FEDERAL CIRCUIT AND FAMILY COURT OF AUSTRALIA (DIVISION 1)

Re: Devin [2025] FedCFamC1F 211

File number:	By Court order file number is supressed
Judgment of:	**STRUM J**
Date of judgment:	3 April 2025
Catchwords:	**FAMILY LAW** – CHILDREN – Gender incongruence/dysphoria — Where the diagnosis of gender incongruence/dysphoria by the child's treating psychologist is challenged by the respondent father and Independent Children's Lawyer – Whether, if gender incongruent/dysphoric, Stage 1 puberty blockers should be administered to the child – Where there are previous final orders for the child to live with the mother – Where the father seeks orders that the child live with him and that he have sole parental responsibility for the child – Where mother seeks that she have sole parental responsibility for the child's long-term health, including in relation to gender identity and the treatment thereof – Where father and Independent Children's Lawyer oppose the administration of puberty blockers to the child – Where it is alleged there is an unacceptable risk of harm to the child – Where the Court does not accept the child's diagnosis of gender incongruence/dysphoria – Where the Court finds the child to be gender fluid or expansive – Where, even if the child were gender incongruent/dysphoric, the Court would not authorise the administration of puberty blockers as proposed by the mother – Finding that it is in the best interests of the child for the child to live with the father and spend time with the mother and for the father to have sole parental responsibility for the child.
Legislation:	*Evidence Act 1995* (Cth) s 140 *Family Law Act 1975* (Cth) Pt VII, ss 4, 4AB, 60B, 60CA, 60CC, 60CG, 61B, 61C, 61DA, 61DAA 64B, 65D, 65DA, 65DAA, 65DAAA, 65H, 67ZC and 69ZT *Family Law Amendment Act 2023* (Cth) *Sex Discrimination Act 1984* (Cth) *Federal Circuit and Family Court of Australia (Family Law) Rules 2021* (Cth) Div 7.1.3 and r 7.18 *Change or Suppression (Conversion) Practices Prohibition*

	Act 2021 (Vic) s 10 and s 11 *Equal Opportunity Act 2010* (Vic)
Cases cited:	*Briginshaw v Briginshaw* (1938) 60 CLR 336; [1993] HCA 34 *Doherty & Doherty* [2016] FamCAFC 182 *Fox v Percy* (2003) 214 CLR 118; [2003] HCA 22 *Gillick v West Norfolk & Wisbech Area Health Authority* [1968] AC 112 *Goode v Goode* (2006) 206 FLR 212; [2006] FamCA 1346 *Government Insurance Office (NSW) v Bailey* (1992) 27 NSWLR 304 *Housing Commission of New South Wales v Tatmar Pastoral Co Pty Ltd and Penrith Pastoral Co Pty Ltd* [1983] 3 NSWLR 378 *Isles & Nelissen* (2022) 367 FLR 338; [2022] FedCFamC1A 97 *Jones v Dunkel* (1959) 101 CLR 298; [1959] HCA 8 *M v M* (1988) 166 CLR 69; [1988] HCA 68 *Mallory & Mallory* [2019] FamCAFC 221 *Mazorski v Albright* (2007) 37 Fam LR 518; [2007] FamCA 520 *Pickford & Pickford* [2024] FedCFamC1A 249 *Pruchnik & Pruchnik (No 2)* (2018) 58 Fam LR 458; [2018] FamCAFC 128 *Re Ash (No 4)* [2024] FedCFamC1F 777 *Re CD* [2024] VSC 456 *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761 *Re Jamie* (2013) FLC 93-547; [2013] FamCAFC 110 *Re Kelvin* (2017) FLC 93-809; [2017] FamCAFC 258 *Rice v Asplund* (1979) FLC 90-725; [1978] FamCA 84 *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218; [1992] HCA 15 *Whisprun Pty Ltd v Dixon* (2003) 200 ALR 447; [2003] HCA 48 Montessori, Maria, *The Discovery of the Child* (Montessori-Pierson Publishing Company, 1948)
Division:	Division 1 First Instance
Number of paragraphs:	382

Date of last submission/s:	20 December 2024
Date of hearing:	12-16 and 19-21 February 2024, 27-31 May 2024, 3-7 June 2024, 12 September 2024 and 20 December 2024
Counsel for the Applicant:	Mr McDermott and Ms Isaacson
Solicitor for the Applicant:	Lander & Rogers
Counsel for the Respondent:	Ms Bonney and Ms Paterson
Solicitor for the Respondent:	Schetzer Papaleo Family Lawyers
Counsel for the Independent Children's Lawyer:	Ms Mallet KC and Ms Aoukar
Solicitor for the Independent Children's Lawyer:	Creative Family Law Solutions

ORDERS

SUPPRESSED

FEDERAL CIRCUIT AND FAMILY COURT OF AUSTRALIA (DIVISION 1)

BETWEEN:	**THE MOTHER** Applicant
AND:	**THE FATHER** Respondent
	INDEPENDENT CHILDREN'S LAWYER

ORDER MADE BY: **STRUM J**

DATE OF ORDER: **3 APRIL 2025**

THE COURT ORDERS THAT:

1. The father have sole parental responsibility for making decisions about all major long-term issues in relation to the child, **Devin**, born 2013, save that prior to making any such decisions, he:

   (a) provide the mother with not less than 28 days' notice of the decision required to be made and his proposal in relation thereto;

   (b) provide the mother with sufficient information to enable her to consider his proposal; and

   (c) give due consideration to the views in relation thereto expressed by the mother –

   and, in the event of a disagreement between the parents, the father make the final decision and notify the mother of same, in writing, within 48 hours thereof.

2. The child live with the father.

3. From the commencement of Term 2 in 2025, the child spend time with the mother as hereinafter provided.

4. In the gazetted Term 1 school holidays, commencing in 2026, the child spend time with each of the parents for one half thereof, at such times as may be agreed between the parents in writing and, failing agreement, commencing at the conclusion of school (or like time) on the last day of Term 1 and concluding at the commencement of

school (or like time) of the first day of Term 2, with changeover between the parents to occur on the intermediate Saturday of such holidays, as follows:

(a) in 2026, and each even-numbered year thereafter, the child spend time with the mother in the week containing the Easter weekend; and

(b) in 2027, and each odd-numbered year thereafter, the child spend time with the father in the week containing the Easter weekend.

5. Unless otherwise agreed in writing between the parents, they, their servants and agents, be restrained from:

(a) consenting to or otherwise facilitating the child attending upon a psychologist or paediatrician at the Children's Hospital Gender Service;

(b) consenting to, or otherwise facilitating, the child commencing the administration of "stage one" puberty blocking medication;

(c) consenting to, or otherwise facilitating, the child commencing the administration of "stage two" cross-sex hormones;

(d) taking any steps to change the child's name, recorded sex and gender with the Registrar of Births, Deaths and Marriages; and

(e) discussing any court proceedings, or the contents of any documents filed in any court, that relate to the parents or the child, with or in the presence or hearing of the child.

6. As soon as practicable hereafter, the father do all necessary things to obtain a referral for the child for an assessment, and any treatment, if required, by a paediatrician and/or child and adolescent psychologist or psychiatrist, and provide the mother with the name and contact details of those treaters ("the treating health professionals").

7. The mother be at liberty, and this order stands as authority for the mother, to communicate and liaise with any of the treating health professionals.

8. The parents forthwith do all acts and things and sign all documents necessary to enrol the child and to facilitate the child attending at:

(a) B School until the conclusion of primary school; and

(b) C School, for the child's secondary education –

unless otherwise agreed between them in writing from time-to-time hereafter.

9. In the event the mother refuses or fails to comply with order 8, the father be authorised to enrol the child in the aforementioned schools without the need to obtain the mother's consent, and he be permitted to provide a copy of this order to the said schools.

10. The Independent Children's Lawyer meet with the child and a Court Child Expert at Court this day to advise the child of, and to explain to the child, these orders.

11. Upon compliance with Order 10, the appointment of the Independent Children's Lawyer be and is hereby discharged.

THE COURT FURTHER ORDERS BY CONSENT IN ACCORDANCE WITH THE MINUTE OF PROPOSED CONSENT ORDERS SIGNED BY THE PARTIES (AS AMENDED BY THE COURT TO GIVE EFFECT TO THE PRECEDING ORDERS) THAT:

12. All previous parenting orders with respect to the child be and are hereby discharged.

Care arrangements

13. The child spend time and communicate with the mother during the gazetted school term periods as follows:

    (a) Each alternate week from the conclusion of school Friday (or 3:30pm in the event of a non-school day) to the commencement of school Monday (or 9:00am in the event of a non-school day), save that if the Monday is a student free/curriculum free day or public holiday the time be extended until the commencement of school on Tuesday (or 9:00am); and

    (b) at such other and further times as may be agreed between the parents in writing.

School holidays

14. For the gazetted school term 2 and 3 holidays, the child spend time with each of the parents for half of the school term holidays, at such times as agreed between the parents in writing and, failing agreement, as follows:

    (a) In even numbered years:

        (i) with the father from the conclusion of the last day of term until 5.00pm on the middle Sunday of the school holidays; and

(ii) with the mother from 5.00pm on the middle Sunday of the school holidays until 5.00pm the Sunday prior to the commencement of the first day of the next school term;

(b) In odd numbered years:

(i) with the mother from the conclusion of the last day of term until 5.00pm on the middle Sunday of the school holidays; and

(ii) with the father from 5.00pm on the middle Sunday of the school holidays until the commencement of school for the next term;

15. For the gazetted term 4 long summer holidays, the child spend time with each of the parents for half of the holidays at such times as agreed in writing between the parents and failing such agreement, as follows:

(a) In odd numbered years:

(i) With the father from the conclusion of school until 5.00pm on the third Sunday (two weeks);

(ii) With the mother from 5.00pm on the third Sunday until 5.0pm on the fifth Sunday (two weeks); and

(iii) Week-about from 5.00pm on the fifth Sunday until 5.00pm the following Sunday thereafter.

(b) In even numbered years:

(i) With the mother from the conclusion of school until 5.00pm on the third Sunday (two weeks); and

(ii) With the father from 5.00pm on the third Sunday until 5.00pm on the fifth Sunday (two weeks); and

(iii) Week-about from 5.00pm on the fifth Sunday until 5.00pm the following Sunday thereafter.

(c) In the event the child is not already in the care of the father, the child be returned to his care at 5.00pm on the Sunday before the commencement of Term 1 each year.

Special Occasions/other

16. Notwithstanding any other provisions herein, the child spend time with each of the parents as follows for special occasions:

(a) On the child's birthday from 3.30pm to 7.00pm if same falls on a school day and from 10.00am to 3.00pm in the event of a non-school day, with the parent with whom the child is not otherwise living or spending time that day;

(b) In the event the child's birthday falls during Easter, the birthday time provision prevail;

(c) With the father from 5:00pm the day preceding Father's Day to the commencement of school the following day (or 9:00am in the event of a non-school day); and

(d) With the mother from 5:00pm the day preceding Mother's Day to the commencement of school the following day (or 9:00am in the event of a non-school day).

17. Notwithstanding any other provisions herein, the child communicate with the parent with whom the child is not then living or spending time by WhatsApp video or telephone call each Wednesday, between the hours of 5:30pm to 6:00pm, with such parent to initiate the contact and the other parent to ensure the child is available to take the call and provided with reasonable privacy during the call, and the other parent to ensure that his/her What's App settings enable both video and telephone communication.

School and extra-curricular enrolments

18. Save and except for where permitted in these Orders, each of the parents be restrained from changing or attempting to change the child's school without the prior written consent of the other parent.

19. Each of the parents be restrained from enrolling or attempting to enrol the child in extracurricular or sporting events at times when the child is in the care of the other parent, without the other parent's prior written consent.

Changeover

20. For the purposes of these Orders, changeover occur at the child's school on a day when the child is attending school, and in the event that changeovers do not occur on a day when the child is attending school:

(a) The father deliver the child to the mother at Suburb D Shopping Centre at the commencement of her time and the mother deliver the child to the father at the commencement of his time at E Shopping Centre;

(b) In the event that E Shopping Centre is closed at the time of changeover, changeover occur at Suburb D McDonalds; and

(c) In the event that E Shopping Centre is closed at the time of changeover, changeover occur at Suburb F McDonalds.

21. Each parent use their best endeavors to ensure they are on time for changeover and not running late due to factors within their control.

The Child's communication with the Parents and each other

22. The child be permitted to communicate with the parent with whom the child is not then living or spending time through WhatsApp telephone and video calls at all reasonable times as requested and the other parent facilitate the call if necessary, including ensuring that their WhatsApp settings enable both telephone and video calls.

23. The parents give the other at least 72 hours advance notice by Our Family Wizard Communication App in the event that they are unable to spend time with the child pursuant to these Orders from time to time.

24. The parents continue to communicate through the Our Family Wizard Parenting app, unless in an emergency, and respond to messages, where necessary, within a reasonable timeframe and ensure that it only be used to communicate about arrangements or matters regarding the child in a child-focused manner and not as a means of either parent communicating or seeking to communicate with the child.

Information about the Child

25. Each parent be at liberty to:

(a) Obtain school reports, newsletters, notices, photographs and the like directly from the child's school at their expense;

(b) Attend parent teacher interviews and discuss the child's progress with the child's school at separate times from each other.

26. Each of the parents personally and by their servants and agents be and is hereby restrained by injunction from:

(a) doing or saying anything to the child or in the presence or hearing of the child that is derogatory of the other parent; or

(b) denigrating, abusing or belittling each other in the presence or hearing of the child.

Travelling with the Child

27. Each parent be at liberty, during their scheduled time with the child, to travel with the child interstate providing that the parent travelling provides the other parent with contact and transport details including flights and accommodation details at least 14 days prior to any intended travel.

28. Either parent be entitled to remove the child from the Commonwealth of Australia during periods that the child is spending time with them on the following conditions:

(a) Neither parent be permitted to travel with the child to a country where the Australian Government has issued a travel advice higher than "Exercise a High Degree of Caution, or "Do not travel";

(b) At least 60 days prior to any departure overseas, the travelling parent provide the other parent with a complete itinerary including air travel and hotel details and contact details;

(c) At least seven days prior to any departure overseas with the mother, the father deliver the child's passport(s) to her;

(d) No later than seven days following the return to the Commonwealth of Australia, the mother return the child's passport(s) to the father;

(e) Each of the parents sign all documents as may be necessary to apply for and renew the child's Australian passport from time to time and meet one half of the costs of same, with such passport being held by the father;

(f) When overseas, the travelling parent ensure the child is able to use a telephone or an audio-visual online communication tool (such as Zoom or Skype) to communicate with the other parent at all times as requested and the other parent be able to communicate with the child by the same means at all reasonable times.

29. During any period of travel, the travelling parent ensure the child is able to telephone the non-travelling parent at all times as requested by the child.

Other

30. Each of the parents forthwith notify the other of any change in residential address, telephone number or email address within 72 hours of any such change.

31. The time to be spent by the mother with the child during school terms resume upon the commencement of a new school term as if the holidays had not intervened, such that if the child spends time with the mother on the last full weekend of the previous term, the child spend time with her on the second weekend of the following term and vice versa.

32. Each parent be authorised to provide a copy of these orders to Police, the child's school, any extra-curricular coordinators and facilitators, general practitioner, psychologists and/or psychiatrists, and any other health practitioners that the child attends upon from time to time.

33. Pursuant to s 68P and s 68Q of the *Family Law Act 1975* (Cth), to the extent that these Orders are inconsistent with an existing Family Violence Intervention Order, these orders prevail.

AND THE COURT NOTES THAT:

A. Section 114Q(1) of the Family Law Act 1975 (Cth) provides that a person commits an indictable offence if:

(a) the person communicates to the public an account of proceedings under this Act; and

(b) the account identifies:

(i) a party to the proceedings; or

(ii) a witness in the proceedings; or

(iii) a person who is related to, or is associated with, a party to the proceedings; or

(iv) a person who is, or is alleged to be, in any other way concerned in the matter to which the proceedings relate.

Penalty: Imprisonment for 1 year.

B. Section 114Q(3) provides that, for the purposes of paragraph (1)(b), an account of proceedings is taken to identify a person if the account includes material that is

sufficient to identify the person to a member of the public. Examples of such material might include the following:

(a) a picture, recording, or physical description of the person;

(b) a name or title that identifies the person;

(c) an address or location where the person resides or works;

(d) details of the person's employment, paid or voluntary;

(e) the relationship or other connection between the person and an identified person or business;

(f) the person's political, philosophical or religious beliefs;

(g) any real or personal property associated with the person.

C. Section 114S(1) provides that, for the purposes of (*inter alia*) s 114Q(1)(a), a communication to a person or body is not a communication to the public if:

(a) the person or body has a significant and legitimate interest in the subject matter of the communication; and

(b) that interest is substantially greater than, or different from, the interests of members of the public generally.

D. Section 114S(2) provides that, without limiting s 114S(1), none of the following is a communication to the public:

(a) a private communication between a party to proceedings and one or more persons who are members of the party's family or friends of the party;

(b) a communication of a pleading, transcript of evidence, or other document for use in connection with any of the following proceedings, to a person concerned in those proceedings:

(i) proceedings in a court;

(ii) proceedings before an officer of a court investigating or dealing with a matter in accordance with this Act, the regulations or the applicable Rules of Court;

(iii) proceedings in a tribunal established by or under a law of the Commonwealth or of a State or Territory;

(c) a communication of a pleading, transcript of evidence, or other document, to a prescribed authority of a State or Territory that has responsibilities relating to the welfare of children;

(d) a communication of a pleading, transcript of evidence, or other document, to:

(i) a body that is responsible for disciplining members of a profession in a State or Territory; or

(ii) a person concerned in disciplinary proceedings against a member of a profession in a State or Territory (being proceedings before a body that is responsible for disciplining members of that profession in that State or Territory);

(e) a communication of a pleading, transcript of evidence, or other document, to a body that grants assistance by way of legal aid for the purpose of facilitating a decision as to whether assistance by way of legal aid should be granted, continued or provided in a particular case;

(f) a communication of material intended primarily for use by the members of any profession (being part of a series of law reports or any other publication of a technical character);

(g) a communication of an account of proceedings to a member of a profession in connection with:

(i) the person's practice of that profession; or

(ii) any form of professional training in which that person is involved;

(h) a communication of an account of proceedings to a student in connection with the student's studies.

Note: The form of the order is subject to the entry in the Court's records.

Note: This copy of the Court's Reasons for judgment may be subject to review to remedy minor typographical or grammatical errors (r 10.14(b) *Federal Circuit and Family Court of Australia (Family Law) Rules 2021* (Cth)), or to record a variation to the order pursuant to r 10.13 *Federal Circuit and Family Court of Australia (Family Law) Rules 2021* (Cth).

IT IS NOTED that publication of this judgment by this Court under a pseudonym has been approved pursuant to subsection 114Q(2) of the *Family Law Act 1975* (Cth).

REASONS FOR JUDGMENT

STRUM J:

INTRODUCTION

1 The pedagogist, Maria Montessori (1870–1952), in her book *The Discovery of the Child* (Montessori-Pierson Publishing Company, 1948), wrote (at p. 63):

> The life of a child is not an abstraction; it is something that is lived by each one in particular. There is only one real biological manifestation, that of the living individual; and education, that is, the active assistance required for the normal expansion of life, should be directed towards these individuals as they are observed one by one. A child has a body which grows and a mind which develops. Both his physiological and psychic development have a single source, life. We should not corrupt or suffocate his mysterious potentialities but wait for their successive manifestations.

2 I refer to this passage, not because I rely upon it in any way in my determination of this case, but, rather, because it is illustrative of a central issue for determination. Montessori's observations, although penned many decades ago and somewhat antiquated in language, continue to explain, at least in part, why it is that, at law, in the Commonwealth of Australia or various of its States and Territories, children under the age of 18 (or, in some cases, 16) years, *inter alia*, cannot vote, gamble or drive motor vehicles unsupervised; why contracts entered into by them may be voidable at common law; why alcohol and cigarettes may not be sold to them; why tattoos or piercings (particularly intimate body piercings) cannot be applied to them, or their names changed, without parental consent; and why, even after the age of 16 years, there are restrictions upon with whom they may engage in sexual relations. That is because, quite simply, they are children with, as Montessori wrote, bodies which grow and minds which develop, such that their mysterious potentialities, and the successive manifestations thereof, should be awaited.

3 There are many wonderous and wonderful aspects of childhood, suffused with an innocence that passes with maturity and adulthood. Children may fervently believe, feel and, indeed, wish for many things which may well fall by the wayside as they develop from childhood into adulthood. At one end of a very broad spectrum, these may be innocuous, whilst, at the other end thereof, they may be deep-seated and genuinely felt or held. But, even then, they are still children, and their beliefs, feelings or wishes in childhood may have potentially grave ramifications for their future lives.

4 This is also recognised by the *Family Law Act 1975* (Cth) ("the FLA"). The trial of these proceedings having commenced prior to 6 May 2024, they are to be determined in accordance with the provisions of Pt VII of the FLA before the amendments thereto by the *Family Law Amendment Act 2023* (Cth) ("the Family Law Amendment Act"), which commenced operation on that date.

5 Relevantly, s 61C(1) of the FLA provides that each of the parents of a child who is not 18 years of age has parental responsibility for that child. Section 65H(1)(a) provides that a parenting order, as defined in s 64B, must not be made in relation to a child who is 18 or over. Section 65H(2) provides that a parenting order in relation to a child stops being in force if, *inter alia*, the child turns 18. Whilst s 60CC provides that, in determining what is a child's best interests, the Court must consider, *inter alia*, "any views expressed by the child and any factors (such as the child's maturity or level of understanding) that the Court thinks are relevant to the weight it should give to the child's views" (s 60CC(3)(a)) and "the maturity, sex, lifestyle and background … and any other characteristics of the child that the Court thinks are relevant" (s 60CC(3)(g)), ultimately, in deciding whether to make parenting orders in relation to a child, as between the parties to the proceedings, the Court retains jurisdiction, as between parents in dispute, until the child attains the age of 18 years.

6 These proceedings concern Devin, a biologically male child, born in 2013. Whether the child's biological (or, as the mother and her experts would say, assigned) sex, accords with the child's gender or gender identity is at the heart of this case. The mother contends that the child is gender dysphoric or incongruent; the father, supported by the Independent Children's Lawyer, contends that the child is gender exploratory, expansive or fluid. There are competing applications between the applicant mother and the respondent father for parenting orders pursuant to Pt VII of the FLA. In summary, each parent seeks orders for sole parental responsibility or aspects thereof, for the child to live with him or her and to spend time with the other parent. Intertwined with the issue of parental responsibility is that of medical treatment, in particular, in relation to the child's gender identity, including whether the child should be administered Stage 1 puberty blocking medication. No party seeks orders pursuant to s 67ZC of the FLA in relation to treatment for the child; rather, they seek orders for sole parental responsibility in relation thereto. To their credit, by the time of closing submissions and even thereafter, the parties were able to narrow the ambit (albeit not the depth) of their dispute and a minute of orders sought to be made by the Court has been provided and orders will be made to give effect thereto.

7 The Independent Children's Lawyer submits, in her written closing submissions, and I agree, that questions of parental approach to, and responsibility for, decision-making with respect to the child's gender identity are central to, and will be largely determinative of, both the Court's decision regarding allocation of parental responsibility for decision-making with respect to medical decisions, as well as with whom the child should live and how the child should spend time with the other parent.

