to Dr 7, Stage 2 treatment will help to alleviate the Gender Dysphoria which is one of the primary drivers behind Jess' current episode of depression. Dr 7 explained that the treatment is likely to result in Jess feeling that her body is moving to be more aligned with her gender identity.

3. Jess' parents have developed a safety plan which includes removing harmful substances (including medicines) and objects which Jess might use to harm herself from their home, ensuring that she is never left alone, and contacting Lifeline. However, because this plan is intended to mitigate acute risk only, and places the family under great pressure, it cannot be considered a strategy to protect Jess over the next eight months. Something more than a temporary expedient is needed to address the life-threatening situation in which Jess now exists.
4. We accept the opinions of Dr 5 and Dr 7 that it is necessary to carry out the proposed treatment in order to save Jess' life and/or to prevent serious damage to her psychological health.

Should the discretion to give consent to the proposed treatment be exercised?

1. Having found that it is necessary to carry out the proposed treatment in order to save Jess' life and/or to prevent serious damage to her psychological health, the discretion to grant consent to that treatment can be exercised. In considering whether to exercise the discretion to give consent to the proposed treatment, Jess' safety, welfare and well-being are paramount.
2. The proposed treatment is not without risk. As explained by Dr 4, in addition to the risk of infertility, the proposed treatment could lead to a rise in blood pressure and clotting. Added to that risk is the unknown, whether in the future Jess will change her mind about her gender identity and, if so, the likely impact on her mental health. A further risk is that by undergoing the proposed treatment Jess may be subject to social and other forms of discrimination.
3. Nonetheless, we conclude that the balance of considerations favour exercising the discretion to grant consent to the proposed treatment:
 1. Over the past couple of years Jess has consistently expressed the view that she identifies as female and feels misaligned in a male body. Jess' treating practitioners have discussed and tested those views with her and concluded that those views are genuinely held.
 2. Jess' parents share the opinion of her treating practitioners that her views are genuinely held. Each support Jess' wish to undertake Stage 2 treatment.
 3. There is no evidence, and nor is it suggested, that Jess has been pressured to undergo Stage 2, or indeed, Stage 1 treatment.
 4. As stated by Dr 4, the proposed treatment is the only available treatment to reduce Jess' Gender Dysphoria.

5. At a meeting to discuss fertility in 2024, Jess was informed by Expert 1 that there is high risk that the proposed treatment may render her infertile. In a letter to Dr 4 dated 16 May 2024, Expert 1 said that Jess understands that the proposed treatment may result in her being unable to have biological children. Nonetheless, Jess is unequivocal: she wishes to commence the proposed treatment.
6. Dr 5 has assessed Jess and found her to be "Gillick competent", that is, to have sufficient maturity and understanding to give valid consent to the proposed treatment. [9]
7. Significantly, as we discussed above, the proposed treatment is now necessary in order to save Jess' life and/or to prevent serious damage to her psychological health.
1. Our decision to consent to the proposed treatment is in the interests of Jess' safety, welfare and well-being.

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 7 Clinical psychologist with the Facility who diagnosed Jess with Gender Dysphoria

Dr 5 Facility psychiatrist who confirmed Jess' diagnosis of Gender Dysphoria.

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 application was initially made by Jess' treating endocrinologist, Dr 4. After the commencement of the proceedings, at the request of the Hunter New England Local Health District and Dr 4, NCAT ordered that the Hunter New England Local Health District be made the applicant in place of Dr 4. The NSW Ministry of Health was joined as party to the proceedings.
2. See end note 1 above.
3. 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).
4. 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. I De Nie, NM van Mello, E Vlahakis, C Cooper, A Peri, M den Heijer, A Meißner, J Huirne, KC Pang, "Successful restoration of spermatogenesis following gender-affirming hormone therapy in transgender women" (2023) 4(1) Cell Reports Medicine.
6. S Bertelloni, G I Baroncelli, M Ferdeghini, F Menchini-Fabris, G Saggese, "Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin-releasing hormone analogues" (2000) 159(5) European Journal of Pediatrics, 369-374.
7. World Professional Association for Transgender Health, Standards of Care for the Health of Transgender and Gender Diverse People, Eighth Edition (Report, 2022), S126 [12.21].
8. In contrast, in a pro forma "Health Professional Report form for Special Medical Treatment" filed 29 July 2024, in answer to the question "Is the proposed treatment necessary to save the person's life?", Dr 4 ticked the box "yes".
9. See, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, at 189.

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

10 December 2024 - Anonymisation at endnote [1]

18 December 2024 - Amended pseudonyms - see annexure

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Decision last updated: 18 December 2024

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