8 The trial of these proceedings, which was initially listed for eight days, on the estimation of the parties' lawyers, commenced on 12 February 2024. On 21 February 2024, not being anywhere near completion, it was adjourned part-heard to 27 May 2024, for 10 further days of hearing. On 7 June 2024, it was adjourned to 12 September 2024, for oral final submissions, addressing written final submissions to be filed in the intervening period. The matter was listed for mention, at the motion of the Court, on 20 December 2024, in relation to subsequent developments in the United Kingdom, arising from the final report ("the Cass Report") of the "Independent Review of Gender Identity Services for Children and Young People" ("the Cass Review"), which was tendered on behalf of the mother (Exhibit M-8) and therefore forms part of the evidence adduced by her, albeit generally not supportive of her case.

9 A central issue in the determination of the parents' competing applications, including by reason of the manner in which they conducted their respective cases, is whether the child is gender dysphoric/incongruent and, if so, whether puberty blockers should be administered. The mother would have the Court answer both of those questions in the affirmative; the father, supported by the Independent Children's Lawyer, would have the questions ultimately answered in the negative.

10 Despite my repeated exhortations to the parents and, to some extent, the experts who supported their respective cases, as well as the lawyers who represented them, to recall that the Court was deciding a *case* involving the best interests of the child and not the *cause* of transgender people, that occasionally seemed to fall on deaf ears. In the case of the father, it is correctly observed in his written closing submissions (at paragraph 7) that "[i]t should be noted at the outset that these are parenting proceedings in relation to a young child with gender exploring traits rather than a cause célèbre for advocating trans rights". In the case of the mother, my concerns are exemplified, in part, by the evidence of Associate Professor L, a paediatrician and adolescent medicine physician, who is the Chief of Medicine at The

Children's Hospital and who was previously the Director of the Department of Adolescent Medicine, as well as of the Gender Service at that hospital (noting that, at times, it was referred to in evidence as the Children's Hospital Gender Clinic, or CHGC). She is also currently a member of the State Government's Transgender and Gender Diverse Expert Advisory Group. She was not called as a single expert but, rather, as an expert witness in the mother's case, the provisions of Div 7.1.3 of the *Federal Circuit and Family Court of Australia (Family Law) Rules 2021* (Cth) ("the Rules") having been dispensed with by orders made by consent on 17 April 2023. Nevertheless, Associate Professor L was subject to the provisions of r 7.18 of the Rules, which provides, *inter alia*, that:

> (1) An expert witness has a duty to assist the court with matters that are within the expert witness's knowledge and capability.
>
> (2) The expert witness's duty to the court prevails over the obligation of the expert witness to the person instructing, or paying the fees and expenses of, the expert witness.
>
> (3) The expert witness has the following duties:
>
> (a) to give an objective and unbiased opinion that is also independent and impartial on matters that are within the expert witness's knowledge and capability
>
> …

11 Notwithstanding those duties, Associate Professor L described herself as, or agreed she was, and/or engaged in, (*inter alia*) "advocacy to remove the legal requirement for trans and gender diverse adolescents to obtain Court authorisation to access gender affirming hormone treatment" (affidavit filed 9 February 2024, p.5); an "advocate for trans rights" (Transcript 28 May 2024, p.105 line 4); an "advocate for transgender healthcare" (Transcript 29 May 2024, p.3 line 31); that she was giving her expert opinion "as an advocate for trans people" (Transcript 28 May 2024, p.105 lines 20-21); and that her "preferred model of healthcare for transgender children is a gender-affirming treatment" (Transcript 29 May 2024, p. 3 line 32-33), comprised, initially, of puberty blockers, followed possibly by cross-sex hormones and gender reassignment or gender surgery. However, advocacy in a court is for lawyers, not witnesses, neither lay nor expert.

12 Similarly of concern, Dr N, a senior clinical psychologist at the CHGS, said that she had found some of the expert reports annexed to affidavits filed by the father and the Independent Children's Lawyer, which did not concur with her gender affirming treatment philosophy "hard to … read" (Transcript 19 February 2024, p.23 lines 38–39). That difficulty

experienced by her is also hard to reconcile with her obligations, as an expert, "to give an objective and unbiased opinion that is also independent and impartial", as required by r 7.18(3)(a) of the Rules.

13 Also of concern is the fact that, in the mother's Case Outline / written opening submissions, prepared by her counsel and solicitors and filed on 7 February 2024, it was submitted at paragraph 65 that:

> By way of background context only, and given some of the evidentiary material put forward by the ICL and the Father about [State S] law, it is necessary to have brief regard the [sic] *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic). …
>
> (Footnotes omitted)

14 In two footnotes appended to that sentence, reference was made by name to two of the expert witnesses of the Independent Children's Lawyer and two of the expert witnesses of the father, all of whom oppose the mother's case, namely, Dr M, Dr O, Professor P and Dr Q. Ultimately, no reliance was placed upon the evidence of the latter two experts, but that is immaterial to the point.

15 At paragraph 65, in relation to the *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) ("the Change or Suppression (Conversion) Practices Prohibition Act") it was submitted that:

> … The [State S] Prohibition Act operates to prohibit persons from engaging in "change or suppression practices" for another person's "gender identity" through the creation of criminal offences, and a civil response scheme (administered by the [State S] Equal Opportunity & Human Rights Commission, or [**EOHRC**]) which is designed to promote understanding of the prohibition of "change or suppression practices" under that Act. …
>
> (Footnotes omitted) (Emphasis in original)

16 At paragraph 66, it was submitted that:

> The [State S] Prohibition Act identifies that it is the intent of the [State S] Parliament to denounce and give statutory recognition to the serious harm caused by change or suppression practices; affirm that a person's gender identity is not broken and in need of fixing, and also does not constitute a disorder, disease, illness, deficiency or shortcoming; and to affirm that change or suppression practices are deceptive and harmful both to the person subject to them and the whole community. A "change or suppression practice" is a practice or conduct directed towards a person, whether with or without their consent, on the basis of their gender identity and for the purpose of changing or suppressing their gender identity or inducing that person to change or suppress their gender identity. The [State S] Prohibition Act deploys a definition of "gender identity" as is reflected in the Equal Opportunity Act 2010 (Vic):

> **[“]gender identity**" means a person's gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references.

(Footnotes omitted) (Emphasis in original)

17 At paragraph 68, further reference was made to the criminal offences created by the Change or Suppression (Conversion) Prohibition Practices Prohibition Act referred to in paragraph 66, including the maximum penalties for natural persons, namely, 10 years imprisonment / 1200 penalty units (s 10) or five years imprisonment / 600 penalty units (s 11).

18 As to the assertion on behalf of the mother that the references to the Change or Suppression (Conversion) Practices Prohibition Act were by way of “background context only”, it was and remains entirely unclear how or why they provided such context or, indeed, why such context was necessary in her case. Further, as to the assertion that such references were necessary “given some of the evidentiary material put forward by the ICL and the Father” (at paragraph 65), it similarly was, and remains, entirely unclear why this was said to be so. Counsel for the mother conceded that the Change or Suppression (Conversion) Practices Prohibition Act has, and could have, no application to these proceedings or to the evidence of the experts. However, as referred to below, it may explain some of the difficulties encountered by the father and the Independent Children’s Lawyer who oppose the mother’s case, in relation to obtaining both expert evidence for these proceedings and alternative treatment proposals for the child.

19 I expressed concern, at the commencement of the trial, regarding any interplay, or inconsistency, between the Change or Suppression (Conversion) Practices Prohibition Act and the FLA. I was told by counsel for the mother that no such issue would arise. Accordingly, in orders made on 12 February 2024, I noted that, notwithstanding injunctions then sought by the father that, unless otherwise agreed in writing between the parents, they, their servants and agents, be restrained from consenting to or otherwise facilitating the child attending upon a paediatrician at the CHGS; commencing the administration of “Stage 1” puberty blocking medication; and commencing the administration of “Stage 2” cross-sex hormones, in relation to the provisions of the Change or Suppression (Conversion) Practices Prohibition Act–

> … no party seeks that the Attorney Generals of the Commonwealth, the State of [State S] or any other of the States or Territories of the Commonwealth be invited to intervene, or that such intervention is necessary in these proceedings pursuant to s 91

> of the *Family Law Act* or asserts that such orders, if made, will constitute a breach of the State Act.

20 I also expressed concern that these references to the Change or Suppression (Conversion) Practices Prohibition Act might be, or might be perceived to be, a subtle, indirect attempt to suborn the evidence of the witnesses referred to in the footnotes appended to paragraph 65 of the mother's Case Outline / written opening submissions. Counsel for the mother disavowed that possibility and I take it no further; however, I remain mystified by the inclusion of those references, which I consider to be of no relevance whatsoever to these proceedings. However, I note the following concerning evidence adduced by the Independent Children's Lawyer regarding any treatment that may not be considered to be "gender affirming treatment", and therefore contended possibly to contravene the Change or Suppression (Conversion) Practices Prohibition Act:

- At paragraph 75 of her report annexed to her affidavit filed 11 April 2023, Dr O states:

  > Some make claims that alternative approaches, such as I have described above, are equivalent to non-effective, harmful, unethical, and/or illegal conversion practices. I have attached a letter I sent to the [State S] Equal Opportunities and Human Rights Commission ([EOHRC]) asking this question and their response … My letter described an approach to [gender dysphoria] other than [gender affirming treatment] and, thus, provides one illustration of possible alternative approaches to [gender dysphoric] youth. In addition, it indicates that (within the uncertainties of the current law) the [EOHRC] appeared to think the approach I described would be unlikely to be counted as an illegal conversion practice.

- At paragraph 68 of his report annexed to his affidavit filed 11 April 2023, Dr M states:

  > Unfortunately, I am not aware of any practitioners within [State S] who are willing to undertake such an approach. Anecdotally, I have heard practitioners express concern that if they do not automatically affirm a child's declared gender identity they would find themselves accused of "conversion therapy" as per the legislation. This is despite social transition not being beneficial or harmful, exploratory therapy being an acceptable approach worldwide, and the fact that there would be no need nor intention to "convert" [the child] to have a "cis" identity, just merely not blinding affirming and medicalising. It may be possible to find therapists who are willing to do this, but they will not be at [City K Children's Hospital] Gender Clinic [sic].

21 Further, the father gave evidence that, in his endeavour to garner evidence in support of his case and in opposition to that of the mother, he had contacted very many (in fact, he said, "hundreds" of) therapists who were not interested in treating children with gender issues,

because of the Change or Suppression (Conversion) Practices Prohibition Act and like pressure, until he located Dr R, based in State T, who is willing to do so.

22 Similarly, of no apparent relevance, was paragraph 64 of the mother's Case Outline / written opening submissions, under the rubric "Ascertaining *Gillick* competence", albeit said to be for the assistance of the Court again by way of background. The child was aged 10 years at the commencement of the trial and 11 years at the conclusion thereof. In recent days, the child attained the age of 12 years. There was no suggestion, let alone evidence, that the child is *Gillick* competent: see *Gillick v West Norfolk & Wisbech Area Health Authority* [1968] AC 112. Therefore, considerations of the kind addressed by the Full Court in *Re Jamie* (2013) FLC 93-547 and *Re Kelvin* (2017) FLC 93-809, as well as by Watts J in *Re Imogen (No 6)* (2020) 61 Fam LR 344, are not presently germane. The child's views, and any factors, such as the child's maturity or level of understanding, that the Court thinks are relevant to the weight it should give to the child's views, are but one of a plethora of factors, some statutorily prescribed, to be taken into account.

23 Further, at a pre-trial mention in these proceedings, on 13 December 2023, counsel then appearing for the mother referred to –

> … the mainstream nature of the concerns and the extent to which the ideas challenging what was otherwise the status quo of medical science about gender dysphoria, the extent to which those ideas have taken hold in the community is something with which it is apparent this court is grappling.
>
> (Transcript 13 December 2023, p.4 lines 15–18)

24 I made it clear then, and not dissimilarly again at trial, that the Court was not concerned "in what the community thinks" or ideologies, but only what, on the evidence, is in the child's best interests. Ideology has no place in the application by courts of the law, and certainly not in the determination by courts exercising jurisdiction under the FLA of what is in a child's best interests. That is because, in deciding whether to make a particular parenting order in relation to the child, the Court is mandated by s 60CA of the FLA, to regard the best interests of the child as the paramount consideration and, in determining what is in the child's best interests, to consider the matters set out in s 60CC(2) and s 60CC(3). Indeed, in order for these proceedings not to become embroiled in the issue of the child's pronouns, the child being variously referred to as "he/him", "she/her" and "they/them", on 12 February 2024, I ordered, *inter alia*, that: "The child the subject of these proceedings, DEVIN born 2013, be referred to in these proceedings either as 'the child' or as '[Devin]".

25 In *Re Jamie* at [108], Bryant CJ, with whom Finn and Strickland JJ agreed, said:

> In summary, I conclude that stage one treatment of childhood gender identity disorder is reversible, is not attended by grave risk if a wrong decision is made, and is for the treatment of a malfunction or disease, being a psychological rather than physiological disease. As such, and absent controversy, it falls within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.

26 Insofar as her Honour referred, in 2013, to Stage 1 treatment of childhood gender identity disorder, namely, puberty blockers, being "reversible [and] not attended by grave risk if a wrong decision is made", the evidence in this case adduced by the father and the Independent Children's Lawyer gives rise to the need to consider whether those findings, based on medical evidence a decade ago, remain factually correct for the determination of this case. However, it is not for a court at first instance to consider, or even opine, in relation to the correctness of the legal principles established by the Full Court, which are binding upon it pending any further appellate reconsideration.

27 Seven years later, in *Re Imogen* at [5], Watts J said:

> Whilst this case is heard in the context of an emerging debate about the diagnosis and treatment of Gender Dysphoria, the outcome is focused upon an assessment of Imogen's particular circumstances.

28 At [57], his Honour also referred to the "proliferation of academic and other writings since *Re Kelvin* and the emergence of alternative thinking about treatment and questions arising from the state of knowledge in respect of the long-term implications of current medical treatment for Gender Dysphoria".

29 With the exception of the name of the child in that case, his Honour's observations at [5] can apply to this case. Relevant to what Watts J referred to as the "emerging debate about the … treatment of Gender Dysphoria" in 2020, was the claim in Version 1.2 of the *Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents* ("the ASCTG"), authored by Associate Professor L et al, to which his Honour referred at [24] that "the effects of puberty suppression is [sic] reversible whilst acknowledging both that the main concern relates to the impact upon bone mineral density and that the long term impact on bone mineralisation is currently unknown". At trial, Version 1.4 of the ASCTG was tendered by the father (Exhibit F-13). Whilst termed, or commonly known as, the "Australian Standards", they do not have the approval or imprimatur of the

Commonwealth or any State or Territory Government, including any such government Minister for, or Department of, Health.

EVIDENCE

30 In addition to herself, the mother adduced evidence from:

- Dr N, senior clinical psychologist at the CHGS;
- Associate Professor L, paediatrician, Chief of Medicine at the Children's Hospital and the former Director of the Department of Adolescent Medicine; and
- Dr U, a child and adolescent psychiatrist.

31 Of those witnesses, Dr U was not required for cross-examination.

32 In addition to himself, the father adduced evidence from:

- Ms V, the father's partner;
- Dr W, clinical psychologist;
- Dr Q, consultant psychologist and psychotherapist;
- Mr Y, consultant psychologist and family therapist; and
- Dr Z, clinical psychologist.

33 Of those witnesses, Mr Y and Dr Z were not required for cross-examination. The father also filed an affidavit of Dr P, paediatrician, annexing a report by him. However, this report was ultimately not relied upon by the father at trial and it is agreed by all parties that it not be taken into account. Similarly, in final submissions, no reliance was placed upon the evidence of Dr Q.

34 The Independent Children's Lawyer adduced evidence from:

- Dr O, consultant psychiatrist and psychotherapist;
- Dr M, general paediatrician;
- Ms LL, psychologist, and author of the Family Reports in this matter;
- Mr CC, clinical child psychologist;
- Dr BB, consultant psychiatrist, who conducted psychiatric assessments of the parents and prepared reports thereon; and

- Ms DD, a parenting co-ordinator appointed for the parents pursuant to orders of the Federal Circuit Court of Australia (as the Federal Circuit and Family Court of Australia (Division 2) was then called) made in 2020, who prepared a report in relation thereto.

35 Of those witnesses, Mr CC, Dr BB and Ms DD were not required for cross-examination.

36 As will be evident from the dates of the trial, specified above, the hearing proceeded over 20 days in total. A voluminous number of exhibits were tendered. I do not propose to refer to, or to repeat, either in full or at any length, all of the evidence in these reasons for judgment. It would be nigh impossible to do so and, if it were possible, these reasons would be far longer than they already are. I have read the affidavits and, where the deponents have been cross-examined, I have heard their evidence tested, and I have taken all of the evidence into account (including the exhibits tendered) in reaching my judgment, even if not referred to specifically. By reason of the length of the trial, the complexity of the issues and the extent of the evidence, these reasons for judgment already are longer, and have taken longer to publish, than I would have wished.

37 It is not necessary for a trial judge to refer to every piece of evidence or argument presented during a trial. In *Whisprun Pty Ltd v Dixon* (2003) 200 ALR 447 at [62], Gleeson CJ, McHugh and Gummow JJ said:

> …A judge's reasons are not required to mention every fact or argument relied on by the losing party as relevant to an issue. Judgments of trial judges would soon become longer than they already are if a judge's failure to mention such facts and arguments would be evidence that he or she had not properly considered the losing party's case.

38 In *Housing Commission of New South Wales v Tatmar Pastoral Co Pty Ltd and Penrith Pastoral Co Pty Ltd* [1983] 3 NSWLR 378 at 385-386, Mahoney JA said:

> It is not the duty of the judge to decide every matter which is raised in argument.
>
> …
>
> Nor is it necessary for a judge who is exercising a discretionary judgment to detail each factor which he has found to be relevant or irrelevant, or to itemize, for example, in the assessment of damages for tort, each of the factual matters to which he has had regard… Nor is a judge required to make an explicit finding on each disputed piece of evidence. It will be sufficient, if the inference as to what is found is appropriately clear…

BACKGROUND

39 The mother was born in 1973. She resides in Town G, in Region H, in State S.

40 The father was born in 1974. He resides in Suburb J, in City K.

41 The parents commenced cohabitation in 2000 and separated in or about early 2017. The mother has not re-partnered. The father has been in a relationship with Ms V, with whom he now lives, since early 2019.

42 At the time of the parents' separation, the child was nearly four years of age. Later that year, interim parenting orders were made which provided, *inter alia*, for the child to live with the mother and spend limited time with the father. About a year later, on 27 November 2018, final parenting orders were made by consent ("the 2018 parenting orders") which provided for the parents to have equal shared responsibility for the child and for the child to live with the mother and spend gradually increasing time with the father, culminating in time on alternate weekends and during school holidays.

43 Peace between the parties did not reign for long, if it ever did. Less than a year later, on 12 September 2019, the mother filed an Initiating Application instituting these further proceedings. This trial having commenced on 12 February 2024, s 65DAAA of the FLA (as it presently stands) is inapplicable. Understandably in the particular circumstances, neither parent, at any stage, has contended that the principles in *Rice v Asplund* (1979) FLC 90-725 are applicable to any aspect of the current proceedings.

44 Less than a fortnight after the mother instituted these proceedings, orders were made on 24 September 2019 which noted the parents' agreement that the child should engage with and undertake therapeutic counselling with EE Service, described by the mother as "an organisation dedicated to upholding the wellbeing and mental health of [City K's] LGBTIQ+ community" (at paragraph 71 of her affidavit filed 14 March 2023).

45 Since the parents' separation, including since the 2018 parenting orders, interim and final intervention orders have been made against the father, on application by, or on behalf of, the mother, for the purported protection of the child and/or herself. The Court takes allegations of family violence seriously and, where made, findings thereof even more so. Nevertheless, family violence and any relevant inferences that can be drawn from family violence orders are but two of the factors required by s 60CC of the FLA to be taken into account. Like fingerprints, no two cases are the same and the weight to be accorded to those factors will vary from case to case.

46 The child attends FF School in Region H, near the mother's home, and was in Year 5 there at the time of trial. Pursuant to Order 3 of interim consent orders made on 7 June 2024 (amended on 25 July 2024), the child currently lives with the mother and spends time with the father during school terms each alternate weekend, from the conclusion of school on Friday (or 3.30pm in the event of a non-school day) until the commencement of school on Monday (or 9.00 am in the event of a non-school day). During the second and third gazetted school term holiday periods in 2024, the child was to spend time with the father from the conclusion of school on the last day of term until 5.00 pm on the Saturday of the middle weekend. During the 2024/2025 gazetted long summer school holidays, the child was to spend time with the father each alternate week, commencing from the conclusion of school on the last day of Term 4 (being 20 December 2024) with changeover at 5.00 pm seven days thereafter.

GENDER INCONGRUENCE / DYSPHORIA

47 The eleventh revision of the International Classification of Diseases ("ICD-11") (Exhibit M-3) defines gender incongruence as being –

> … characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.

48 Gender incongruence of childhood is defined in ICD-11 as being –

> … characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike of the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

49 The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") (Exhibit M-4) defines gender dysphoria as referring to "the distress that may accompany the mismatch between one's assigned gender and how a person perceives their true gender" and states that whilst there is "tension within the field as to how best to conceptualize [sic] the disorder … the fundamental nature of the disorder – distress about one's assigned gender – remains a consistent and unifying feature".

50 Gender dysphoria in children is defined in DSM-5 similarly as being "characterized [sic] by marked incongruence between the person's assigned gender and their expressed gender". The diagnostic criteria set out in DSM-5 for gender dysphoria in children are:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 [sic] months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
>
> 1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
>
> 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
>
> 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
>
> 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
>
> 5. A strong preference for playmates of the other gender.
>
> 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
>
> 7. A strong dislike of one's sexual anatomy.
>
> 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
>
> B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

51 As referred to below, there is disagreement between the experts relied upon by the mother, on the one hand, and the father and the Independent Children's Lawyer, on the other hand, in relation to whether the child meets the ICD-11 criteria for gender incongruence of childhood and/or the DSM-5 criteria for childhood gender dysphoria. It is not entirely clear, on the evidence, whether dysphoria is further along a continuum than incongruence or merely akin to a synonym therefor. However, I note that in the Cass Report it is stated (at paragraph 14.15) that, in relation to international guidelines for the use of puberty blockers for gender dysphoria, there is considerable variation regarding the criteria for starting puberty blockers, with the most common being the presence of gender dysphoria that has emerged or worsened at puberty, and only two guidelines specifying "the need for gender incongruence rather than dysphoria". I am fortified in so concluding as, in the Cass Report, in considering the

definitions of gender incongruence (ICD-11) and gender dysphoria (DSM-5), it is reported that "[y]ounger children with gender incongruence may not experience dysphoria, but it commonly arises or increases as they enter puberty" (Cass Report p. 18).

52 Dr N, at paragraph 67 of her report dated 15 January 2024 ("January 2024 report") and annexed to her affidavit filed that day opines that:

> The ICD-11 classification of *Gender incongruence of childhood* is often the preferred set of diagnostic criteria as it is less reliant on out-dated gender-based stereotypes for young people. Furthermore, the ICD-11 diagnosis sits within the "Conditions related to sexual health" chapter as opposed to the "Mental and behavioural disorders" chapter, which previously served to perpetuate stigma and misunderstandings that negatively affect trans people.
>
> (Emphasis in original)

53 Notwithstanding the mother's assertion in her trial affidavit filed on 27 February 2023 (at paragraph 25) that prior to the 2018 parenting orders, "issues in relation to [the child's] gender identity had begun to emerge" and that the child had "been transitioning gender prior to the date of the Orders", there is simply no corroborative evidence thereof whatsoever. There is no suggestion it formed any part of, or was raised in, the earlier parenting proceedings, culminating in those orders, or that it was even mentioned in the Family Report of Mr GG dated 2 November 2017.

54 The child first attended upon Dr N on 6 February 2020. Nearly four years later, by 15 January 2024, the child had attended only 15 sessions in total with Dr N, approximately once every three months, always accompanied by the mother. Dr N's evidence in her January 2024 report (at paragraph 76) is that, pursuant to the father's requests, she "invited" the child, several times, to engage in joint appointments with him but that, on each occasion, the child communicated discomfort with this idea and did not want to attend appointments with the father "yet".

55 She opines (at paragraph 68) that the child meets the ICD-11 criteria for gender incongruence of childhood.

56 However, she reports (at paragraphs 69–70) that, "as reports submitted by some other professionals involved in this matter" queried her choice of diagnostic criteria and whether the DSM-5 criteria were met, she subsequently ascertained that the child also meets the DSM-5 criteria for gender dysphoria in children.

57 At paragraph 30, Dr N reports:

> [The child] has clearly communicated about her [sic] enduring female gender identity and her [sic] need to have this affirmed. She [sic] describes a stable and enduring sense that her [sic] gender identity is different from the gender assigned to her [sic] at birth (i.e., male). For example, when looking at an image of the "Gender Unicorn" … [the child] indicated her [sic] gender identity is "female/girl". When I asked [the child] whether she [sic] has times when she [sic] thinks or feels differently about her [sic] gender identity, she [sic] answered "No, it's always female. Male never really felt right".

58 Exhibit C-2, which was tendered by consent of all parties, is a document titled "Questions considered by the experts and Answers provided during the Conference of Experts", comprising Associate Professor L, Dr U, Dr N, Dr Q, Dr P, Dr R, Dr O, Dr M and Mr CC, compiled by the Independent Children's Lawyer and dated 11 December 2023 ("the Conference of Experts document"). Dr N is the only one of the experts upon whom the child has attended.

59 In relation to whether the child currently meets the criteria for gender incongruence of childhood (ICD-11) or childhood gender dysphoria (DSM-5), the Conference of Experts document records that the only experts to answer unreservedly in the affirmative were Dr N and Dr U, upon whom the mother also relies. Associate Professor L, who is the other expert witness for the mother, was unable to answer those questions, not having undertaken her own assessment of the child. Similarly, Dr Q and Dr R, for the father, were unable to answer the question, due to there being insufficient evidence or information to make such an assessment, it being Dr R's opinion that it can be easy to meet the criteria. Dr P (for the father) and Dr O, Dr M and Mr CC (for the Independent Children's Lawyer) all responded in the negative. Whilst the evidence of Dr Q and Dr P, in their reports annexed to their affidavits, was ultimately not relied upon at trial, there is no suggestion that their opinion in the Conference of Experts document is to be disregarded. It therefore falls to the Court to determine this issue, on the balance of probabilities, albeit that, even if the Court were to make a finding of gender incongruence of childhood or childhood gender dysphoria, that would be in no way determinative of the issue of puberty blockers. The resolution of these questions is a matter of the quality of the evidence, and not the quantity of the witnesses.

60 In relation to the related question of whether there is substantial scientific evidence that gender incongruence of children in childhood is, in the majority, persistent, Dr N and Dr U responded in the affirmative, as did Associate Professor L who expressed the opinion that it does persist in the majority of children. All of the other experts responded in the negative. Dr Q commented that the majority of children desist and resolve gender incongruence as they go

through puberty. In the opinion of Dr P, according to the DSM-5, most do not persist. In the opinion of Dr R, on the evidence, the answer is in the negative.

61 Other than the immediately preceding report by Dr N, dated 27 February 2023 ("February 2023 report") (which only referred to ICD-11), the earlier reports prepared by her dated 11 August 2020, 15 December 2021 and 8 March 2022, do not suggest that the child had previously been assessed for, let alone diagnosed with, gender incongruence or dysphoria, rather than the mere possibility thereof (referred to in the report dated 15 December 2021 at paragraph 4) being adverted to. Indeed, as at 11 August 2020, Dr N makes clear that the child had not been diagnosed with gender dysphoria but, rather, presented with some stereotypically feminine interests and preferences which she referred to as being "gender expansive". That is a descriptor by which the father and the Independent Children's Lawyer abide.

62 At issue in this case is not only Dr N's diagnosis that the child, *prima facie*, might meet the ICD-11 criteria for gender incongruence of childhood or the DSM-5 criteria for gender dysphoria in children, but also how she came to so diagnose the child. To that end, she was extensively and revealingly cross-examined, in particular by Senior Counsel for the Independent Children's Lawyer.

63 The father and the Independent Children's Lawyer both submit and, for the reasons below, I agree, that the evidence of Dr N, over five days at trial, revealed significant issues with the diagnostic process undertaken by her and the conclusions reached by her.

64 In her report dated 4 April 2023 ("April 2023 report") at paragraph 3, Dr O reports that "[Dr N's] reports do not provide any details of the biopsychosocial assessment that was reportedly undertaken" and that a "biopsychosocial formulation has not been provided". There is no evidence that Dr N did conduct a biopsychosocial assessment of the child, or refer the child for the same, despite conceding that, across the child's engagement with the CHGS, both parents (but especially the father) had, at different times, raised issues that suggested such an assessment was indicated. She conceded in cross-examination that there could be benefit in the child undergoing an assessment for autism spectrum disorder (Transcript 28 May 2024, p.66 lines 2–3). Therefore, insofar as it is submitted on behalf of the mother (at paragraph 12 of her written submissions) that Dr N, previously reported in the January 2024 report, *inter alia*, that there had been no indication that the child had difficulties, such as attention deficit hyperactivity disorder or with adaptive behaviour that

required specialist assessment; that the child had not been rated within the clinical range for syndromes of anxiety/depression, withdrawal, social problems, thought problems or attention problems; and that, whilst the child had exhibited signs of elevated anxiety at times, some separation anxiety and features of generalised anxiety, this was not viewed as existing as an independent clinical anxiety disorder, I place little weight thereon, given Dr N's subsequent concessions in cross-examination. Although Dr N rejected the proposition of causation of gender incongruence, such as by reason of autism spectrum disorder, that is against the weight of the evidence in this case, even if only as to the inter-relationship or commonality between the two conditions. Even if it be only a possibility, given the gravity of the issue and the ramifications thereof, it would have behoved her to undertake an assessment therefor and, more broadly, a biopsychosocial assessment of the child.

65 In the course of cross-examination, the analysis of Dr N's notes, produced upon subpoena, significantly undermined key descriptions of diagnostic elements, such as "consistent, persistent female identity" (the February 2023 report p.3). Contrary to that diagnostic element, in an email from Dr N to the father dated 14 September 2021 (Exhibit ICL-40), she advised the father that since the child first became involved at the CHGS 18 months previously –

> … he [sic] presents as gender expansive. And while [the child] has never spoken at length with me about identifying as gender diverse (whether that be gender neutral, female or another identity) he [sic] has never said that he [sic] feels consistently cisgender, either. …

66 It is difficult to reconcile that with the child manifesting a consistent and persistent female identity. It is even more difficult to reconcile that with the mother having told Dr N, in a telephone conversation, less than a month earlier, on 31 August 2021, that she felt there may be a "need to proceed down a legal avenue for approval to [sic] blockers" and that "at the start of [the child's] wondering about gender identity he [sic] used to say 'maybe I'm part boy and part girl' and since then has identified as a female and 'has not wavered' from that experience" (Exhibit ICL-39).

67 Similarly, Dr N's note of a telephone conversation with the mother, on 2 February 2023, refers to how the child's "gender identity needs to be affirmed" and what the child "would like as an outcome" (Exhibit ICL-16).

68 The Independent Children's Lawyer also points to Dr N's diagnosis having been undertaken by her in the context of the child's attendance at the CHGS since the age of six years, issues

being discussed with the child in a gender affirming treatment model, the child living in the maternal gender-affirming home environment and being significantly (if not fully) socially transitioned prior to diagnostic assessment.

69 It is incontestable, on the mother's evidence, that the child does live in a gender affirming home environment with the mother. It is not necessary, for the purpose of these reasons for judgment, for the Court to pass comment generally upon the gender affirming treatment model adopted and implemented by the CHGS. Of relevance, rather, is the impact, if any, of that model upon the child and the child's disputed diagnosis.

70 Associate Professor L wrote the first draft and approved the final draft of the ASCTG and it is a work of which she said she is proud. Insofar as Associate Professor L relies upon the ASCTG, describing it as "best practice" (report dated 12 September 2023 at paragraph 2), and as the "most progressive and trans-affirming guidelines" (affidavit filed 13 September 2023 p.5) in Australia, I approach her evidence in this regard with caution, in the circuitous circumstances where she is the lead author thereof. By way of analogy, it might be said to be akin to a judge expressly relying upon an earlier first instance decision of his or hers as authority for a particular proposition. As I observed during the hearing, of which observation I was reminded in closing submissions, she is akin to being the proverbial "judge, jury and executioner". Indeed, in cross-examination, Associate Professor L conceded that her opinion that the ASCTG is "best practice" was essentially tantamount to her agreeing with herself. Insofar as Dr N relies upon the ASCTG, I similarly approach her evidence in this regard with caution in circumstances where Associate Professor L is her superior at the CH and Dr N would otherwise be disagreeing with her.

71 The introduction to the ASCTG states:

> The Australian Standards of Care and Treatment Guidelines (ASOCTG) aim to maximise quality care provision to trans and gender diverse children and adolescents across Australia, whilst recognising the unique circumstances of providing such care to this population. Recommendations are made based on available empirical evidence and clinician consensus, and have been developed in consultation with professionals working with the trans and gender diverse support organisations, as well as trans children and adolescents and their families. They have been endorsed by the Australian Professional Association for Trans Health (AusPATH), the peak organisation in the region actively promoting communication and collaboration amongst professionals of all disciplines involved in the healthcare, rights and wellbeing of people who identify as trans or gender diverse.
>
> There are potential challenges in accessing trans and gender diverse healthcare for the Australian population. This is especially the case for children and adolescents

who are vulnerable due to cultural and linguistic diversity (including Aboriginal and Torres Strait Islander populations), out of home care, intellectual disability, or detention within the youth justice system. Australia's vast geographical distances create further barriers to treatment access for those living in rural and regional locations.

With increasing visibility and social acceptance of gender diversity in Australia, more children and adolescents are presenting to community and specialist healthcare services requesting support, advice and gender affirming psychological and medical treatment. A large population-based study undertaken in New Zealand in 2012 estimated that approximately 1.2% of adolescents identify as transgender and it is therefore likely that referrals to healthcare professionals will continue to rise in the foreseeable future.

Being trans or gender diverse is now largely viewed as part of the natural spectrum of human diversity. It is, however, frequently accompanied by significant gender dysphoria (GD), which is characterised by the distress that arises from incongruence between a person's gender identity and their sex assigned at birth. It is well recognised that trans and gender diverse individuals are at increased risk of harm because of discrimination, social exclusion, bullying, physical assault and even homicide. Serious psychiatric morbidity is seen in children and adolescents. A study of the mental health of trans young people living in Australia found very high rates of ever being diagnosed with depression (74.6%), anxiety (72.2%), post-traumatic stress disorder (25.1%), a personality disorder (20.1%), psychosis (16.2%) or an eating disorder (22.7%). Furthermore 79.7% reported ever self-harming and 48.1% ever attempting suicide.

Increasing evidence demonstrates that with supportive, gender affirming care during childhood and adolescence, harm can be ameliorated and mental health and wellbeing outcomes can be significantly improved.

As mentioned above, the recommendations made in this document are based primarily on clinician consensus, along with previously published standards of care from the World Professional Association for Transgender Health (WPATH), treatment guidelines and position statements, and finding from a limited number of non-randomised clinical studies and observational studies. It is clear that further research is warranted across all domains of care for trans and gender diverse children and adolescents, the findings of which are likely to influence future recommendations.

(Footnotes omitted).

72 The ASCTG defines the following terms:

Gender identity: A person's innermost concept of self as male, female, a blend of both or neither. One's gender identity can be the same or different from their sex assigned at birth.

Gender expression: The external presentation of one's gender, as expressed through one's name, clothing, behaviour, hairstyle or voice, and which may or may not conform to socially defined behaviours and characteristics typically associated with being either masculine or feminine.

Gender diverse: A term to describe people who do not conform to their society or culture's expectations for males and females. Being transgender is one way of being gender diverse, but not all gender diverse people are transgender.

73 The ASCTG sets out the "general principles for supporting trans and gender diverse children and adolescents", including the following:

> **Individualise care**
>
> Every child or adolescent who presents with concerns regarding their gender will have a unique clinical presentation and their own individual needs. The options for intervention that are appropriate for one person might not be helpful for another. For example, although many trans and gender diverse individuals may benefit from both hormonal intervention and surgery, some may choose only one of these options, and others may decide to have neither. The importance of tailoring interventions is especially true for those expressing a non-binary gender identity, but equally applies to those who present with a trans male or trans female identity. Consistent with the above, decision making should be driven by the child or adolescent wherever possible, and this applies to options regarding not only medical intervention but also social transition.
>
> **Use respectful and affirming language**
>
> Understanding and using a person's preferred name and pronouns is vital to the provision of affirming and respectful care of trans children and adolescents. Providing an environment that demonstrates inclusiveness and respect for diversity is essential, with Australian research reporting that healthcare environments experienced as discriminatory for trans and gender diverse people are correlated with poorer mental health outcomes. Some children or adolescents may request use of a preferred name or pronoun only in certain circumstances, such as when their parents are, or are not, present in the room. This is important to respect and enact to enable optimal patient-clinician engagement, and ensure confidentiality and patient safety.
>
> **Avoid causing harm**
>
> Avoiding harm is an important ethical consideration for health professionals when considering different options for medical and surgical intervention. Withholding of gender affirming treatment is not considered a neutral option, and may exacerbate distress in a number of ways including increasing depression, anxiety and suicidality, social withdrawal, as well as possibly increasing chances of young people illegally accessing medications.
>
> In the past, psychological practices attempting to change a person's gender identity to be more aligned with their sex assigned at birth were used. Such practices, typically known as conversion or reparative therapies, lack efficacy, are considered unethical and may cause lasting damage to a child or adolescent's social and emotional health and wellbeing.
>
> **Consider sociocultural factors**
>
> Fear of experiencing stigma and discrimination by health professionals can be a barrier for trans and gender diverse individuals in accessing general medical healthcare as well as treatment directly related to gender dysphoria. Indigenous trans and gender diverse Australians experience problems of racism and gender related discrimination in the broader Australian context as well as transphobia within traditional community groups, which adds an additional barrier to treatment access. It is also important to recognise difficulties that may exist for children or adolescents and their families who

> belong to particular religious or cultural groups. In these circumstances, beliefs and values may be at odds with a gender affirming approach and may prevent them from accessing support within their local community.

74 Of particular relevance, and concern, in this case are the stated principles that the "[w]ithholding of gender affirming treatment is not considered a neutral option" and the related references to "psychological practices attempting to change a person's gender identity to be more aligned with their sex assigned at birth" lacking efficacy, being considered unethical and possibly causing lasting damage to a child or adolescent's social and emotional health and well-being. Whilst in no way howsoever endorsing the practices referred to, and identified, as "conversion or reparative therapies", it is concerning that an oddly binary approach is adopted in relation to children, especially of the age of the child the subject of these proceedings; that is, to affirm unreservedly those who present with concerns regarding their gender, brooking no questioning thereof. The case of the mother, supported by the evidence of Dr N, is that because the child says so, the child is, and must unquestioningly be affirmed as being, female in gender identity. However, that overlooks the obvious, namely, that the child is still a child and not even, if it matters, a teenager.

75 Further, relation to the child living in a gender affirming home environment with the mother, and the impact thereof on Dr N's diagnosis of the child, there is extensive evidence that, in her care, and with her approval, the child has become immersed, through HH Service, in Region H where the child and she live, in a social circle dominated by transgender young people who are older than the child and are undergoing various stages of affirming treatment. The mother first introduced the child to HH Service, which she described as being a support group for "families and allies" of transgender children, including at the young age of six years. She conceded in cross-examination that it is the child's and her main social support group at present. Further, it was through this group, and a workbook with a "trans focus", that the child first became aware of puberty and the concept of puberty blockers. Indeed, in cross-examination, Dr N accepted the possible contextual/environmental influence upon the child of other children and young people at HH Service. Whilst this concession was made in the context of discussions or comments regarding puberty blockers, it is nevertheless a concession regarding possible contextual/environmental influence upon the child.

76 Extensive material, produced upon subpoena and tendered into evidence, concerningly reveals that the extent of the mother's contribution, both within Dr N's sessions with the child

and external to it, has been extensive, with very limited input from the father sought or considered by Dr N. Examples include the following.

77 The mother alleged, and told Dr N, that the child had "self-harmed" the child's penis, in the bath, at the age of six years, in May 2019. However, in the mother's affidavit, filed on 20 August 2020, she made no mention at all of any self-harm by the child. In the mother's affidavit filed on 12 September 2019, she merely referred to the child's thoughts of self-harm and wanting to "cut his [sic] penis off" (at paragraph 12). In her affidavits filed on 27 February 2023, 21 March 2023 and 24 January 2024, she referred to thoughts of, or threats by the child, regarding self-harm. Prior to her oral evidence at trial, the mother otherwise had only alleged actual (as opposed to contemplated or threatened) self-harm by the child, in September (rather than May) 2019 to a third person. The mother's account to the third person, who was not called to give evidence, and her evidence to the Court were markedly at odds. To the third person, she said that she did not even witness the alleged self-harm but that she was told about it by the child who said: "I hit it [i.e. the penis] with one million force". To Dr BB, the mother alleged that the child "was referred to the [OO] Hospital Mental Health Service for a suicide risk assessment, noting that [the child] was deemed to be of low risk at the time". The allegation seems to have gathered momentum with the passage of time and the approach of the trial. Her evidence to the Court in this respect at trial was confused and confusing, prevaricating about when and how anything occurred. She said she saw his left hand, clenched in a fist, punching his penis some three times, which was submerged in water in the bath. She could not contemplate that any more benign or innocent explanation, such as self-exploration or even infantile self-gratification, could have been even a possibility. In circumstances where, on the mother's own evidence, the child was not displaying or complaining of any symptoms of pain, I do not accept, on the balance of probabilities, that the child attempted to self-harm his genital area as the mother alleged. Dr N's evidence is that, even if what the mother described occurred, in her expert opinion, that would not constitute self-harm. Further, in the mother's written closing submissions (at paragraph 66) it is conceded that "the Court may be properly circumspect as to whether this event could be properly or objectively described as self-harm". In any event, Dr N has not reported that the child has expressed to her any thoughts of, or reported engaging in, any incidents of, self-harm. To the contrary, in the mental health review undertaken by her on 18 May 2023 (Exhibit ICL-18), she recorded that the child "denied any suicidal thoughts or thoughts/actions regarding self-harm in recent months". Further, in cross-examination, she

opined that the risk thereof was low, pointing only to the more generalised risks that may arise for gender dysphoric/incongruent children at the actual onset of pubertal changes.

78 It was striking that when, in the course of cross-examination about her allegations of self-harm by the child, it was pointed out to the mother that what she said she believed to be self-harm might not be so but might, in fact, be far more innocuous, there was no expression of relief by her, thereby confirming her rigid, fixed views.

79 Similarly of concern is the mother having informed Dr N, as recorded in her file note dated 8 November 2022 (Exhibit ICL-12), that the child had attended the general medical practitioner, Dr JJ, that month "re: increased distress with dysphoria and growth", when that is not apparently supported by the contemporaneous file note of the child's attendance that day upon, in fact, a different general medical practitioner. Given that the file note referred to something as benign as a grazed knee, it could reasonably be expected that, if something as serious as that which the mother alleged to Dr N had in fact been discussed, it would also have been recorded in the file note.

80 Further, a file note of a telephone attendance on 9 August 2022 (Exhibit ICL-11), records the mother having told Dr N that she had bought "the gender identity workbook for kids" and that the child was "really interested in exploring this and looked over it/*wrote in it* for several hours" with her (emphasis added). However, when the workbook was called for and subsequently produced by the mother at trial, it was entirely empty, contrary to her evidence that the child had written in it (Exhibit ICL-21). Dr N, who had not previously sighted the workbook, expressed surprise when told in cross-examination that it was completely unmarked. The mother's attempted explanation then, namely, that the child did not want any answers to the workbook recorded, is, I find, irreconcilable with what she told Dr N and I do not accept it.

81 Also of concern is the reference in Dr N's February 2023 report to the child having "dysphoria that results from a lack of affirmation". However, when this was explored in cross-examination, Dr N accepted that, throughout her involvement with the child prior to the end of 2022, there was no evidence of dysphoria that she had directly observed. Thus, it follows that the only dysphoria must have been that reported to her by the mother.

82 Consistent with the child having been surrounded by gender affirmation and external influence prior to any diagnosis of gender incongruence or dysphoria, is the evidence that the

mother unilaterally actioned the child wearing "gender affirming underwear", in particular, small, tight and padded underpants, designed to pressure and flatten the penile area, as well as discussed puberty blockers with the child, without any prior consultation with, or advice from, Dr N, let alone any prior consultation with, or consent from, the father. The gender affirming underwear was tendered and marked Exhibit F-5. Rather, the mother's evidence is that such underwear was recommended to her, and advice in relation thereto was provided to her, by other parents at HH Service. Related thereto are the "bralets" or padded bras provided by the mother for the child, the child having become aware thereof from other friends who were wearing them. Putting the risks, or the potential for risk, of the gender affirming underpants to one side momentarily, the fact that the mother and the child became aware of the underpants and padded bras through HH Service and friends bolsters the concern raised by the father and the Independent Children's Lawyer regarding the extent to which the child's gender fluidity and exploration, and Dr N's diagnoses of gender incongruence/dysphoria, may be matters of, or including, nurture rather than nature.

83 It is submitted in the mother's written closing submissions (at paragraph 60) that there is no suggestion that the child has been harmed by wearing gender affirming underwear. However, even if that be so, it is not to the point, retrospectively. What is of concern is that the mother sourced and provided such underwear to the child without seeking and obtaining professional medical advice in relation thereto, as well as parental consent from the father. Similarly, insofar as Associate Professor L opined that it was not a matter requiring professional advice, it would nevertheless have behoved the mother to make that enquiry, given the purpose of such underwear is to pressure and flatten the penile area, such that it would not be inconceivable that injury might be caused.

84 In relation to puberty blockers, the merits of which I consider below, Dr N, in the January 2024 report, reports at paragraph 38 that the child informed her of first learning about them –

> … from listening to the stories and experiences of adolescents attending [HH Service] with her [sic]. She [sic] was aware these young people had received treatment with puberty blockers through their involvement at the [CHGS] [sic] and had shown an interest in learning more about this treatment option.

85 Dr N reports, at paragraph 71(n) of the January 2024 report, that gender affirmation for the child has been complicated by the fact that the mother is affirming of the child's female identity and preferences, whereas the father "does not support [the child's] female identity or involvement at the [CHGS] [sic]". Whilst the father does not support the child's involvement

at the CHGS and, in the circumstances of this case, I ultimately conclude not unreasonably so, I do not accept that the father does not support the child's present apparent female identity. Whilst viewed from Dr N's perspective, that may be so, in that the father does not support any medical intervention at present, or until the child attains the age of 18 years, the evidence is that the father has accepted and supported, at least in retrospect, reversible social transitioning, instigated by the mother.

86 In circumstances where the child had been attending upon Dr N since February 2020, the timing of her application of the diagnostic tools in the ICD-11 and the DSM-5 requires scrutiny. As referred to above, throughout her involvement with the child over nearly three years, between early 2020 and late 2022, there was no evidence of dysphoria that she had directly observed. However, by her February 2023 report, the child had been diagnosed by her with gender incongruence of childhood, in accordance with ICD-11. Trial directions made on 10 August 2022, which initially listed the matter for trial on 17 April 2023, required the mother to file the affidavits of evidence in chief of all of her witnesses by 27 February 2023. It was on that date that the February 2023 report of Dr N was prepared and filed.

87 On 17 April 2023, the trial was adjourned, upon the application, and by consent, of the parties, to February 2024. For the purposes of the adjourned trial, trial directions were made on 13 December 2023 which required the mother to file, *inter alia*, any further affidavit by Dr N, limited to matters arising since 21 March 2023, by 15 January 2024. Again, it was on that date that the latest report of Dr N was prepared and filed, in which, this time, she opined that the child met the DSM-5 criteria for gender dysphoria in children where, as she stated at paragraph 69, "some other professionals involved in this matter queried [her] choice of diagnostic criteria and whether [the child] meets DSM-5-TR criteria". It is, therefore, apparent, that her initial ICD-11 diagnosis and her subsequent DSM-5 diagnosis were each undertaken as the pending trial dates approached. Dr N conceded in cross-examination that the time pressure of the court process was one factor in the decision to conduct a diagnostic tool when she did. However, the Independent Children's Lawyer submits, and I agree that, albeit one factor, it was a major one. Without such a diagnosis (or diagnoses), it is nigh inconceivable that the mother could have seriously prosecuted her application in relation to puberty suppression, let alone had any prospect of success. I find that the timing was more than merely coincidental.

88 The case of the mother, supported by the evidence in chief of Dr N and Associate Professor L is that gender identity is internal and immutable, and not open to external influence. The mother, in cross-examination, rejected even the possibility that external factors or influence might have any role to play in the child's gender identity. However, neither of those experts were able to point to any empirical or substantive basis for their opinion but, rather, only to anecdotal reports from transgender adults about their experience of their gender identity. Further, neither expert was able to point to any other aspects of human identity that are similarly said to be immutable. The proposition for which they contend is also difficult to reconcile with the evidence of Associate Professor L that, nevertheless, the disapproving attitude of some parents may have influenced their children's behaviour, as they grew older, to identify with their children's sex. The proposition is also difficult to reconcile with the necessarily conceded incidence of detransitioning (albeit that the frequency thereof is disputed), as well as the evidence of some children's gender incongruence/dysphoria resolving upon going through puberty. Dr O gave evidence, that was not successfully challenged, regarding other factors interacting with, or potentially forming part of the factors influencing gender identity and presentation, such as, for example, the lack of language for young children to express their possible homosexual desires. I find Dr O, whose evidence I consider throughout these reasons for judgment, to be an impressive, considered and unbiased expert, whose evidence is of great assistance in the resolution of this difficult dispute between the child's parents.

89 Another issue of concern is that whilst neither Dr N nor Associate Professor L contended, and it would seem not unreasonably so, that gender identity is something known by a child at birth, they could not proffer a definitive age at which it could be known or understood. However, they contended without explanation that the child would have had the capacity for such self-knowledge by the time of answering the initial questionnaire at the CHGS, at the age of merely six years.

90 Of concern is the seeming dismissal by the mother, as well as largely by Dr N and Associate Professor L, of the possible relevance of other factors, such as maternal influence and underlying neurodivergence, playing any part in the child's presentation. Given the possibility adverted to, *inter alia*, in the Cass Report, to which I refer below, regarding the inter-relationship and overlap between features of autism spectrum disorder and gender dysphoria, it is remarkable that the child was not assessed for any neurodivergence. Although denied by Associate Professor L, and reluctantly conceded by Dr N in cross-examination that

there would be benefit in the child undergoing an assessment for autism spectrum disorder, I consider that prudence would have dictated that such an investigation be undertaken, whether before, contemporaneously with or subsequent to Dr N's diagnoses, and certainly before puberty blockers were contemplated, given the gravity of the issue.

91 The evidence of the mother's experts, Dr N and Associate Professor L, is, in many respects, at odds with the Cass Report which was tendered by counsel for the mother (Exhibit M-8), with the unsurprising consent of the father and the Independent Children's Lawyer. What is, perhaps, surprising is that the Cass Report in full, as well as documents related thereto (such as Exhibits M-9, M-10 and M-11), were tendered on behalf of the mother, even though they are not supportive of her case. It might have been reasonably anticipated that such evidence would be tendered by the father or the Independent Children's Lawyer in opposition to the mother's case.

92 After closing submissions, and whilst this judgment was reserved, another judge of this Court, in *Re Ash (No 4)* [2024] FedCFamC1F 777, delivered judgment in relation to a 16-year-old child, with a diagnosis of gender dysphoria that was (ultimately) conceded (see at [59]). Those two facts – the child's diagnosis and age – alone suffice to distinguish that case from the present one, although there are other manifold distinctions which are not presently germane. At [167], his Honour said that "it would be a mistake to view the Cass Review as arising out of an apolitical scenario", referring to the Cass Report itself noting "internal tension between members of a previous iteration of the review panel, and the deep conflict between various professional groups". How such tension and conflict might suggest that the Cass Report did not arise out of an apolitical scenario is unclear and, with respect, I consider his Honour's comments to be speculative. At [170]–[171], his Honour not dissimilarly said that he did "not overlook that there *may* have been an overt political imperative behind the Cass Review – which was, after all, initiated by the UK executive government" (emphasis added), referring to statements made publicly by the then United Kingdom Prime Minister, whilst the Cass Report was being finalised, and therefore concluding that the Cass Report "was undertaken in a vexed environment". Whilst the Cass Report, like this case, may, indeed, have been undertaken in a vexed environment, it is entirely unclear on what basis his Honour speculated that there may have been a political imperative behind the Cass Report or that a public comment by the then United Kingdom Prime Minister might, in some way, have influenced it.

93 Chapter 6 of the Cass Report addresses developmental considerations for children and adolescents and, at paragraph 6.6, refers to three important ways in which sex differences are expressed (gender role behaviours; gender identity; and, later, sexual orientation). It states at paragraph 6.7 that it "is thought that all three of these can be influenced by biological and social factors, and this is an evolving area of research". It is opined at paragraph 6.20 that contemporary research is needed to better understand the influence of early childhood experiences on gender identity development, but that it would appear that "a complex interplay between testosterone levels, external genitalia, sex of rearing and socio-cultural environment all play a part in eventual gender identity" (at paragraph 6.31). At paragraphs 6.33–6.34, the Cass Report states, not unsurprisingly, that:

> 6.33 Adolescence is a period of rapid social, emotional, physical and cognitive development that can be difficult for some young people to navigate. Pubertal changes in hormones result in changes to the physical body and the brain, alongside major changes in social expectations and demands.
>
> 6.34 An understanding of brain development and the stages of adolescence is essential in understanding how gender identity relates to the other aspects of adolescence. It is also important to consider in relation to the management of gender incongruence and gender -related distress during this period.

94 At paragraph 6.42, the Cass Report refers to the "increasing evidence" that the changes in brain maturation during adolescence are driven by a combination of logical age and sex hormones released through puberty, and concludes in this regard at paragraph 6.44:

> In summary, childhood, adolescent and young adulthood a dynamic developmental periods for gender expression, cognitive development and overall brain maturation, and at the same time, young people having to never engaged in increasingly complex world. This important developmental backdrop needs to be taken into account when thinking about how gender incongruence may develop in any one individual and how best to address it.

95 Chapter 8 of the Cass Report addresses possible factors influencing the "very altered profile of the children and young people who are now being seen in NHS gender services" in the United Kingdom (paragraph 8.2), stating at paragraph 8.1:

> More than two decades ago, Cohen-Kettenis and Gooren (1999) wrote: "Adult gender identity and gender role behaviour develop gradually over a long period of time and are influenced by multiple, interacting factors, active at different developmental periods… Our understanding of this process has increased considerably, but a large part of it still remains enigmatic". This quote still resonates in 2024.

96 Although those observations are made in the context of children and young people being seen in National Health Service ("NHS") gender services in the United Kingdom, there is no suggestions that those observations themselves are not germane or are location-specific.

97 Considered in Chapter 8 are biological and psychosocial factors. At paragraph 8.23, it is stated that:

> For children and young people with gender incongruence, 'innate' or biological factors may play a part in some individuals, in ways that are not yet understood, and in others psychosocial factors, including life experiences, societal and cultural influences, may be more important. …

98 The psychosocial factors considered include: societal acceptance; changes in concept of gender and sexuality; manifestation of broader mental health challenges; peer and socio-cultural influence; and availability of puberty blockers. Importantly, the Cass Report states that "[s]implistic explanations of either kind ('all trans people are born that way' or 'it's all social contagion') do not consider the wide range of factors that can lead young people to present with gender-related distress and undervalues their experiences" (at paragraph 8.25) and that, rather, "gender incongruence is a result of a complex interplay between biological, psychological and social factors" (at paragraph 8.52). Those statements accord with much of the evidence in this case, as well as with commonsense, and I place significant weight on them.

99 In the conclusion to Chapter 8, the Cass Report relevantly states:

> 8.54 Although we do not have definitive evidence about biological causes of gender incongruence it may be that some people have a biological predisposition. However, other psychological, personal and social factors will have a bearing on how gender identity evolves and is expressed.
>
> 8.55 In later childhood and into early puberty, online experience may have an effect on sense of self and expectations of puberty and of gender. As discussed in relation to adolescent development, this is a time where the drive to fit in with peers is particularly strong. Young people who are already feeling 'different' may have that sense exacerbated if they do not fit in with the demonstrations of masculinity and femininity they are exposed to socially and/or online.
>
> 8.56 Peer influence during this stage of life is very powerful. As well as the influence of social media, the Review has heard accounts of female students forming intense friendships with other gender-questioning or transgender students at school, and then identifying as trans themselves.
>
> 8.57 It is the norm for people to view their experiences of life events, health and illness through their own cultural lens and personal beliefs. Cultural norms in younger people might impact how they interpret their personal, sexual and gender identity.

> 8.58 Puberty is an intense period of rapid change and can be a difficult process, where young people are vulnerable to mental health problems, particularly girls. Unwelcome bodily changes and experiences can be uncomfortable for all young people, but this can be particularly distressing for young neurodiverse people who may struggle with the sensory changes.
>
> 8.59 The data on young people's mental health, social media use and increased risks associated with online harm give an appreciation and understanding that going through the teenage years is increasingly difficult, with stressors that previous generations did not face. This can be a time when mental distress can present through physical manifestations such as eating disorders or body dysmorphic disorders. It is likely that for some young people this presents as gender-related distress.
>
> 8.60 A study followed 2,772 adolescents from age 11 to 26. Gender non-contentedness (as defined by the question "I wish to be of the opposite sex") was high in early adolescence, reduced into early 20s, and was associated with a poorer self-concept and mental health throughout development. It was also more often associated with same-sex attraction when compared to those who did not have gender non-contentedness (Rawee et al., 2024).
>
> 8.61 There is no single explanation for the increase in prevalence of gender incongruence or the change in case-mix of those being referred to gender services. Pragmatically all the above explanations for the observed changes in this heterogeneous population are likely to be true to a greater or lesser extent, but for any individual a different mix of factors will apply.

100 Although Associate Professor L disagrees with much of the Cass Report, which manifestly runs contrary to her life's work as an "advocate" for the cause in relation to which the Cass Report urges, at least, greater caution, even she conceded in cross-examination, that some "symptoms" of gender incongruence could overlap with, for example, traits of autism spectrum disorder, such that there is a diagnostic difficulty.

101 In a supplementary report prepared by Associate Professor L dated 18 May 2024 and tendered on behalf of the mother (Exhibit M-7), she provided her responses to the Cass Report ("May 2024 supplementary report"). It is submitted by the Independent Children's Lawyer (at paragraph 39.3), and I agree, that Associate Professor L's responses were "misleading or omitted findings/material that detracted from her opinion" contrary to the obligations as an expert witness prescribed by r 7.18(3)(d) of the Rules. Some of the many examples proffered are concerning.

102 Cass Report Recommendation 6 recommends that a full program of research be established in the United Kingdom to look at the characteristics, interventions and outcomes of every young person presenting to the NHS gender services, including the establishment of a "puberty blocker trial" as part of a program of research which also evaluates outcomes of psychosocial interventions and masculinising/feminising hormones, as well as a research study with

follow-up into adulthood. In her May 2024 supplementary report at paragraph 12, Associate Professor L asserts that the CHGS has a clinical evaluation program in place, as well as a longitudinal cohort study established by it in 2017, which aims to follow-up and assess clinical outcomes for 600 patients and families over a period of 20 years. However, in cross-examination, Associate Professor L conceded that the study is not a clinical trial and that there are significant issues with follow-up into adulthood.

103 In her response to Cass Report Recommendation 25, namely, provision for people considering de-transitioning, Associate Professor L asserts at paragraph 31 of her May 2024 supplementary report that "the number of young people re-transitioning with regret is extremely low". However, Associate Professor L referenced only one study which, indeed, showed a very small percentage of de-transitioning, but did not reference either the criticisms of studies on de-transitioning numbers, or the other studies showing higher numbers. Further, in cross-examination, Dr O said that, whilst it is trite to state that not all people who transition subsequently regret so doing, so too, not all who regret transitioning subsequently de-transition/re-transition.

104 In her criticism of the scientific methodology used by the Cass Report, Associate Professor L states at paragraph 41:

> With the absence of any available clinical services, a research program relevant to clinical care cannot be established. This essentially stops all access to medical intervention for trans adolescents in England. It is likely that it will take many years to properly establish the services required, despite the recommendations from the Cass Review that expansion of services are needed to meet the needs of this population. It is this current situation, leaving families without access to care, that has caused distress, despair and anger across the LGBTIQ+ community and their allies.
> …

105 She then refers at paragraph 45 to, and relies upon, an article in the Scientific American publication which, she states "outlines the historical pattern of use of selective information, science and mis-representation of research to justify opposition to trans healthcare"; "describes three waves of oppression of transgender people internationally over the past century"; and "suggests that we are currently living through the third wave of transgender oppression". She continues:

> 46. According to these authors, the first wave occurred in 1930s when the Nazis rose to power, burning books containing LGBTIQ+ information and stopping medical research and clinical practice in trans health care. Nazi ideology was based on the science of eugenics, with scientists developing a "hierarchy of human types" based on race, gender and sexuality. Based on this premise, the

Nazis murdered thousands of LGBTIQ people in the Holocaust.

47. The second wave, occurring in the 1970s once trans health care had been re-established, coincided with trans health care becoming "mainstream" across the US. Trans people became "visible on television, talking about their bodies and fighting for their rights." In response, a psychiatrist known as Dr Jon Meyer, published a short academic paper in 1979 assessing gender affirming surgery that "ushered in the second wave of historic backlash to trans medicine". Despite Meyer's conclusions from his study that there were no negative effects from surgery and no patients expressed regret, finding the surgery "subjectively satisfying", this gender affirming surgery was concluded as providing no "objective advantage in terms of social rehabilitation". Social rehabilitation was assessed based on employment status, marital and domiciliary stability. Within months, multiple clinics across the US and around the world were closed and only a handful of clinics remained by the 1990s.

48. During the early 2020s, described as the third wave, we have seen the rise of distrust in science. We have also seen the rise of the "culture wars" and the impact this has had on trans healthcare … The opposition to trans medicine today is described by the authors as being reactionary against the normalisation of LGBTIQ+ people, with increases in trans acceptance, trans visibility and movement towards equality. This recent opposition to trans care has seen legislators across the US banning books with LGBTIQ+ content from libraries and schools, threatening trans people with arrest for using public toilets and banning medical intervention for trans young people across multiple US jurisdictions. The policy announced by the NHS England and the Cass Review appears consistent with this, reducing access to social transition and medical interventions due to stated concerns of rising numbers of trans children presenting to the NHS.

106 The emotive suggestion, by an expert witness, that the Cass Report forms part of a "third wave of transgender oppression" commencing with the Nazis has no place whatsoever in the independent evidence that should be expected of such an expert. It demonstrates ignorance of the true evils of Nazism and cheapens the sufferings – and mass murder – of the millions of the victims thereof, which included, but were most certainly not limited to, transgender people, as well as gay and lesbian people, amongst other groups of people. I consider there to be no comparison whatsoever.

107 Amongst the factors identified in evidence, and accepted by Dr N as either being present in the child or not having been assessed or excluded, despite reason to think they were present, were, *inter alia*, the following: anxiety; significantly impaired family functioning; disordered eating or relationship with food; possible neurodivergence; and social isolation or limited social supports and interactions. The findings of the Cass Report, the evidence of Dr R and Dr O, and the concessions made by Associate Professor L in cross-examination with respect to the overlap and potential for differential attribution of "symptoms", underpin the need for these factors to have been considered in the case of the child, both as part of the diagnostic

process and in the formulation of the response thereto. However, concerningly, that did not occur. Accordingly, I approach the diagnoses of Dr N with caution and, indeed, concern.

108 There was evidence regarding a number of matters, the potential impact of which upon Dr N's diagnosis of the child was not taken into account by her in coming to her diagnoses. These included, but are not limited to, the mother having secretly given the child a mobile telephone to use in case of emergency in the father's home (when no emergency with which the father could not deal was reasonably foreseeable); the mother falsely representing to Dr N that the father was opposed to the child wearing a dress to school; the mother providing gender affirming underwear for the child without first seeking advice from the CHGS or consent from the father; and a secret female name for the child, of which the father remarkably only became aware during the course of the trial, the mother having previously refused to disclose such name(s) to him.

109 An example of Dr N's misapprehensions is to be found in her notes of an attendance by the child upon her on 16 February 2023 (Exhibit ICL-17), in which she stated:

> … Gender affirmation for [the child] has been complicated by the fact her [sic] mother … is fully affirming of her [sic] female identity and preferences, whereas father [sic] … does not support [the child's] female identity nor involvement at the gender service, and he likely views [the child's] gender diversity is being driven by supposed complexities in the mother-child relationship. The clinician has observed [the mother] to be nurturing, thoughtful and gentle in her approach with [the child]. [The child] also speaks about discomfort opening up to her [sic] father about deeply personal issues, so it is considered most probable that [the child's] father is the parent who has formed a false assumption about their child's gender identity. …

110 A number of matters arise from this passage. On the evidence, I do not accept that the father is, or has been, unsupportive of the child's gender identity. His concerns, which I find are well-founded, regard the exclusion by the mother and her experts of any other possible explanations for the child's presentation, and the proposed/probable administration of any medical treatment for the child, presently of Stage 1 puberty blockers. He has not opposed, and does not oppose, social affirmation by the child, which has been occurring. Insofar as the father does not support attendance by the child at the CHGS, in the circumstances, given their single approach of gender affirming treatment, as well as their exclusion of him from sessions with the child, I do not consider that to be unreasonable. Insofar as Dr N opined that the father likely viewed the child's gender diversity as being driven by supposed complexities in the mother-child relationship, I consider his true position, accurately described, to have been (and to be) more nuanced. Rather, it includes the relative social isolation of the mother and

the child in Town G, in Region H, with little familial or social interaction beyond the LGBTQI+ community to which the mother does not even herself belong other than by reason of the child, she herself not identifying as (or being) such. Insofar as Dr N referred to the mother being nurturing, thoughtful and gentle in her approach with the child, she did not afford herself the opportunity to observe the father with the child. The father's oral evidence, and the manner in which he delivered it, suggested to me that he is at least equally nurturing, thoughtful and gentle in his approach to the child.

111 The Independent Children's Lawyer, as well as the father, contend that the mother has sought to guide and influence Dr N in her diagnosis of the child, including against communication with the father, notwithstanding the orders for equal shared parental responsibility and in relation to medical and like treatment for the child in the 2018 parenting orders. I consider that is generally borne out by the notes of Dr N that were tendered into evidence. They disclose that, prior to attendances by the child upon Dr N, the mother regularly contacted Dr N to "set the scene", proverbially, thereby at least indirectly influencing Dr N.

112 Further, Dr N's notes disclosed no discussion, display or indication by the child in any session of any dysphoria or distress related to gender until after issues of puberty blockers were first raised on 9 June 2022 (Exhibit ICL-24). Indeed, even shortly thereafter, in a session on 21 July 2022, Dr N noted the child had previously referred to being able to tolerate a masculine puberty (Exhibit ICL-26). It is submitted by the Independent Children's Lawyer and the father that it was only after the father refused the referral of the child to a paediatrician at the CHGS and that the matter was first set down for trial, at or about the time of the case management hearing on 10 August 2022, that reports of gender dysphoria commenced, including the following:

- On 9 August 2022, a file note of a telephone attendance by the mother upon Dr N records that the mother "reminded" her that the child had self-harmed prior to engaging with the CHGS (Exhibit ICL-11).
- On 16 August 2022, a file note of a telephone attendance by the mother upon Dr N records, as part of the plan for the child to "[i]f possible, cover formal diagnosis of Gender Dysphoria (in children) with [the child] in the next session" and to "[h]elp the family to continue making progress with [the child] opening up and discussing their identity, their needs etc. with the view that this information will be pertinent to the hearing" (Exhibit ICL-14).

- In an exchange of emails, on 22 and 23 August 2022 (Exhibits ICL-6 and ICL-28), the mother expressed to Dr N the she "felt it was important to advise" Dr N of a number of things including that, the previous week, the child "decided they would start wearing skorts [sic] over their leggings … and on Friday morning asked [her] to pack some skirts to wear over their leggings when at dad's on the weekend, which they did". Given that the child did wear skirts whilst spending time with the father, apparently without issue on the part of the father or the child, the mother's allegation to Dr N that the child was apprehensive about clothing was unnecessary and gratuitous. In her second email, the mother advised Dr N that the child "hasn't disclosed anything as yet re the weekend … however they have indicated they're worried about the lumps and bumps showing through their clothes and needing to cover them up more, hence wearing skirts over leggings more than previously". The mother seems to have overlooked the fact that in the first email she had advised Dr N that the child had, in fact, already disclosed something in relation to the preceding weekend, namely, that the child had worn skirts whilst spending time with the father, without any apparent issue. Further, the mother appears to have formed an unduly narrow, if not myopic, concern regarding the child's expression of "worry" regarding the "lumps and bumps showing through their clothes". Rather than consider possible alternative explanations for the child's apparent worry, such as that the child was simply a child approaching puberty with all the changes it entails, she at best perceived it, and at worst seized upon it, as confirmatory of gender incongruence or dysphoria on the part of the child.
- In a file note of a telephone conversation on 8 November 2022 (Exhibit ICL-12), noted to be "ahead of review on 10/11/22", in which the mother "wished to provide an update ahead of this review", Dr N recorded a number of matters of which she was informed by the mother, which are of concern to the Court. First, as discussed above, the mother incorrectly advised Dr N that the child had recently attended upon Dr JJ, general medical practitioner, "re: increased distress with dysphoria and growth", when the evidence is that the child, in fact, attended upon a different medical practitioner, in relation to a grazed knee, with no mention of gender issues or distress. Secondly, the mother advised Dr N that she had unilaterally provided gender affirming underpants for the child "which initially seemed helpful but the pressure of fabric lead to erections and extreme distress" (emphasis added). The evidence is that she did so

without having first sought Dr N's advice or the father's consent. Thirdly, the mother advised Dr N that the child had "also stopped swimming and seems a lot more dysphoric about their genitals and worry about approaching puberty" (emphasis added). However, at that stage, the child had not been diagnosed with gender incongruence, let alone gender dysphoria. Fourthly, the mother advised Dr N that she had asked the child about "personal growth, and he [sic] has denied any underarm or pubic hair growth so is unlikely to have started puberty growth but is distressed in anticipation". Fifthly, the mother advised Dr N that the matter had been listed for trial in April 2023 and the note records that "the first step is to obtain permission for referral to a Paediatrician at the [CH GS] [sic]" and that "the child is unlikely to be able to access puberty blockers as soon as required (assumption [the child] may not tolerate genital growth well)". However, at that stage, on the evidence, it was speculative to assume that the child might not tolerate genital growth well and that puberty blockers would, in fact, be required.

- Indeed, when Dr N administered a body image questionnaire to the child on 10 November 2022 (Exhibit F-12), for the first time after nearly three years, Dr N recorded (*inter alia*) that the child was "dissatisfied", as opposed to "very dissatisfied", with regards to eyebrows, penis, testicles and hair, but that the child did not want to talk more about genitals and when asked about any wish to change the appearance of that area if possible, the child "said they did not want to talk about it today". When asked about chest and scrotum, the child responded: "I don't think about it much". In relation to voice, Dr N recorded that the child liked it "the way it is now"; understood that it will change "*if* they progress through (a masculinising) puberty" (emphasis added); and said "I know there are things you can do to stop that". It is therefore clear that, by that time, the child had been led to believe that a masculinising puberty was optional, rather than a foregone conclusion, because there were things that could be done to stop it.

113 In cross-examination, Dr N ultimately conceded, albeit somewhat reluctantly so, that the imminent trial was, at least in part, causative of the diagnosis being undertaken.

114 In the circumstances, I accept that, with the impending trial, there was a concerted rush on the part of the mother to garner evidence in relation to the child's gender identity. Whilst that rush must be viewed in the context of the circumstances, namely, where that would be an

issue at trial, I find that the mother at least distorted some of the child's symptoms in an endeavour to further the outcome she sought at trial. Nevertheless, it is another factor of concern in determining whether, on the balance of probabilities, the child is gender incongruent or dysphoric, as the mother contends, or merely gender fluid or expansive, as the father contends.

115 Another reason for concern regarding Dr N's observations, including as to the relationship between the child and each of the parents, is that she wholly failed to observe the child with the father.

116 I also note the fact that Associate Professor L, or one of her paediatric colleagues at the CHGS, to whom the mother proposes the child be referred, has not seen the child, nor read any of Dr N's clinical notes, nor apparently discussed the child's case with Dr N.

117 Contrary to the evidence of Dr N and Associate Professor L is the evidence of Dr O, consultant psychiatrist and psychotherapist, whose detailed and considered report was annexed to her affidavit filed 11 April 2023. Dr O has clinical experience in treatment of transgender adults, some of whom attend upon her in relation to de-transition and regret. As in the case of the Cass Report generally, Dr O opines that the child's presentation may be attributable to a complex interaction of factors, including external influences, rather than a gender identity which is internal, immutable and innate. Her evidence regarding the potential for misattribution of the presentation of other "symptoms" as gender dysphoria is of concern, for example, the potential for pre-pubescent children who may be experiencing what will emerge to be homosexuality being mis-identified as transgender. In this regard, Dr O said, in the course of cross-examination on behalf of the mother:

> … I'm saying that we might have alternative treatments for gender dysphoria as opposed to … prioritising medical and surgical treatments. Because gender dysphoria in youth can be complex and multifaceted. For example, it can sometimes be a developmental stage that will naturally resolve. It may sometimes be a precursor to later homosexual orientation …
>
> (Transcript 5 June 2024, p 43 lines 35–40)

118 By way of example, Dr O referred to her presentation at the Royal Australia and New Zealand College of Psychiatrists where there was a "lived experience interview" with a man aged 30 years, who had gender dysphoria as a child and had gone through medical and surgical treatment but who thereafter came "to terms that he is a gay man and had a massive amount of internalised homophobia".

119 In cross-examination on behalf of the mother, Dr O referred to studies of pre-pubertal children with gender dysphoria, prior to social transition and medical intervention, as well as studies on gender non-conformity, which she said clearly demonstrated that a high percentage of those children would, in adulthood, not identify as transgender, but be homosexual, albeit that she believed that "the majority settled into being heterosexual". She continued:

> … So the concern is, if people who are going to ultimately be homosexual have a stage of development where they're experiencing gender dysphoria, discomfort with their own body, as this suggests, are they being wrongly, inappropriately, led down a path which leads to medical and surgical interventions, which then, as I say, has quite serious consequences for their lifelong trajectory. … [I]t's interesting, somewhere like Iran which has a death penalty for being gay but permits sex change, and that has to be an option taken … by some people … to avoid a death penalty they undergo transition so then they become a heterosexual couple.
>
> (Transcript 5 June 2024, p. 37 lines 33–44)

120 Dr O raises a number of concerns regarding the diagnostic processes for gender dysphoria generally and, in particular, in relation to Dr N's purported diagnosis of the child. These include, in relation to the child, the absence of a biopsychosocial assessment of the child and of any differential diagnoses or comorbid diagnoses, as well as consideration and discussion regarding the potential risks of social gender affirming treatment. Of particular concern, in this regard, is Dr O's evidence regarding the relevance of, and potential interplay between, comorbid or underlying mental health conditions, which I am not satisfied have been explored by Dr N, or adequately so. In the circumstances, Dr O calls into question whether the child accurately fits the DSM-5 diagnostic description for "clinically significant distress or impairment" and whether this is clearly derived from gender identity issues.

121 It is common ground that the child has socially transitioned. This has been allowed by the mother, albeit with a degree of concern and reticence on the part of the father over time, which I find not to be unreasonably on his part. Dr O opines at paragraph 54 of her April 2023 report that "early social transition may lead to an iatrogenic persistence of childhood gender dysphoria", referring to children who are not socially transitioned and in whom most gender dysphoria/gender incongruence resolved before or while undergoing puberty. The concern is that where social transition occurs early and before diagnosis, as in the case of the child, there is a danger that the social transition can then become used as a diagnostic sign which causes a circuitous result, namely, the child is viewed as having had a consistent and persistent transgender identity because of wearing a dress, as a result of social transition.

122 Dr M is a general paediatrician, an affidavit by whom was also filed by the Independent Children's Lawyer. He deposes that the dominant part of his practice is neurodevelopment disorders, such as autism spectrum disorder and attention deficit hyperactivity disorder and that, as part of his practice, he sees gender non-conforming and gender questioning children. Although challenged on behalf of the mother for not having experience of the gender affirming treatment model and for his criticism thereof, as well as for having communicated with the father by letter on 27 July 2022 (Exhibit M-35), I do not consider his evidence to have been relevantly impugned. In particular, I consider his recommendation to the father in that letter, that the child "be allowed to explore his expression without becoming fixed in any particular box of any particular type of gender identity" to have been perfectly proper, especially in circumstances where the child had then only recently attained the age of nine years. Insofar as Dr M was challenged in relation to his publicly expressed views, that is his expert medical opinion regarding the physiological and psychological damage that medical intervention during puberty, such as medical gender affirming treatment, causes to children. Insofar as he was challenged in relation to his opinion at paragraph 5 of his affidavit that he does "not believe a 10 year old can have a fixed transgender identity", that is his expert medical opinion, in respect of which he was not successfully challenged. Further, insofar as he was criticised for his opinion that "humans cannot change sex" (as opposed to gender), not only is that the physiological reality, but it requires consideration within the context of the entirety of his evidence in this regard, at paragraph 65 of his affidavit:

> [The child] should be supported to express himself [sic] however he [sic] wants, but grounded in reality. Humans cannot change sex. It is not possible for [the child] to be a girl, a woman when he's [sic] older, or a female. He [sic] can only ever be a male, or a male whose body has been medicalised. It should be celebrated that [the child] is a male who refuses to be constrained by current society's expectations of his sex, while at the same time maintaining the reality of that sex. [The child] should be prepared for puberty in that it brings changes and while these changes can be confronting and distressing for many of the human race, it will give him [sic] benefits when he [sic] is older. It is important that the adults in [the child's] life remember that puberty is not a disease, it is a normal developmental stage of humans that brings sexual and reproductive maturity. Avoiding this means [the child] will never reach this stage of maturity.

123 So expressed, I do not consider Dr M's opinions, for which he was criticised by the mother, to be transphobic or ideologically extreme (or, indeed, extreme at all). A distinction is drawn between sex, which is biological, on the one hand, and gender, which is a matter of identity, on the other. A biological male and a transgender female, even one with breast implants and/or a vaginoplasty, have and always will have XY chromosomes. Conversely, a biological

female and a transgender male, even one with a mastectomy and a phalloplasty, have and always will have XX chromosomes. Save for rare chromosomal anomalies, that biological fact is immutable, irrespective of gender identity.

124 In cross-examination, there was the following exchange between counsel for the mother and Dr M, in relation to that paragraph:

> MR McDERMOTT: [Dr M], do I take it from that paragraph that leaving aside the issue of transition from childhood to adulthood, in your view, it's not possible to have what might be called a trans woman, as a matter of reality – is that right, or am I understanding that paragraph incorrectly?
>
> [DR M]: Yes, you're understanding it incorrectly. A trans woman can exist, but a trans woman or a child male who identifies as trans cannot be female.
>
> …
>
> HIS HONOUR: Sorry, sorry. A trans woman can exist?
>
> [DR M]: Yes. I'm not saying trans women don't exist. They exist. They're just not female. They don't change their sex. They're still male.
>
> HIS HONOUR: Thank you.
>
> MR McDERMOTT: And does that have any practical consequences or implications, from your perspective? Why are you raising that particular matter, as part of your opinion?
>
> [DR M]: it's completely relevant to [the child], in terms of any hormone treatments that are given.
>
> MR McDERMOTT: In what sense, Doctor?
>
> [DR M]: Because any body – any male – sorry, any – our bodies are sex based in terms of hormones. So any male body that is given female hormones suffers the consequences of that, and the – the – the vice versa is also true. Any female body that's given male hormones suffers the impacts of that. So our hormones are sex based, and the levels and – of what's normal and what's abnormal are determined by our sex.
>
> (Transcript, 5 June 2024, p.7 lines 9–33)

125 Indeed, in relation to his opinion in his affidavit that "it should be celebrated that [the child] is a male who refuses to be constrained", Dr M explained that:

> … what I mean by that is it's – I don't believe that what anyone wears or anyone – how they have their hair or anything like that is what determines us to be male or female, and, unfortunately, we live in a society with rigid stereotypes that determines that long hair equals female and short hair equals male and clothes determine that, and when you have a male – in particular, I think males who buck that trend – that's quite a brave … thing to do and is not as common as the other way round, I don't think.

126 Dr M was not challenged in relation to this evidence, nor was it put to him, that, by reason of those views, he is transphobic.

127 In the circumstances, I accept the submission of the Independent Children's Lawyer, supported by the father, that there are multiple and compelling reasons to seriously question Dr N's diagnoses and hence the basis for the treatment pathway for the child sought by the mother. Both of her expert witnesses acknowledged the relevant absence of a biopsychosocial assessment of the child and acknowledged that the approach of, and the work proposed by, the father's proposed treater, Dr R, are reasonable. That the mother, after repeatedly hearing this evidence from her own witnesses, continued unreservedly to rely upon Dr N's diagnoses and to reject Dr R's approach, at least implicitly, by not conceding these points and persisting in the cross-examination of the expert witnesses of the father and the Independent Children's Lawyer, raises questions as to her insight and/or her motivations.

128 The diagnosis of gender incongruence/dysphoria is relevant to the treatment pathway proposed by Dr N and Associate Professor L, and sought by the mother to be endorsed by this Court, which I consider below. Dr N holds a firm view, from which she will not (or only very reluctantly) divert, that the child has an established gender identity and that the CHGS' gender affirming treatment, including medical treatment, approach is the only appropriate treatment approach. From the evidence of Dr N and Associate Professor L, the CHGS has a single approach; gender dysphoria, if diagnosed there, is treated with puberty blockers and attendances upon Dr N or one of her colleagues. No alternative treatment options are offered by the CHGS for gender dysphoria diagnosed there, other than prescription of puberty blockers by a paediatrician, such as Associate Professor L. I note that Associate Professor L did not accept the proposition put to her in cross-examination that a referral of a child to a paediatrician within the CHGS would likely lead to medical affirmation in the form of puberty blockers. However, in response to a question by me, Dr N could not identify a single case of a child who had been referred by her, or one of her colleagues, to a paediatrician at the CHGS who had not been prescribed puberty blockers.

129 Section 140 of the *Evidence Act 1995* (Cth) ("the Evidence Act") provides:

> (1) In a civil proceeding, the court must find the case of a party proved if it is satisfied that the case has been proved on the balance of probabilities.
>
> (2) Without limiting the matters that the court may take into account in deciding whether it is so satisfied, it is to take into account:
>
> (a) the nature of the cause of action or defence; and

(b) the nature of the subject-matter of the proceeding; and

(c) the gravity of the matters alleged.

130 In relation to "the gravity of the matters alleged", specified in s 140(2)(c), it is apt to recall what Dixon J stated in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361–362:

> … when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. It cannot be found as a result of a mere mechanical comparison of probabilities independently of any belief in its reality. … it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. …

131 In circumstances where, *inter alia*:

- Dr N did not undertake a comprehensive biopsychosocial assessment of the child, as would be required to properly meet the diagnoses, and therefore the impact of strong maternal influence, or factors such as anxiety, trauma, adverse childhood experiences, possible neurodivergence and societal pressure (such as through HH Service) was not considered;
- there is no proper basis for concluding that the child is experiencing clinically significant distress, the Court having rejected the mother's evidence in relation to what she ultimately asserted to be only one incident of self-harm in 2019;
- there was no observation of the father with the child during the four years the child has attended upon Dr N;
- the mother has been heavily involved in, and attended, all sessions between the child and Dr N and, in the initial questionnaire and meeting, established the narrative that informed subsequent interactions by Dr N with the father (including that he is a perpetrator of family violence), which cast the father in a non-affirming and negative light and influenced, by omission or by commission, the observations of Dr N;
- Dr N's belated and reluctant eventual concession that, although not consistent with her experience, the child's view of gender identity may have been influenced by the mother;

- the father was not even provided with an intake questionnaire or involved in the annual questionnaires, to enable the CHGS to obtain data and feedback from both of the child's parents;
- the mother (without including the father) contacted and primed Dr N before and between each consultation, reinforcing upon Dr N the mother's own view that the child is transgender and suffering from distress and dysphoria; and
- the timing and influence of the then-impending trial on the rush for Dr N to diagnose the child in February 2023 –

taking into account the matters referred to in s 140(2) of the Evidence Act, I am not satisfied that the mother has proved, on the balance of probabilities, that the child is, in fact, gender incongruent or gender dysphoric and/or that Dr N's diagnoses thereof are correct. That is not to say, however, that the child does not exhibit some traits of, or consistent with, gender incongruence or gender dysphoria; even on the case of the father and the Independent Children's Lawyer, the child does so. Rather, on the evidence, given the gravity of the matter, I am not satisfied, to the requisite degree, that the child actually is so and, taking all matters into account, has been properly diagnosed as being so.

132 I note that even Dr U, who prepared a report annexed to an affidavit that was filed on behalf of the mother, and who was not required for cross-examination, opines (at p. 17) that:

> … A comprehensive bio-psychosocial assessment should be undertaken of [the child], considering co-morbidity. However, being diagnosed with a potential additional diagnosis such as [autism spectrum disorder], for instance, would not preclude treatment for gender dysphoria. …

133 Insofar as counsel for the mother submits (at paragraph 5 of the written submissions filed on her behalf) that gender identity is a protected attribute under specific Commonwealth and State laws, on the evidence, and for the reasons herein, I do not accept that the child who, it will be recalled, was aged 10–11 years at trial, has an actual, fixed gender identity yet, as opposed to being gender fluid or gender exploratory. Further, as I have referred to above, at the commencement of the trial, counsel for the mother expressly disavowed any inconsistency or conflict between, on the one hand, the FLA and, on the other hand, Commonwealth and State laws such as the *Equal Opportunity Act 2010* or the *Sex Discrimination Act 1984* (Cth). I do not accept, nor was I referred to any authority, suggestive that this Court's powers under Pt VII of the FLA are in any way so constrained. Rather, I am required to make orders that, in the exercise of the broad discretion conferred upon me, I

consider to be in the child's best interests, taking into account the matters prescribed in s 60CC.

GENDER AFFIRMING TREATMENT – PUBERTY SUPPRESSION

134 In the event I be wrong in relation to my findings regarding Dr N's diagnoses of the child, I turn to consider whether, if the child were, in fact, gender incongruent or dysphoric, gender affirming treatment, and in particular, medical treatment in the form of puberty blockers should be, or be able to be, administered to the child.

135 The mother's evidence is that she has confidence in the CHGS to provide her with accurate information about potential administration of puberty blockers and medical affirmation generally. She said that the aim of the child's attendance at the CHGS is for the child to transition to a transgender female. She considers puberty blockers will be likely for the child but, at this stage, says she seeks for the child to be referred to a paediatrician at the CHGS so that this issue can be fully explored.

136 In cross-examination, the mother said, for the first time, that she was open to another, independent paediatrician, assessing the child, as the father has repeatedly proposed, rather than one at the CHGS, with its gender affirming treatment approach. She conceded, however, that she had never previously responded to his proposals in this respect. She nevertheless maintained that she considered the CHGS still to be the best place for the child. She was unable to explain her change of position and, in the absence of explanation therefor, I infer that it was because she considered it would assist her case, rather than because she truly, albeit belatedly, embraced it.

137 The mother conceded that she has never sought to communicate with a person de-transitioning or re-transitioning, or a person dissatisfied with the CHGS and its gender affirming treatment approach. She also conceded that she has not considered any other ways to treat any distress on the part of the child other than by way of puberty blockers.

138 Key components of gender affirming treatment approach propounded by the CHGS, as identified in the evidence include: acceptance and affirmation of a child's or young person's stated gender identity, without question; facilitation of early childhood social transition; provision of puberty blockers at early puberty to prevent the pubertal changes consistent with biological sex; and possibly the use of cross-sex hormones and, subsequently, surgical interventions in mid-to-late adolescence to align physical characteristics with gender identity.

139 In her first report annexed to her affidavit filed on 13 September 2023, Associate Professor L reports (*inter alia*) as follows:

> 25. Should a young person in Australia be diagnosed with Gender Incongruence of Adolescence, desire access to medical intervention and understand the risks and benefits of this treatment, they should be offered medical care in accordance with the Australian Standards of Care and Treatment Guidelines.
>
> …
>
> 27. These three evidenced-based and peer-reviewed published guidelines make recommendations which include use of pubertal suppression and gender affirming hormone treatment which are associated with improved mental health including recused suicidality …

140 In her second report annexed to her subsequent affidavit filed on 9 February 2024, Associate Professor L reports at paragraph 3(c) that:

> It is my clinical experience that young people who access puberty suppression at the optimal time in early puberty (Tanner stage 2-3) have significantly better mental health outcomes due to the following reasons:
>
> i. they do not have to experience the exacerbation of distress which occurs when a trans young person traverses a puberty that does not align with their gender identity.
>
> ii. They do not experience as much minority stress including the experiences of social isolation, bullying, stigma, and marginalisation due to the physical alignment with their gender identity.
>
> iii. The concordance of the young person s appearance with cisgender peers provides enhancement of physical and psychological safety.
>
> iv. They tend to have supportive parents/guardians as this is required to provide consent for treatment.

141 In her May 2024 supplementary report, Associate Professor L opines at paragraph 37 that the only recommendations of the Cass Review "in relation to the model of care that differ from the care at the RCH are those relating to puberty suppression and gender affirming hormones". In relation to the recommendation of the Cass Review that puberty blockers only be used through a "puberty blocker trial", Associate Professor opines (at paragraph 38) that "[f]orcing a person and their family to be the subjects of a research trial to receive *necessary care and treatment* is considered coercive and unethical" (emphasis added). I consider below whether puberty blockers are, in fact, "necessary care and treatment" for the child. At paragraphs 42–43 of her May 2024 supplementary report, Associate Professor L continues:

> 42. Multiple medical organisations, psychological associations, trans and human rights organisations in Australia have expressed their opposition to the Cass Review and policy decisions which reduce the rights of trans people through denial of access to necessary healthcare. … Internationally, as stated by the

> WPATH and USPATH statement from 17 May, "many countries have reacted critically regarding the Cass Review, disagreeing with its unfounded medical opinion to severely limit the use of puberty-blocking medication and hormone therapy for TGD young people. These countries include Canada, the Netherlands, Belgium, Germany, Austria, Switzerland, and many states in the United States. In Germany, a new guideline on adolescent transgender care has been completed (in collaboration with Austria and Switzerland) and has been approved by 27 professional societies. This guideline does not restrict puberty blockers and will follow the WPATH SOC8 recommendations in its adolescent chapter. The Cass Review appears to be an outlier, ignoring more than three decades of clinical experience in this area as well as existing evidence showing the benefits of hormonal interventions on the mental health and quality of life of gender diverse young people." …
>
> 43. The Cass Review does not look at, nor address, the existing evidence of the harms and the risks to trans children and young people from denial of access to trans healthcare. This includes the known risks of depression, anxiety, self-harm and suicide.

142 Associate Professor L concludes that it is her opinion that "trans people and their families are best placed to know what is in their best interests" (at paragraph 57) and that "the voices of trans people were not valued, nor seen as equal by those who made decisions about the Cass Review governance structure and membership, and its recommendations", which has "resulted in a reduction in the human rights of trans people in England and other parts of the UK" (at paragraph 58). Further:

> 59. Given the known risks of depression, anxiety, self-harm and suicide in trans children and adolescents who cannot access care, closure of services and denial of access to medical care is likely to have significant and life-threatening ramifications for the UK. The political debate that has been exacerbated by reporting on the Cass Review, and the misinformation and disinformation disseminated in the media about trans people and their care, causes further harm and worsens the stigmatisation, discrimination and abuse that trans people experience on a day-to-day basis.
>
> 60. It is my clinical experience that trans children and adolescents who have family support and access to the RCH Gender Service, with integrated, holistic and multidisciplinary psychological support and access to medical treatment when appropriate, thrive. It is my opinion that for the vast majority of these trans children and adolescents it significantly improves their lives and for some, it has saved them from death via suicide.

143 Insofar as Associate Professor L opines that "trans people and their families are best placed to know what is in their best interests", one is left to wonder how that is so, given the complexity of the expert medical evidence adduced in this case. Further, even if that be so, in circumstances where the parents are in disagreement as to what is in the best interests of their child and turn to the Court, it is for the Court to so decide, based on the evidence adduced.

144 Dr N, in cross-examination, conceded that the side-effects of puberty blockers, even when ceased, are not entirely reversible and include ongoing risks to fertility and bone density, which the child, at this age, could not properly understand or appreciate.

145 In relation to the possibility of amelioration of the risks to fertility, Associate Professor L gave evidence that, prior to the administration of puberty blockers, a testicular biopsy could be undertaken to extract sperm. However, if puberty blockers are administered before the onset of puberty, as the mother seeks, there may well be no sperm to extract. Faced with that conundrum, Associate Professor L speculated that the biopsy might remove testicular tissue which could be frozen in the "hope" that medical progress might, in the future, enable use to be made thereof for reproductive purposes, in lieu of sperm. That would appear to be entirely experimental, rather than therapeutic, medicine.

146 In relation to the risks to bone density, Associate Professor L conceded that bone density is accumulated during puberty and that, in the absence thereof, the risk of fracturing in later life is increased.

147 Associate Professor L also conceded that a person's understanding of their gender is partly nature and partly nurture and that it is difficult to unscramble the proverbial omelette. She also opined that, once gender identity is established or expressed in a particular way, although capable of change "in some circumstances", "it's very difficult to change" and, somewhat contradictorily, "trying to change one's gender identity is not actually possible" (Transcript 29 May 2024, p.14 lines 26 and 31). However, as I have found above, given the gravity of the implications thereof, on the whole of the evidence, viewed globally, I do not accept that the child is, in fact, gender incongruent/dysphoric nor, therefore, that the child's gender identity is established; rather, at this stage in life, the child is gender fluid, exploratory and/or expansive, as contended by the father and the Independent Children's Lawyer.

148 The mother relies (at paragraph 9 of her written submissions), *inter alia*, on what was the official position of the Australian Psychological Society as at 12 September 2019, in a media release entitled "[Australian Psychological Society] Refutes 'Social Contagion' Arguments" (tendered on her behalf and marked Exhibit M-29), namely, that "[a]s a professional organisation committed to evidence-based practice, the [Australian Psychological Society] opposes any forms of mental health practice that are not affirming of transgender people". However, that was over five years ago; much proverbial water has passed under the bridge since then, including the Cass Report in 2024 and, as Dr R said in cross-examination (which

evidence is uncontroverted), this statement is under review. Accordingly, I place little weight upon the official, but possibly, if not probably, outdated position of the Australian Psychological Society.

149 Central to my determination of the issues in this case are: what are the risks (if any) of gender affirming treatment, in particular, puberty blockers; and whether there are any reasonable alternative treatment approaches.

150 In cross-examination, Associate Professor L broadly accepted that there was no clinical consensus as to the use of puberty blockers (or cross-sex hormones), but maintained that, within "particular expert groups", there is consensus (Transcript 29 May 2024, p. 11 line 20). Nevertheless, she agreed that there is a clear debate regarding the appropriate care for a transgender child, she being positioned on one side of that debate. I have already made findings in relation to whether or not this child is, in fact, gender incongruent or dysphoric, and they do not bear repetition again here.

151 The evidence of Dr O, which was not substantially impugned, and which I accept, includes the following:

- Given both the lack of evidence and expert consensus regarding gender affirming treatment, youth gender dysphoria should be viewed as an area of medicine where there is genuine scope for debate about treatment options. Treating clinicians should clearly explain, in an unbiased manner, to parents and children, the benefits and harms, the uncertainties and the available alternatives.
- The risks posed by medical (and surgical) gender affirming treatment include risks to fertility, sexual function, bone health, brain development, cardiovascular function and carcinogenesis, as well as the risks of being a lifelong medical patient and of later regret.
- One of the risks of puberty blockers and cross-sex hormones identified by Dr O is because of findings that over 95 per cent (albeit that Dr M, in his report, opines that it is 98 per cent) of children commenced on puberty blockers progress to cross-sex hormones. She opines that it is doubtful that puberty blockers may be best viewed as a "pause button" that merely allows a child more time to consider their options; rather they may "lock-in" a child to ongoing gender dysphoria and progression to cross-sex

hormones, by impeding the usual progress of sexual orientation and gender development.

- Puberty blockers, especially when given at the earliest stages of puberty, which the child in this case has not even reached, followed by oestrogen/cross-sex hormones (which, she opines, would be the likely trajectory), lead to infertility and sexual dysfunction. In this scenario, there is no capacity for fertility preservation (because of lack of mature sperm production) and the extent of later reversibility of this infertility is unknown. In addition, the lack of genital growth caused by puberty blockers (followed by oestrogen), means such child will have a "micro-penis" because the penis will not develop with puberty, it having been blocked. Such child, progressing into teenagerhood, will have the underdeveloped penis of a younger, pre-pubescent child. If Stage 3 genital surgery is undertaken, there is a risk of surgical complications, as well as difficulty in constructing a vagina of sufficient depth and width from such a micro-penis. Further, whether or not surgery is undertaken, there is a high, and even possibly inevitable, risk of sexual dysfunction, especially anorgasmia. Dr O also opines that another important risk to highlight is that of later regret/de-transition.

152 It is submitted on behalf of the mother that, whilst Dr N was cognisant, and not critical, of the father's specific concern as to the risks associated with sexual dysfunction in later life arising from medical affirmation, she nevertheless referred, in cross-examination, to children and young people, as they grow older, engaging in different forms of risk-taking and complex decision-making. Whilst that might be so, including in cases where the parents are *ad idem* or unaware, it is an entirely different matter where, for example, the risk possibly, or proposed, to be undertaken is the subject of parental disagreement and a justiciable controversy.

153 Dr O proposes another avenue for gender dysphoric/incongruent youth other than gender affirming medical treatment, namely, developmentally informed and holistic psychotherapeutic approaches. She reports at paragraphs 68–74 of her April 2023 report:

> 68. There are a range of contemporary psychotherapeutic approaches that are being provided to [gender dysphoric] youth as alternatives to [gender affirming treatment]. It is important to note that psychotherapeutic approaches, although well-evidenced for other psychological conditions, in this condition are, as is [gender affirming treatment], based on a limited evidence-base. More research into efficacy is required. Such approaches include: Careful assessment and diagnostic formulation, appropriate treatment of co-existing psychological conditions,

supportive/exploratory/educative psychological care, family and group therapy, developmentally informed gender exploratory psychotherapy, trauma-informed psychotherapy, and a non-promotion of early childhood social transition (sometimes labeled [sic] under the umbrella term of "watchful-waiting," which should not be interpreted as "doing nothing").

69. A common theme of all these approaches is that they view youth [gender dysphoria/gender incongruence] as complex and multifaceted. For example, [gender dysphoria/gender incongruence] may sometimes be a developmental stage that will naturally resolve; and/or may sometimes be a precursor to later homosexual orientation; and/or it may sometimes be a secondary psychological phenomenon arising from a complex interaction of biopsychosocial factors (genetics, [autism spectrum disorder], attachment patterns, ACE, social/medical influence); and/or it may sometimes emerge as part of a complex psychiatric presentation; and/or it may sometimes be "true trans" (as the Dutch describe it) largely viewed as an innate and immutable gender identity that does not align with sex and is viewed as largely independent of the effects of environment (although, there is little knowledge of etiology).

70. A psychotherapeutic process can lead to increased understanding of an individual's [gender dysphoria/gender incongruence] and help enable true informed decision-making regarding social and medical transition options. Such a holistic therapeutic process takes time, requires intense engagement, and should not be rushed. Therapy needs to be individualized, be developmentally and context dependent, and will likely include elements such as: a) Empathy and understanding of a child's experiences and distress; b) the development of coping skills and managing emotional distress (e.g., cognitive-behavioral [sic] therapy, mindfulness therapy); c) suicide risk management; d) support of children in their gender variance/non-conformity, but not a premature encouragement/affirmation of a cross-sex identity; e) "gender-work" which involves exploring and developing the child's understanding of the complicated biopsychosocial nexus of 'biological sex–gender–sexuality/sexual orientation–psyche–body'; f) education regarding social, medical and surgical transition and alternative options to managing GD; g) development of an understanding of the relationship between gender dysphoria and any mental health conditions/autism/ACE/trauma/sexual orientation/family and social issues; h) realistic discussion of pros and cons of early versus delayed transition; i) flexible and open attitude to outcome in terms of sexuality and gender as the child grows and matures.

71. As a recent Westmead Children's Gender Service publication has stated:

"To provide adequate care, clinicians need to understand and confront the complexity of the clinical presentations. They need, in particular, to use a broad, holistic, systemic (i.e., biopsychosocial) framework that takes into account the full range of interacting factors— social, economic, relational, family, psychological, and biological—that have defined the life circumstances of the child and the family seeking care for gender dysphoria." "Some families—but also some clinicians—function within a non- holistic (non-biopsychosocial) framework where the child's developmental experiences are disconnected from their clinical presentation. This non-holistic framework is likely to promote a healthcare delivery model that dehumanizes the child (by not examining the child's and family's lived experience) and that promotes medical solutions (correcting the identity/body mismatch) for a problem that is much more complex. Third, as

noted earlier, our experience suggests that, insofar as the gender affirmative model is taken as equivalent to medical intervention, clinicians (including ourselves) who work in gender services are coming under increasing pressure to put aside their own holistic (biopsychosocial) model of care, and to compromise their own ethical standards, by engaging in a tick-the-box treatment process. Such an approach does not adequately address a broad range of psychological, family, and social issues and puts patients at risk of adverse future outcomes."

72. One benefit of utilizing psychological treatment approaches is that it gives the child time to mature and be able to provide their own true informed consent for complex social and medical interventions that have life-long consequences. It may be that delaying social and medical intervention, rather than causing irreparable pain for the rest of life, as some suggest, might come to be appreciated and understood by the young person as that the adults wished to protect them from premature irreversible decisions that might later be regretted. It might be that later in life they appreciate, whatever gender identity they are, that they have fertility and sexual function. These are not fanciful ideas – there are young detransitioners who are now speaking up about wishing the adults had said "No," [sic] and that they had received adequate psychotherapy instead of [gender affirming treatment]. They feel deep grief and distress about the [gender affirming treatment] they were permitted to undertake in their youth. There are also adult transpeople who report being glad they transitioned later in adulthood, and sometimes after having children. Even if the young person decides at an age of maturity, when they have the capacity to give informed consent, to transition, it may be that they are pleased that given the gravity of the decision, it was theirs to make and not one to be made on their behalf or by themselves when they were too young to fully comprehend the decision. These are all possibilities, rather than the simplistic view that delaying social and medical transition is an inevitable pathway to worse mental health and social functioning outcomes.

73. An approach that prioritizes psychological approaches and delays medical/ surgical treatments does not have the adverse risk profile that do medical and surgical treatments, especially when implemented in youth.

74. These possible benefits need to be weighed against the main risk of delayed medical transition, which is undergoing undesired pubertal physical changes and, especially for biological males, the greater difficulties of later achieving, if one wants, the desired cosmetic outcome of a more feminine appearance.

(Footnotes omitted)

154 At paragraphs 76–81 of her April 2023 report, Dr O considers whether, in particular, the parents and the child in this case are likely to obtain from the CHGS paediatricians, such as Associate Professor L, accurate and comprehensive answers to the questions raised by her in relation to gender affirming treatment which, she opines, would be necessary for true informed consent from the parents (and assent by the child) and when considering the child's views for the purposes of s 60CC(3)(a) of the FLA.

76. My discussion in preceding sections of this report raises several important points relevant to the answer to this question. First, my observation is that

there is a tendency for [CHGS] [sic] clinicians to overstate the certainty of the evidence, to underplay risks and to dismiss the possibility of alternative treatments …. Second, the [CHGS] [sic] has an ideological commitment to [gender affirming treatment], which it single-mindedly promotes. Third, [Dr N's] report, although brief, indicates her clinical practice/discussions with [the child] and parents follows this ethos. All this suggests that [the child] and parents are not receiving/and will be unlikely to receive accurate information from [CHGC] [sic] clinicians to enable them to make true informed treatment decisions.

77. I hold further concerns. First, with-in clinic [CHGS] [sic] communications encourage social transition and exclusively focus on glowing accounts of youth who have been "empowered" to transition … Such communications may act as a type of covert pressure on the clinic's young patients to transition ....

78. Second, in [State S], children, parents and clinicians are subject to powerful messages from the [CHGS] [sic] and a range of other agencies. For example, it is inaccurately implied that if parents do not affirm their child's stated gender identity or permit [gender affirming treatment] then their child is at high risk of suicide. Claims are made to the effect that parents who do not support their child's social transition or oppose their child's attendance at a gender clinic or do not consent to [puberty blockers] are acting violently and putting their child "at risk," (which implies notification to child protection services may occur), or that they are guilty of illegal conversion practises.

79. The [CHGS] [sic] clinicians describe that their "individualised approach" involves following the child's lead, but the communications I have just described must make us consider whether, in reality, it is more the case of the child following the [CHGS]'s [sic] lead, both by with-in clinic communications and by the [CHGS]'s [sic] advertising/promotion of [gender affirming treatment] to media, parents, schools, mental health agencies, other health professionals and policy makers.

80. All these types of issues mean that it is important to consider the impact that influence and coercion might have on the capacity of a minor or the parents to give assent/informed consent. This is especially important in a situations which involve vulnerable minors and their families, who might be presumed to be at particular risk of being unduly influenced or coerced by prestigious physicians and powerful institutions, especially where there is a marked power differential, and when such influence and coercive elements extend beyond the clinic (via media, social media, support groups, regulatory agencies, podcasts and various publications).

81. In sum, these issues raise important questions to which, in my opinion, the Court needs to give careful consideration. Given the [CHGS] [sic] ethos, it would seem unlikely that true informed consent, from the parents and assent from [the child] will be able to occur. First, because the [CHGS] [sic], appears to not be providing and is not likely to provide the necessary accurate, unbiased, and comprehensive information regarding the uncertainties and the harms of [gender affirming treatment], nor realistic information on possible alternative treatments. Second, because elements such as influence, and coercion are likely to be undermining [the child's] and parents' capacity to provide true informed consent.

(Footnotes omitted)

155 Having regard to the evidence adduced by the mother, in particular that of Dr N and Associate Professor L and, for example, the ASCTG, I accept the evidence of Dr O and agree with her concerns, which I share.

156 Dr O's expert recommendation is that the child be assessed by a private psychologist for consideration of whether individual psychological therapy could be of benefit. She envisages that this therapy would differ from that at the CHGS, as it would not be solely based on a single model of gender affirming treatment but, rather, would seek to explore and expand the child's self-understanding, as well as helping to manage distress, including distress about puberty onset. She recommends that such a therapeutic process be more intensive than that which the child has hitherto received (and would continue to receive) at the CHGS. She considers it essential that the child have individual sessions, rather than with a parent present. She reports (paragraph 82 of the April 2023 report):

> … Such a therapeutic approach would hold a perspective that gender is embedded in a broader matrix of many elements of [the child's] life and seek to understand the complex ways these may relate to each other. It would also explore, educate, and inform [the child] about future medical and non-medical options and pathways. Such a therapy would keep an open and neutral perspective regarding future gender identity and sexual orientation, knowing that this will likely become clearer over time with therapy and with the growth, development and maturation of mind, brain, and body.

157 The Cass Report states (at paragraph 14.4) that the practice of pausing puberty was initially based on a theory, the rationale for which was that pausing puberty early would help young people to "pass" better into adulthood and "extend the diagnostic period" by buying time to think.

158 The authors of the Cass Report observe (at paragraph 14.5) that "[i]t may appear surprising that the novel use of a drug for this purpose did not require a more rigorous drug trial". They explain (at paragraph 14.6) that GnRH hormones (referred to as puberty blockers in the treatment of young people) have undergone extensive testing for use in precocious puberty, which they note to be "a very different indication from use in gender dysphoria", and which have met strict safety requirements to be approved for precocious puberty. However, they note (at paragraph 14.7) that the situation for the use of puberty blockers in gender dysphoria is different, in that "they are blocking the normal rise in hormones that should be occurring into teenage years, and which is essential for psychosexual and other developmental processes".

159 The Cass Report notes (at paragraph 14.13) that most international guidelines in relation to the use of puberty blockers for gender dysphoria emphasise full reversibility as a justification for their use, whilst highlighting potential adverse effects on bone health and uncertainty regarding cognitive development. It is also noted (at paragraph 14.15) that there is considerable variation about the criteria for starting puberty blockers, with the most common being "the presence of gender dysphoria that has emerged or worsened at puberty".

160 In relation to the intended benefits, the Cass Report states (at paragraph 14.25) that the data suggests that "puberty blockers are not buying time to think, given that the vast majority of those who start puberty suppression continue to masculinising/feminising hormones, *particularly if they start earlier in puberty*" (emphasis added).

161 Insofar as it is submitted on behalf of the mother (at paragraph 21) that "[Dr N] has **not** opined that puberty blockers **must** be administered to [the child], rather that [the child] be given the option of discussing treatment with a paediatrician in the context of the diagnosis she steadfastly maintained" (emphasis in original), two matters arise. First, I have already found that I do not accept the accuracy or reliability of that diagnosis to the standard of proof required by s 140 of the Evidence Act. Secondly, I am not satisfied on the evidence that, no matter how mature this 11-year-old child (or, indeed, any 11-year-old child) might be, such a child could properly discuss, and understand, the ramifications of treatment with puberty blockers.

162 Returning to the Cass Report, generally consistent with the expert evidence adduced by, and the case put on behalf of, each of the father and the Independent Children's Lawyer, it states at paragraphs 14.36–14.37:

> 14.36 Adolescence is a time of overall identity development, sexual development, sexual fluidity and experimentation.
>
> 14.37 Blocking this experience means that young people have to understand their identity and sexuality based only on their discomfort about puberty and a sense of their gender identity developed at an early stage of the pubertal process. Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered.

163 A further concern reported by the Cass Report (at paragraph 14.38) is that –

> … adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on

the young person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences.

164 In relation to the impact on subsequent genital surgery, the Cass Report states (at paragraphs 14.41–14.42):

> 14.41 If puberty suppression is started too early in birth-registered males it can make subsequent vaginoplasty (creation of a vagina and vulva) more difficult due to inadequate penile growth. In some transgender females this has necessitated the use of gut in place of penile tissue, which has a higher risk of surgical complications.
>
> 14.42 A recent paper suggests that for transgender females it is recommended to wait until Tanner Stage 4 to allow adequate penile growth for vaginoplasty.
>
> (Citations omitted)

165 In relation to other physical health impacts of puberty blockers, the Cass Report records (at paragraphs 14.43–14.44):

> 14.43 Multiple studies included in the systematic review of puberty suppression found that bone density is compromised during puberty suppression, and height gain may lag behind that seen in other adolescents. However, much longer-term follow-up is needed to determine whether there is full bone health recovery in adulthood, both in those who go on to masculinising/feminising hormones and those who do not.
>
> 14.44 The same is true of other short-term physical effects of puberty suppression, with little knowledge about whether it leads to any long-term effects, such as on metabolic health and weight.
>
> (Citations omitted)

166 In relation to prolonged exposure to puberty suppression, the Cass Report states (at paragraph 14.45):

> 14.45 Puberty suppression was never intended to continue for extended periods, so the complex circumstances in which young people may remain on puberty blockers into adulthood is of concern. In some instances, it appears that young adults are reluctant to stop taking puberty blockers, either because they wish to continue as non-binary, or because of ongoing indecision about proceeding to masculinising or feminising hormones. For others, there may have been a delay in adult services taking over their care.

167 It is helpful to set out the Cass Report's summary in relation to puberty blockers.

> 14.46 There are many reports that puberty blockers are beneficial in reducing mental distress and improving the wellbeing of children and young people with gender dysphoria, but as demonstrated by the systematic review the quality of these studies is poor.
>
> 14.47 The Review has heard that the widespread claims that puberty blockers reduce the risk of death by suicide in this population may place pressure on families to obtain private treatment.

…

14.49 The University of York systematic review found no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support.

14.50 It is important not to lose sight of the fact that hormonal surges are a normal part of puberty and are known to lead to mood fluctuations and depression, the latter particularly in girls.

14.51 It is not unexpected that blocking these surges may dampen distress and improve psychological functioning in the short-term in some young people, but this may not be an appropriate response to pubertal discomfort.

14.52 Conversely, a known side effect of puberty blockers on mood is that it may reduce psychological functioning. This variability in individual response to predicted physiological effects is reflected in the secondary analysis of the GIDS early intervention study.

14.53 The very strongly held beliefs amongst some young people and parents/carers that puberty blockers are highly efficacious may be attributed to a number of factors:

- the support for this position in published papers and from some clinicians working in the field
- signposted information and advice provided to children, young people and their families on the perceived benefits, including on social media
- the fact that puberty blockers have come to be seen as the entry point into and start of a transgender treatment pathway
- a lack of information about the limitations of the evidence base
- the lack of other options offered to address symptoms of distress and bodily discomfort.

14.54 The focus on puberty blockers and beliefs about their efficacy has arguably meant that other treatments (and medications) have not been studied/developed to support this group, doing the children and young people a further disservice.

14.55 Studies should evaluate whether simple measures such as stopping periods with the contraceptive pill have the potential to manage immediate distress, as well as other more conventional evidence-based techniques for managing depression, anxiety and dysphoria. None of these alternative approaches preclude continuing on a transition pathway, but they may be more effective measures for short-term management of distress.

…

14.57 For transgender females, there is benefit in stopping irreversible changes such as lower voice and facial hair. This has to be balanced against adequacy of penile growth for vaginoplasty, leaving a small window of time to achieve both these aims.

(Citations omitted)

168 The Cass Report concerningly concludes, in this regard, at paragraph 14.58:

> In summary, there seems to be a very narrow indication for the use of puberty blockers in birth-registered males as the start of a medical transition pathway in order to stop irreversible pubertal changes. Other indications remain unproven at this time.

169 In its "Summary and Recommendations", the Cass Report states, *inter alia*, the following relevant matters (at paragraph 13), which are generally consistent with, and corroborative of, the evidence adduced by, and the case of, the father and the Independent Children's Lawyer:

- Young people's sense of identity is not always fixed and may evolve over time.
- Whilst some young people may feel an urgency to transition, young adults looking back at their younger selves would often advise slowing down.
- For some, the best outcome will be transition, whereas others may resolve their distress in other ways. Some may transition and then de/re-transition and/or experience regret.
- There remains diversity of opinion as to how best to treat these children and young people. The evidence is weak and clinicians have reported that they are unable to determine with any certainty which children and young people will go on to have an enduring transgender identity.
- Current understanding of the long-term health impacts of hormone interventions is limited and needs to be better understood.

170 Further, and relevantly for present purposes, the Cass Report, in its "Summary and Recommendations", also reports, *inter alia*, as follows:

> 36. There are different issues involved in considering gender care for children and young people than for adults. Children and young people are on a developmental trajectory that continues to their mid-20s and this needs to be considered when thinking about the determinants of gender incongruence. An understanding of brain development and the usual tasks of adolescence is essential in understanding how development of gender identity relates to the other aspects of adolescent development.
>
> …
>
> 39. Pragmatically the above explanations for the observed changes in the population are all likely to be true to a greater or lesser extent, but for any individual a different mix of factors will apply.
>
> …
>
> 58. Although a diagnosis of gender dysphoria has been seen as necessary for initiating medical treatment, it is not reliably predictive of whether that young person will have longstanding gender incongruence in the future, or

whether medical intervention will be the best option for them.

…

65. The central aim is to help young people to thrive and achieve their life goals. The immediate goal of the care and treatment plan must be to address distress, if this is part of the child/young person's presentation, and any barriers to participation in everyday life (for example, school community or social activities).

66. For the majority of young people, a medical pathway may not be the best way to achieve this. For those young people for whom a medical pathway is clinically indicated, it is not enough to provide this without also addressing wider mental health and/or psychosocially challenging problems such as family breakdown, barriers to participation in school life or social activities, bullying and minority stress.

…

69. In addition to treating co-existing conditions, the focus on the use of puberty blockers for managing gender-related distress has overshadowed the possibility that other evidence-based treatments may be more effective. The intent of psychosocial intervention is not to change the person's perception of who they are, but to work with them to explore their concerns and experiences and help alleviate their distress regardless of whether or not the young person subsequently proceeds on a medical pathway.

…

74. There are different views on the benefits versus the harms of early social transition. Some consider that it may improve mental health for children experiencing gender-related distress, while others consider that it makes it more likely that a child's gender dysphoria, which might have resolved at puberty, has an altered trajectory potentially, culminating in life-long medical intervention.

…

76. The systematic review showed no clear evidence that social transition in childhood has any positive or negative mental health outcomes, and relatively weak evidence for any effect in adolescence. However, those who had socially transitioned at an earlier age and/or prior to being seen in clinic were more likely to proceed to a medical pathway.

77. Although it is not possible to know from these studies whether earlier social transition was causative in this outcome, lessons from studies of children with differences in sexual development (DSD) show that a complex interplay between prenatal androgen levels, external genitalia, sex of rearing and sociocultural environment all play a part in eventual gender identity.

78. Therefore, sex of rearing seems to have some influence on eventual gender outcome, and it is possible that social transition in childhood may change the trajectory of gender identity development for children with early gender incongruence.

…

81. The systematic review undertaken by the University of York found multiple

studies demonstrating that puberty blockers exert their intended effect in suppressing puberty, and also that bone density is compromised during puberty suppression.

82. However, no changes in gender dysphoria or body satisfaction were demonstrated. There was insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychosocial wellbeing, cognitive development, cardio-metabolic risk or fertility.

83. Moreover, given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinising/feminising hormones, there is no evidence that puberty blockers buy time to think, and some concern that they may change the trajectory of psychosexual and gender identity development.

84. The Review's letter to NHS England (July 2023) advised that because puberty blockers only have clearly defined benefits in quite narrow circumstances, and because of the potential risks to neurocognitive development, psychosexual development and longer-term bone health, they should only be offered under a research protocol. This has been taken forward by NHS England and National Institute for Health and Care Research (NIHR).

85. The University of York also carried out a systematic review of outcomes of masculinising/feminising hormones. Overall, the authors concluded that "There is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow-up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health. There is suggestive evidence from mainly pre-post studies that hormone treatment may improve psychological health, although robust research with long-term follow-up is needed".

86. It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion.

87. The percentage of people treated with hormones who subsequently detransition remains unknown due to the lack of long-term follow-up studies, although there is suggestion that numbers are increasing.

…

90. When clinicians talk to patients about what interventions may be best for them, they usually refer to the longer-term benefits and risks of different options, based on outcome data from other people who have been through a similar care pathway. This information is not currently available for interventions in children and young people with gender incongruence or gender dysphoria, so young people and their families have to make decisions without an adequate picture of the potential impacts and outcomes.

…

98. Assessing whether a hormone pathway is indicated is challenging. A formal diagnosis of gender dysphoria is frequently cited as a prerequisite for accessing hormone treatment. However, it is not reliably predictive of

> whether that young person will have longstanding gender incongruence in the future, or whether medical intervention will be the best option for them.
>
> 99. In addition, the poor evidence base makes it difficult to provide adequate information on which a young person and their family can make an informed choice.
>
> 100. A trusted source of information is needed on all aspects of medical care, but in particular it is important to defuse/manage expectations that have been built up by claims about the efficacy of puberty blockers.
>
> 101. Although young people often express a sense of urgency in their wish to access medical treatments, based on personal experience some young adults have suggested that taking time to explore options is preferable. The option to provide masculinising/feminising hormones from the age of 16 is available, but the Review would recommend an extremely cautious clinical approach and a strong clinical rationale for providing hormones before the age of 18. This would keep options open during this important developmental window, allowing time for management of any co-occurring conditions, building of resilience, and fertility preservation, if required.
>
> 102. The overarching conclusion from the evidence presented in this Review is that the puberty blocker research protocol, which is already in development, needs to be one part of a much broader research programme that seeks to build the evidence on all potential interventions and determine the most effective way of supporting these children and young people.

171 The concerns raised in the Cass Report, which was tendered into evidence by the mother, is generally consistent with, and corroborative of, the expert evidence adduced by the father and the Independent Children's Lawyer. The Cass Report was an "[i]ndependent review of gender identity for children and young people" in the United Kingdom, "commissioned by NHS England to make recommendations on the questions relating to the provision of these services as set out in the terms of reference" (Cass Report at p.16) and the Cass Report was "independent of the NHS and Government and neither required nor sought approval or sign-off of this report's contents prior to publication" (Cass Report at p.17). The independence of the Cass Report was not challenged by the mother and, as I have recorded above, with respect, I do not accept the speculative comments by the trial judge in *Re Ash* at [167] and [170].

172 In *Re Ash*, it was observed at [48], as apparent "difficulties" with the Cass Report, that:

> … Neither the chair, Dr Cass, nor any review team members, were called to give evidence, and hence the review's conclusions could not be directly tested. Indeed, a significant foundation of the review, a systematic literature review by York University, could not be directly tested, as none of its authors were called either. …

173 I perceive no such difficulty nor, it would seem, did counsel for the mother, who tendered the Cass Report as evidence in her case. It is simply part and, in the circumstances, I consider, an

important part, of the general body of evidence in this case. Whilst Associate Professor L and Dr N disagreed with aspects thereof, no part of the Cass Report to which I refer, and upon which I rely herein, was successfully impugned by their evidence. Further, the Cass Report is relevantly consistent with the evidence of, *inter alia*, Dr O, Dr M and Dr R, whose evidence I accept. Therefore, insofar as the judge in *Re Ash* said at [51] that it was not his "role to determine if the Cass Review is sound or flawed", I respectfully disagree in this case. The final report of the Cass Review is in evidence before me and, in the circumstances in which it was tendered, without objection, I consider it to be qualitatively no different to any other piece of evidence, and it has not been suggested otherwise. Although in evidence because it was tendered by consent, it is, in a sense, qualitatively analogous to a business record tendered pursuant to the relevant provisions of the Evidence Act, the author of which is not, and is not required to be, called to give evidence. The evidence is before the Court and the weight to be accorded thereto is matter for the trial judge.

174 However, insofar as the judge in *Re Ash* continued at [51] that it was not his role to determine "if, *as a general proposition*, gender affirmation of adolescents by medicalised intervention is wise or not" (emphasis added), I respectfully agree. Not dissimilarly to my observations elsewhere herein, his Honour said at [20], albeit in relation to Stage 2 cross-sex hormones:

> … Notwithstanding the fact that from the very outset I informed the parties that I would not permit the trial to be run as a kind of Royal Commission into the administration cross-sex hormones to adolescents, sadly this direction was only partially heeded and hearing ballooned from just four days, to 15.

175 His Honour further said at [51]:

> … In the instant case, because his parents cannot agree, my task is simply to decide what to do about Ash, on the unique facts of his life. This is no test case, and it will not establish any general precedent, no matter what I decide.

176 My task is no different, albeit that, on the evidence, I come to a diametrically opposite conclusion.

177 In relation to puberty blockers, Dr M's evidence, which was not substantially, let alone successfully, challenged in cross-examination is that it is well documented in gender clinics across the world that 98 per cent of children and adolescents who commenced puberty blockers progress on to gender affirming hormone therapy with oestrogen or testosterone. Contrary to this being a "pause" or "time to think", he refers to evidence that "this concretes or consolidates a gender identity confusion that would otherwise resolve with the progression of puberty" (at paragraph 36 of his affidavit).

178 Concerningly, the evidence of Dr M is as follows:

> 46. If [the child] was to commence puberty blockade this would most likely commence at Tanner Stage 2. This is the stage of puberty in boys when the testes first start to enlarge indicating the onset of puberty. Tanner Stage 1 is pre-pubertal.
>
> 47. These injections of GnRH agonists (such as Lucrin) would arrest [the child's] body at this physical development stage. We know that **almost all children who commence puberty blockers progress onto gender affirming hormones**. This means [the child's] body would be arrested at this physical development stage of Tanner Stage 2 for the rest of his life.
>
> 48. [The child's] penis will never grow or mature.
>
> 49. His [sic] testes will remain in an early puberty state. He [sic] will not develop or produce sperm. **He will be sterile**. Fertility preservation will not be possible because sperm production only occurs in the latter stages of puberty.
>
> 50. Because his [sic] penis will never mature he will have no sexual function. The President of WPATH, Dr Marci Bowers, who is transgender and a surgeon who performs genital surgeries on males, states that all of the males who have been puberty blocked at Tanner Stage 2 **are unable to reach orgasm**.
>
> 51. [The child] will likely develop relative thinning of the bones due to lack of increase in bone density that occurs during puberty. This requires close monitoring and treatment, something [the child] would not need if he [sic] went through puberty.
>
> 52. There are unknown effects on the development and maturation of the brain. [City K Children's Hospital] has only recently employed a PhD candidate to study possible effects despite blocking children's puberty for several years.
>
> 53. If [the child] progresses onto oestrogen, he [sic] will have a significant increased risk of cardiovascular disease (stroke, heart attacks) and male breast cancer. This includes a 7-fold increase in ischaemic stroke, a 6-fold increase in heart attacks, a 5-fold increase in pulmonary embolism (blood clot to the lungs) and a 46-fold increase in breast cancer risk (although it remains rare overall.)
>
> 54. If [the child] desires surgery when older to create a replication of a vagina (a "neovagina") there will not be enough penile and scrotal tissue to be used for inversion, so a segment of bowel will likely be used. This surgery has high complication rates. In the original Dutch cohort, one of the original 70 patients died following complications of this surgery, due to necrotising fasciitis …
>
> 55. There are also unknowns due to the lack of long-term data on puberty-blocked children when they grow up, but [the child] will be a medical patient for the rest of his [sic] life to manage these knowns and unknowns. No children's gender clinic, including those studying the original Dutch cohort, has produced any long-term data on outcomes of puberty blockade and cross sex hormone treatments. [City K Children's Hospital] Gender Clinic has not produced any long-term data on the patients it has treated.

(Citations omitted) (Emphasis in original)

179 Evidence was also adduced by the Independent Children's Lawyer from Mr CC, who was not required for cross-examination and whose qualifications and evidence are therefore unchallenged. He is a clinical child psychologist, of nearly two decades standing, with a research, teaching, and clinical specialisation in the fields of autism spectrum disorder, specific learning disorders, gender diversity and gender dysphoria, "LGBT [sic] support", child maltreatment, attachment disorders and therapeutic foster care. He deposes to providing holistic assessment and individualised support and intervention for children and adolescents with gender dysphoria and gender incongruence.

180 In particular, I take into account, and place weight upon, his evidence that:

- The presentation of gender identity as innate, internal and immutable is fundamentally contested by a significant number of experts in the field, including those with direct treating experience with gender diverse and gender questioning children.
- There is growing concern and disquiet among experts about the appropriateness and effectiveness of the medical gender affirming treatment model of CHGS.
- The notion that medical treatments alleviate gender dysphoria in children is simplistic. Medical treatments are not required to affirm a person's gender identity and they do not systematically reduce dysphoria in the mid-to-long-term.
- Whilst medical gender affirming treatment is "one possible treatment pathway", it may be a suboptimal option for natal males who seek future surgical intervention in the form of penile inversion (vaginoplasty).
- The complexities of these issues can only be informed by detailed assessment of data, evidence-based diagnostic clarity, impartial psychoeducation for young people and their caregivers and a non-biased supportive stance that does not commit to an "essential" treatment pathway *a priori* of the young person's maturation and development.
- In terms of optimal clinical support for a transgender girl, open discussion of puberty, sexual maturity, sexual diversity and strategies to maintain identity, but also to experience puberty through to later stages, are important factors to support optimal body transition options if gender affirming surgery is a preferred option in later life stages.

181 Dr R, a clinical psychologist called by the father, provided a more balanced, holistic approach than that contended for by the mother, Dr N and Associate Professor L. She said in cross-examination, in respect of which she was not successfully challenged, and which I accept, that she does not believe that, at the age of 11 years or until sexual maturation, the child could have a concrete (as opposed to abstract) understanding of sexuality and sexual functioning, such as to properly understand the long-term ramifications of gender affirming treatment, in particular, puberty blockers. She opined that puberty and ensuing sexual experience need to be experienced by children and that gender identity can reconcile with biological sex in puberty. She said that, with the onset of puberty, the child might come to experience a penis as being not merely functional, for the purpose of urinating, but as a source of sexual pleasure.

182 As opposed to the unquestioning gender affirming approach of the CHGS (including medical affirmation), Dr R, upon whom the father proposes (and the Independent Children's Lawyer agrees) that the child should attend, opines that, although working with children and adolescents with gender incongruence/dysphoria is a specific area of practice, the overall processes for therapy more broadly are similar across all areas of psychological practice. Accordingly, when providing services to children, she opines that psychological practice must also consider additional factors, such as family and socio-cultural context, as well as developmental issues, such as brain-development, brain-based skills and abilities, and key developmental tasks. Her approach to therapy for children and young people, as a therapist who has been working with children, adolescents, adults and families (including those with gender, sexual and neuro diversities) for over 25 years, is comprised of four phases which, she reports, "are common to all evidence-based psychological practice" (at paragraphs 7–8 of her letter dated 14 August 2023 annexed to her affidavit). These are the assessment phase, the formulation phase, the intervention phase and the review phase. She states (at paragraph 6):

> My overall approach to therapy is cross-theoretical and feedback informed. Using a cross-theoretical framework, no one theoretical model is adopted or privileged over another prior to the commencement of therapy. Rather the presenting issues, and the needs of each individual client and their family are used to determine which approaches are most likely to be beneficial to them.

183 Dr R said that if, after appropriate broad testing, the child is found to be dysphoric, treatment should be directed to alleviating the distress between the child's biological sex and gender identity. She does not consider such treatment, which she undertakes, to constitute "conversion therapy" or otherwise to breach the Change or Suppression (Conversion)

Practices Prohibition Act, nor does she consider affirmation of gender identity to require medical treatment, relevantly, puberty blockers.

184 Neither Dr N, nor Associate Professor L, considered Dr R's approach to be unreasonable when specifically put to them in cross-examination. I find that Dr R was measured and commendably balanced in her approach and presented a viable and appropriate alternative "next step" for the child. Although Dr R is based in City KK, and therefore requiring some use of electronic sessions (noting the father's preparedness to take the child to City KK from time to time if required), the benefits to the child of her more open-minded approach and, indeed, her open approach, outweigh the tyranny of distance, certainly in the post-COVID-19 era, where the use of electronic communication has become far more widespread, routine and familiar, including in this Court. Indeed, whilst Dr R understandably expressed a preference to work with children and young people "in person wherever that's possible", her evidence is that she does see clients living interstate via telehealth. She will undertake what, quite remarkably, has not yet been undertaken, namely, a biopsychosocial assessment of the child, as a first or early step in the process.

185 As for the father's other witness, Dr Q, I place no weight upon her evidence, which was marred by demonstrations of such a strength of alignment to a particular approach, including by the use of emotive language, as to render her evidence of little use.

186 I consider that, *inter alia*, findings of the Cass Report, the expert evidence of Dr R, Dr O and Dr M and the limited concessions made by Associate Professor L, with respect to the overlapping potential for differential of attribution of symptoms, all combine to underpin the need for these factors to be considered as part of the diagnostic process.

187 I am not satisfied that, given the current levels of symptoms or distress expressed or manifested by the child, even if gender incongruent or dysphoric, the purported benefits of puberty blockers outweigh the identified risks thereof. I do not accept that the child's desire for puberty blockers can be determinative, or even of significant weight, given, not only the child's age but, equally so, the concessions by Dr N that the information given to the child thus far was "rose tinted" (Transcript 28 May 2024, p. 51 line 31) and by Associate Professor L that this could influence the child's desire for such treatment (Transcript 30 May 2024, p.20 lines 1–5). Further, on the evidence, I do not accept that the child, at this age and pre-pubertal stage in life, can properly understand the implications and potential risks of puberty blockers. The Independent Children's Lawyer submits, and I agree, that the answers given by

Associate Professor L on this issue were internally flawed and circular. Whilst, in relation to risks to fertility, she conceded that sperm production is reduced by puberty blockers, she dismissed this as being a long-term concern, because ability to produce sperm will return if they are ceased after short-term use. Even if that be the case, the evidence is that the vast majority of children continue with this treatment and progress to Stage 2, after which sperm production would not recommence.

188 I do not accept the evidence of Dr N in the January 2024 report at paragraph 95 that should the child "be denied an opportunity to access treatment with puberty blockers, she [sic] will be at heightened risk of increased gender dysphoria and a decline in her [sic] general mental health". The evidence, including that of Dr O, Dr M and Dr R, which was not substantially undermined in cross-examination by counsel for the mother, is that there are other acceptable, if not more acceptable, avenues open to the child.

189 In the circumstances, I conclude that, even if, contrary to my findings above, the child were gender incongruent or gender dysphoric, given the evidence regarding the risks, balanced against the alleged benefits, of puberty blockers (as well as Stage 2 treatment, namely, the administration of cross-sex hormones), I would not, as between the parties, permit the child to continue gender affirming treatment at the CHGS (or elsewhere) and, in particular, Stage 1 medical treatment. It is of considerable concern that, notwithstanding the weight of the evidence, including, but not limited to, the Cass Report, the CHGS continues to represent to parents and children that puberty blockers are fully reversible and relatively risk-free and yet, through practitioners such as Dr N and Associate Professor L, to concede the lack of evidence to support that position.

190 I refer, in particular, to the evidence of Dr N that no child or young person who has been diagnosed with gender dysphoria by, and has asked for puberty blockers from, the CHGS, and has supportive parents, has ever been refused. Not dissimilarly, Associate Professor L said that almost all such children, if referred to a paediatrician at the CHGS, would be provided with the treatment. Further, the evidence is that, once on puberty blockers, such a child or young person is between 95 and 98 per cent likely to progress to cross-sex hormones. This supports the argument that the CHGS is, in fact, essentially a single medical pathway once Stage 1 hormone treatment commences. The risks, not only of Stage 1 treatment, but also of future infertility, sexual dysfunction, inability to orgasm or have any sexual pleasure, inherent in Stage 2 treatment, cannot be ignored. I also have regard to the evidence in relation

to the likely pain and trauma for the child, as an adult, in the event of a later change of mind and wish to de-transition. It is inconceivable that the child could, at present, truly comprehend what would be placed at risk and potentially, if not likely, forgone if a decision were made, at this stage, to embark on a medical gender affirming treatment pathway.

191 Rather, I accept the expert opinion of Dr M (at paragraph 63 of his report) that –

> … the most likely best strategy for [the child] would be to give him [sic] time to breathe, to allow life to settle in his [sic] visitation pattern, to not push nor deny any expression, to not seek treatment or information on a condition/state that [the child] may or may not have that may or may not eventuate into something more formative. Both parents should avoid [the child] being "boxed in" to any identity. It is possible that ongoing engagement with [City K Children's Hospital] Gender Clinic and its affirmative nature could serve to concrete [the child's] alternate gender identity that might otherwise desist if left to live life without influence of gender affirmation.

192 After the close of evidence at trial, but before closing submissions in this matter, in *Re CD* [2024] VSC 456, the Supreme Court of Victoria in late July/early August 2024, upon application by the CH, determined that one parent of a 12-year-old child could unilaterally authorise Stage 1 treatment, in the absence of consent of the other parent. However, in that case, the other parent was absent from the child's life, there were no family law orders, particularly no orders varying parental responsibility (such as imposing equal shared parental responsibility) and the father was not a party to the Supreme Court proceedings. Unlike in this Court, there was no Independent Children's Lawyer. Further, there was no contradictor or contradictory evidence in the Supreme Court. It is unclear why the CH chose, or shopped for, that forum, rather than this Court, when this Court's *parens patriae* jurisdiction has been long established: *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218 at 225. In other circumstances, that decision might, at best, be persuasive authority; in this case, it is entirely distinguishable on the facts. However, of relevance to this case and of concern generally, is the fact that no mention whatsoever was made in *Re CD* of the then recently released Cass Report. One is left to speculate why the Cass Report was apparently not brought to the attention of the Supreme Court by the RCH, which was the applicant in those proceedings. The Supreme Court proceeded upon uncontroverted evidence, as follows (at [12]):

> CD's treating clinicians strongly recommend that she commence stage 1 puberty blocking treatment using gonadotrophin releasing hormone analogues (GnRHa). This treatment halts the progression of the physical changes that come with puberty, but is reversible and may be stopped at any time. The clinicians say that undertaking stage 1 treatment will provide CD with both immediate psychological relief, and additional time to explore her gender identity before making decisions about the use of other

> "stage 2" hormonal treatments, such as oestrogen. Her paediatrician's opinion is that CD is likely to remain stable in her female gender identity, in which case she will also derive long term benefit from having had GnRHa treatment to prevent unwanted and irreversible masculinisation during puberty. If she later becomes unsure about her gender identity, she can stop the treatment.

193 The Supreme Court proceeded upon the basis that Stage 1 treatment for gender dysphoria is no different to any other medical treatment, such as childhood vaccinations, surgery to mend a broken bone, or chemotherapy to treat cancer, to which a parent may consent (at [38]). Given the evidence in this case, the benefit of which the Supreme Court did not have, I disagree with those analogies.

194 Rather, given the far more extensive evidence in this case, including evidence contradictory of the evidence before the Supreme Court in *Re CD*, which I accept, I conclude, as I must, by reason of the preceding decisions of the Full Court, that whilst "the legal requirements for consent to stage 1 treatment for gender dysphoria are no different from those that apply to any other medical treatment to which a parent may consent" (*Re CD* at [38]), Stage 1 treatment is qualitatively different to childhood vaccinations, surgery to mend a broken bone or chemotherapy to treat cancer. It may be that, by reason of what was described by Watts J in *Re Imogen* as the "emerging debate about the diagnosis and treatment of Gender Dysphoria", including in the aftermath of the Cass Report, the Full Court may, in the future, see fit reconsider the categorisation in *Re Jamie* of Stage 1 treatment as being reversible and not attended by grave risk if a wrong decision is made, such as to fall within the wide ambit of parental responsibility and not require court authorisation. That is a fact (and a relevant one), not a criticism.

195 In *Isles & Nelissen* (2022) 367 FLR 338, the Full Court, comprised of Alstegren CJ, McClelland DCJ, Aldridge, Austin and Tree JJ, considered the issue of "unacceptable risk" and the distinction between fact finding and risk assessment.

196 The Full Court said:

> 1. Long ago, in parenting proceedings characterised by one parent's allegation that the other had sexually abused their child, the High Court of Australia ("the High Court") emphasised the distinction between two very different things: on the one hand, proving alleged sexual abuse according to the civil standard of proof and, on the other, establishing the risk of the feared sexual abuse occurring in the future: (*M v M* (1988) 166 CLR 69).
>
> …
>
> 4. In relation to the second question pertaining to risk, the High Court said (at 77-78):

> " … [T]he court must determine whether on the evidence there is a risk of sexual abuse occurring if custody or access be granted and assess the magnitude of that risk. … [T]he test is best expressed by saying that a court will not grant custody or access to a parent if that custody or access would expose the child to an unacceptable risk of sexual abuse."

…

> 7. *M v M* put beyond doubt the proposition that courts exercising jurisdiction under Pt VII of the *Family Law Act 1975* (Cth) ('the Act') must protect children from credible risks of harm due to sexual abuse. Such risks, like all prospective events, are capable of classification in only one of three mutually exclusive categories: possibilities, probabilities, or certainties. Once it is accepted courts should (and do) react to dangers in the form of risks of harm which may merely be possibilities, it is an oxymoron to expect such possibilities to then be forensically proven on the balance of probabilities according to the civil standard of proof. By definition, possibilities are not, and could never be, probabilities. Risks of harm are not susceptible of scientific demonstration or proof (*CDJ v VAJ (No 1)* (1998) 197 CLR 172 at [151]), but are instead postulated from known historical facts and present circumstances.

197 At [53], the Full Court said that "while conjecture about the future is based on historical facts and circumstances, it is only the relevant historical facts which need be proven on the balance of probabilities". Here, I have made factual findings, on the balance of probabilities, in relation to gender affirming treatment and, in particular, medical treatment; my conjecture about the future for the child must be based on those facts.

198 At [56], the Full Court continued:

> It is trite but true to observe that the law is as the High Court states it to be, so the principles enunciated in *M v M* about "unacceptable risk" were woven into the fabric of family law in instances of alleged actual and prospective child sexual abuse. The Full Court later extended such principles to cases involving allegations of children being at risk of physical or emotional harm for other reasons (*A, In Marriage of* (1998) 146 FLR 188 at [3.14]-[3.15] and [3.24]).

199 At [85], the Full Court said that the "assessment of risk is an evidence-based conclusion and is not discretionary" and that:

> … The finding about whether an unacceptable risk exists, based on known facts and circumstances, is either open on the evidence or it is not. It is only the overall judgment, expressed in the form of orders made in the children's best interests, which entails an exercise of discretion. That discretionary judgment is influenced by the various material considerations enumerated within s 60CC of the Act, of which the evidence-based finding made about the existence of any unacceptable risk of harm is but one.

200 The Full Court continued at [86]:

> We have already acknowledged how risks of harm are not susceptible of empirical proof, but a mathematical hypothetical will nevertheless illustrate how findings of

> "unacceptable risk" cannot be measured by the civil standard of proof. Imagine a child will be minded by one of three randomly allocated carers. Assume one of the carers would sexually abuse the child, but the other two would not, meaning the child stands a 33.33 per cent chance of being sexually abused if left in care. No sensible adult would take the risk of leaving the child in care because, even though the prospect of sexual abuse is only *possible* but not *probable*, the risk is still too high to tolerate. In other words, it is unacceptable. If parents (and courts) were to instead only react to risks which are probabilities then, in that example, the child would still be left in care unless shown he or she was susceptible to sexual abuse by two of the three carers and the risk was then rated at 66.66 per cent.
>
> (Emphasis in original)

201 I have made findings about the risks posed by gender affirming treatment and, in particular, likely medical treatment. To adopt, for illustrative purposes, the mathematical hypothetical propounded by the Full Court in *Isles & Nelissen*, even if there were only a 33.33 per cent chance of the child being harmed by puberty blockers, I consider that no sensible person would take the risk of putting the child in that situation because, even though the prospect of harm would only be possible, as opposed to probable, the risk is too high to tolerate and is, therefore, unacceptable.

THE APPLICANT MOTHER

202 In the Family Report prepared by Ms LL in November 2021 ("the first Family Report"), she opined (at paragraph 33) that, in relation to the involvement of the mother and the child with the local support group for LGBTQI+ people, HH Service, the mother's "acceptance into a marginalised and disempowered subculture probably provided her with [a] sense of belonging". In the January 2024 report, Dr N opines (at paragraph 37) this to be "some criticism of [the mother] seeking out such supports" and that the mother "does not present as a parent who receives any benefit from supporting her transgender child". However, from the evidence, it does appear that the mother herself does derive benefit from involvement with HH Service and that she has little, if any, social interactions with people outside of that group or, more broadly, her local LGBTQI+ community.

203 Similarly, Dr BB, who prepared a psychiatric assessment of the mother in September 2021, recorded, in relation to the mother's self-reported interests, activities and hobbies, that she was "involved in the local gender [HH Service] [sic] regarding gender identity … and enjoys meeting people through the [HH Service] [sic]". Dr BB described the mother as being "closely aligned to the transgender movement" and being "strongly convinced of [the child's] identity as a female, and was further supportive of [the child] engaging in hormonal blocking treatment in the context of forthcoming puberty which in her view can begin as early as the

age of 9". I note that, at this stage, the child had not been diagnosed with gender incongruence/dysphoria and, accordingly, could not engage in puberty blockers which the mother nevertheless said she supported and, in the circumstances, baselessly so. Similarly, Dr BB referred to the mother having been "heavily involved with a variety of transgender groups" and appearing "strongly of the view that [the child's] ultimate gender destination was that of a female".

204 Dr BB reported, in relation to the mother, that she "was largely humourless with restricted affect, leads an isolated existence, is estranged from her parents, is closely aligned to the transgender movement, and is a member of the local gender [HH Service] [sic]" and that she "identifies as an abused woman".

205 Further, he opined that, having assessed the mother, he "was left with significant reservations as to her application for sole parental responsibility, particularly in the context of [the child's] treatment and management as a child with gender dysphoria in which matters of consent are critical".

206 I similarly have significant reservations, all the more so in circumstances where, contrary to the mother's representations to Dr BB, the child had not then been diagnosed with gender incongruence or dysphoria. In oral closing submissions, Senior Counsel for the Independent Children's Lawyer was critical of the mother and, on the evidence, I consider, appropriately so, for exploring gender incongruence/dysphoria on the part of the child prior to diagnosis, thereby influencing, if not pre-empting, the diagnosis, as I have found to be the case. Further, it was submitted, and I agree, that the mother has used the child's fluidity and alleged (but, I have found, unproven) gender dysphoria/incongruence in an endeavour to distance, if not alienate, the child from the father. This is made out, in part, by the fact that the child's gender, said to be innate and immutable, was not in issue in the prior proceedings between the parents, culminating in the 2018 parenting orders, but has been the central plank of her case in these subsequent proceedings.

207 Dr BB also reported at paragraph 5 that he –

> … was left with significant reservations in regard to [the mother's] ability to support the relationship between [the child] and his [sic] father … and in my view her application for sole parental responsibility belies her true feelings and motivations to reduce contact between [the child] and [the father] and his part in [the child's] life.

208 The contention, on the part of the father and the Independent Children's Lawyer, that the mother derives benefit herself from involvement with HH Service and that she has little, if

any, social interactions with people outside of that group or, more broadly, the LGBTQI+ community, was clearly on the cards in this case. The mother was the only lay witness in her case and did not adduce any evidence from any relatives or friends which might have disabused me of that impression and given me a different impression or insight into her life. Dr BB was not required for cross-examination, notwithstanding his evidence to which I have referred.

209 In her first Family Report, Ms LL described the mother as speaking "quietly and in a monotone voice" and that the mother "while not unpolite, was not engaging either" (paragraph 19). Further, she opined that the mother's account was "unbalanced and at times confusing" and that the "overall picture portrayed by [the mother] was that of [the child] existing in an unsafe world only she could help them [sic] navigate". Those observations are consistent with my observations of the mother at trial. I note however, that in her second Family Report dated 17 February 2023 ("second Family Report"), Ms LL reported that the mother's presentation was "somewhat different" and she "appeared more forthcoming in support of her claims, displayed a greater range of affect and engaged reasonably well" (paragraph 8).

210 I am cognisant that, albeit in an appellate context, it has been observed, as in *Fox v Percy* (2003) 214 CLR 118 at 128-129 (per Gleeson CJ, Gummow and Kirby JJ), that:

> 30. It is true, as McHugh J has pointed out, that for a very long time judges in appellate courts have given as a reason for appellate deference to the decision of a trial judge, the assessment of the appearance of witnesses as they give their testimony that is possible at trial and normally impossible in an appellate court. However, it is equally true that, for almost as long, other judges have cautioned against the dangers of too readily drawing conclusions about truthfulness and reliability solely or mainly from the appearance of witnesses. Thus, in 1924 Atkin LJ observed in *Société d'Avances Commerciales (Société Anonyme Egyptienne) v Merchants' Marine Insurance Co (The "Palitana")* (1924) 20 Ll L Rep 140 at 152:
>
> " … I think that an ounce of intrinsic merit or demerit in the evidence, that is to say, the value of the comparison of evidence with known facts, is worth pounds of demeanour."
>
> 31. Further, in recent years, judges have become more aware of scientific research that has cast doubt on the ability of judges (or anyone else) to tell truth from falsehood accurately on the basis of such appearances. Considerations such as these have encouraged judges, both at trial and on appeal, to limit their reliance on the appearances of witnesses and to reason to their conclusions, as far as possible, on the basis of contemporary materials, objectively established facts and the apparent logic of events. This does not eliminate the established principles about witness credibility; but it tends to reduce the occasions where those principles are seen as critical.

(Footnotes omitted).

211 However, in *Government Insurance Office (NSW) v Bailey* (1992) 27 NSWLR 304 at 313, Kirby P said:

> By conventional theory, the observations made by a trial judge of the appearance and demeanour of a witness giving evidence are not only available to be used in the determination of a dispute but amount to important ingredients of the decision-making process. They normally provide the primary decision-maker a distinct advance which controls, and even limits, the exercise by the appellate court of its statutory functions in an appeal by way of re-hearing …

212 Although Kirby P was in dissent as to the outcome of that appeal, Clarke JA and Hope AJA did not disagree with the general principles stated by his Honour.

213 My observations of the mother's demeanour in the course of cross-examination, which accord with those of Dr BB in his interview with her, are not for the determination of, for example, her credit, which I can determine independently thereof; rather, they are, as Kirby J remarked "important ingredients of the decision-making process". In considering, *inter alia*, with which of the parents the child should live, I take into account, as an ingredient in my decision-making process, Dr BB's and my observations that the mother "was largely humourless with restricted affect" and contrast it with the open, warm and loving demeanour that the father and his partner, Ms V, conveyed in the course of their cross-examination.

214 Insofar as the mother reported to Ms LL in the first Family Report, referring to the child and her, that "when it's just the two of us [the child] is completely free to be whoever they want to be" (at paragraph 22), given the preponderance of the evidence referred to herein, I do not accept that. Even if that be the mother's genuinely held view, I find it to be a distorted one. Whether intentionally or otherwise, I find that she has endeavoured and, to some extent, unfortunately succeeded to mould the child into the person and, in particular, the gender, that she desires.

215 Ms LL reports (at paragraph 23) that the mother's "efforts to ensure [the child] is 'free' have included identifying the school best able to support [the child's] gender expression" and that she regards the child's current school "as supportive of diversity and gender-affirming". Whilst it cannot be gainsaid that the child's exploration of gender identity should be supported, this is further confirmatory of what I consider to be the mother's over-emphasis of the child's gender, rather than a more balanced approach of simply letting this child be a child, with much self-discovery in store including, but certainly not limited to, gender identity and sexual orientation.

216 Insofar as the mother told Ms LL that she sought sole parental responsibility because she "didn't want [the child's] well-being continually compromised by ideological battles between their parents about minor issues that resulted in major conflicts" (paragraph 24), that is more descriptive of the mother, than the father.

217 In her second Family Report (at paragraph 12), Ms LL notes the mother having reported "the school and Trans community have been embracing and supporting of [the child's] preferences". Insofar as the school is concerned, that is to be welcomed. However, insofar as the transgender community is concerned, that is unsurprising.

218 The evidence gives rise to a number of concerns regarding the child whilst in the mother's primary care preceding trial. The mother leads a circumscribed and isolated existence, with little or no contact with her family of origin, and a limited (if any) social life beyond the confines of her local LGBTQI+ community, notwithstanding that she does not identify as being LGBTQI+ herself. In particular, she and the child have become immersed in the local transgender support group, HH Service, which largely consists of older children, who are further along, and more entrenched in, their transgender "journey" than this young child, as well as those children's "affirming" parents.

219 The mother has engaged in a number of restrictive "gatekeeping" practices which, I find, were intended to, and had the effect of, minimising the father's involvement and time with the child. These were comprised of allegations of family violence by the father which, on the evidence considered elsewhere herein, I do not accept; her instigation of a "blood type diet" without any medical foundation or advice; and her insistence that the child is a transgender child, requiring medical treatment, who is entirely unsupported by the father. She provided a secret mobile telephone for the child to contact her surreptitiously whilst in the father's care, signalling to the child that the child might not be safe, and might need her, whilst in his care.

220 The negative effect of this is well exemplified by the following episode, regarding which the mother deposed in her affidavit filed 27 February 2023 (at paragraphs 48–50):

> 48. [The child] again attended for time with the father in June 2019 pursuant to the Orders. On the first night at 7:18pm [the child] secretly telephoned me in a highly distressed state. They begged me to come and get them and to bring them home because they *"weren't safe"*. I asked [the child] why they were so upset, and they told me that they didn't know. I told [the child] that unless I knew what was wrong or that it was an emergency, I couldn't collect them. They told me that *"it is an emergency"*. I managed to calm [the child] down however remained very concerned for [the child's] welfare as this was the first time that they had called me in such a distressed state from their father's

house before.

49. Following this visit I was extremely concerned at [the child's] mental state and the escalation in conflict between [the child] and the Father. On the advice of [MM Service] and [NN Service], I applied for an extension and variation of the Intervention Order protecting myself and [the child] against the father. That application was heard at the [...] Magistrates [sic] Court [in] June 2019 and a full exclusion interim order was made for [the child] and myself with the usual exception as to compliance with parenting orders. The matter was further listed for mention [in] September 2019 and the interim order in favour of [the child] and myself was maintained until the Final Hearing of the matter [in] March 2021 when as referred to herein, it was extended for a further period of two years.

50. Given my concerns as to the father's reaction when served with the varied interim order, [the child] and I moved to a refuge for a period of two weeks with the assistance of [NN Service]. [NN Service] further assisted with the installation of CCTV cameras at my house and the repair of a broken window lock.

(Emphasis in original)

221 On the mother's own evidence, the child "secretly" rang her, using the secret mobile telephone provided by her. The child was unable to proffer any reason to the mother for being in a "highly distressed state", for not feeling "safe", or for being "so upset", nor any explanation of what the supposed "emergency" was. At most, she clarified in cross-examination, the child said: "someone's coming", without identifying, or being able to identify, who the person was. This was the first time the child had called her in such a supposedly distressed state from the father's home. Rather than seek clarification from the father, she turned to MM Service and NN Service for advice, which was apparently to apply for an extension and variation of an intervention order "protecting [her]self and [the child] against the father". However, in the absence of any explanation by the child, or clarification from the father, it is entirely unclear why further "protection" might be warranted. In the result, a "full exclusion interim order" was made for the child in June 2019 and the matter was listed for mention in the Magistrates' Court in September 2019. She deposes that, notwithstanding her entirely unparticularised "concerns as to the father's reaction when served with the varied interim order", the child and she moved to a refuge for a period of two weeks with the assistance of NN Service. All of the mother's conduct in this regard, from the child's telephone call through to admitting the child and herself into a refuge was, I consider, at best, an extreme and unwarranted overreaction and, at worst, an endeavour to set the scene in her favour in these proceedings.

222 The mother has engaged over many years in co-sleeping with the child, thereby increasing the child's dependency on, and any distress at being separated from, her.

223 She has unilaterally, and single-mindedly, focused upon the child's gender issues, without any real consideration of whether they may be attributable to a factor or cause other than, or combined with, gender incongruence/dysphoria, even prior to purported diagnosis by Dr N. This includes her unilateral acquisition and provision to the child of gender affirming clothing, such as the restrictive underwear, without discussion with, and the consent of, the father or any expert advice, in complete disregard of any possible resultant effect upon, or injury to, the child's penis and testicles, notwithstanding her evidence that the purpose of such evidence was to flatten the genital bulge. However, in cross-examination, she conceded, that at the time of their purchase, there were no signs of pubertal penile growth, as the child had not entered puberty. She also conceded that, not only had such underwear not been recommended by the CHGS, but that she had bought it after hearing about it from other parents at HH Service. When the father eventually became aware of the gender affirming underwear, and questioned her about it, she replied in an email (about which she remained unapologetic at trial), asking him what was his "actual concern re the underwear" and how it had come to his attention. In cross-examination, however, the mother conceded that, notwithstanding the father's concerns regarding the underwear, as well as a padded bra that she had procured for the child, all without consultation with, or consent by, him, he had nevertheless not sought to stop the child from wearing them. I consider that to corroborate, in part, the father's case that he has abided by the child's social transitioning, instigated by the mother. I do not need to determine, for present purposes, whether he was correct in doing so.

224 The mother's evidence is that she provided a gender workbook (referred to above) to the child, and that he spent hours working on it. Notwithstanding that it was entirely blank when produced upon a call for production, thereby exposing her lie, I nevertheless place weight on this as evidence of her single-minded endeavour to achieve the end sought by her. In her care, a secret female name for the biologically male child was devised, and she refused to disclose it to the father. Indeed, years later, the father only first learnt of it when she was required to disclose it in the witness box at trial. She alleged suicidal ideation and self-harm on the part of the child, which I find not to have occurred, and she could not, or would not, contemplate any innocuous alternative explanations therefor.

225 In the course of her evidence, over five days, the mother was reluctant, if not unable, to make any concessions favourable to the father, or to concede that any of her actions, whether in relation to the child's equivocal gender identity or the gatekeeping practices implemented by her, have had a detrimental impact on the child. I find that they have done so.

THE RESPONDENT FATHER

226 I find the father to be a considered, attuned and sensitive parent, well able to promote the emotional and physical safety, as well as the health and psychological well-being of the child. He was a calm, careful and reflective witness, able to admit mistakes, child focused and, at times, teary and emotional when talking about the child. He conveyed a warm and affable personality, even under the stress of cross-examination. He was not overly critical or cruel in his comments about the mother. He appeared saddened, rather than angry, by her accusations of family violence against him and the effect of them upon his ability to spend time with the child, notwithstanding the immense and sustained pressure that it caused him over several years.

227 He has not sought to prevent the child's social affirmation, instigated by the mother, albeit that he has belatedly, apparently by reason of the evidence in this case, become aware of the possibly negative implications thereof, as a possible precursor to medical affirmation. It was conceded by the mother that, when in his care, including when sending the child to school, the father has not prevented the child from wearing gender affirming underwear and female clothes, including dresses, skirts, "skorts" (an item of traditionally female clothing, being a combination of skirt and shorts) and leggings, as well as a gender-neutral school uniform. Further, the father has abided by the mother allowing the child to grow long hair, worn with hairclips or in a ponytail. He has abided by the child using female pronouns, albeit that the evidence suggests considerable equivocation by the child in this regard over time. Any reticence in this regard on the father's part, I find, has not been due to any *mala fides* or "anti-transgender" sentiment but, rather, his proper concern that the child simply be allowed to be a child, without being guided in a particular direction, and/or his understandable concern for the child, such as to not be bullied or teased at school.

228 Unlike the mother, who is convinced that the child is a transgender child, the father is more open-minded and does not seek to pigeon-hole the child in any way. Rather, he wishes to let the child be a child and, with the passage of time and maturation, to grow into whatever the child is or wishes to be – whether transgender, cisgender or otherwise. His evidence did not

convey a sense of an ideological approach; rather, that of a loving parent who is content for the child to engage in exploration before any potentially dangerous steps are undertaken later in life, the implications of which are presently beyond the child's comprehension. In relation to the issue of gender identity, he said in cross-examination that "it's not something the child needs to decide now", there being less invasive and risk-laden alternatives than gender affirmative treatment, with the high likelihood of puberty blockers in the first instance. Those alternatives include therapy of the kind proposed by Dr R. However, he said, quite understandably, that in an ideal world, the child would just "get on with life", without even the need for such therapy. He may be overly optimistic in this regard, after the child's past four years in the care of the mother and the CHGS.

229 In his affidavit filed 2 February 2024, at paragraph 62, the father deposes that, in his primary care, the child would be provided with, *inter alia*:

- A safe, happy and healthy lifestyle, with genuine support from Ms V and himself.
- Appropriate support in relation to the child's gender expression and questions, with encouragement for open conversations with the child regarding the child's thoughts and feelings as the child grows older and enters adolescence. He would be proactive in obtaining support for the child from health professionals, such as Dr R and Dr M and other appropriate practitioners, as the child grows older to assist the child in talking openly about feelings, childhood and gender exploration. The father would ensure the child sees professionals who operate with a broad approach, rather than attend the CHGS which is focused on gender affirming treatment and medicalisation.
- His ongoing support in the child's relationship with the mother and for any anxiety and concerns the child may have as a result of a change of residence to the father's house.
- Relief from the pressure and anti-social behaviour that the child has been exposed to whilst in the mother's care.
- Exposure to the child's extended family, which comprises, *inter alia*, the child's paternal and maternal grandparents, uncles, aunt and various cousins.
- A comfortable living environment with the child's own bedroom and bathroom. The father's house in Suburb J is within walking distance to parkland, public transport, local schools, cafes, a market, a lawn bowls club and shops.

- An increased social life and exposure to celebrations, such as Christmas, and activities that the child has enjoyed whilst spending time with the father, including swimming, diving, boating, picnics, a community garden, skating, scootering, and spending time with family and friends. However, in relation to Christmas, I note that the father (like the mother) does not seek any specific orders in relation thereto, and it will lie where it falls during the child's time with each of them.
- A supportive education at local schools, such as B School and C School, both of which are said to be above average in rankings. The father has spoken with and inspected both. His house is zoned so that both schools would be able to accommodate the child's enrolment. From his research and discussions with the schools, he considers that they have "healthy and traditional values in a contemporary society such as respecting elders, using manners and treating everyone as equals". The principals there apparently understand the type of gender journey that the child is on and have advised they have a no uniform policy, so as to allow children to express themselves, among other supports and activities, such as vegetable gardens, bands, choirs, performing arts, languages, the science, technology, engineering and mathematics education program, a focus on being involved in the community and onsite animals. The father deposes that, if the child were to commence a new school, the child's friendships from FF School would still be able to be maintained through extra-curricular activities and weekend catch-up activities.

230 In the written closing submissions filed on the father's behalf, it is submitted that the father can offer the child the following benefits, which are related both to protection from abuse and harm, as well as the facilitation of a meaningful relationship with both of the child's parents. These are (at paragraph 12):

> a. a childhood filled with many diverse experiences during which [the child] can explore developmentally normative interests and friendships (for example a family snorkelling holiday in [State T], a coding program for children);
>
> b. a psychologically robust parent-child relationship that is neither based on the parent's needs nor placing the child in the role of caretaker of the parent;
>
> c a parent-child relationship that is not strengthened by nor predicated upon the child's rejection of the other parent;
>
> d. permission to and endorsement of the child loving both parents simultaneously;
>
> e. reduced stress and anxiety around diet, dress and gender identity;

f. a less isolated home life;

g. activities that are not focused on gender identity or only undertaken with older children whose basis for friendship is that they are gender questioning or gender transitioning;

h. a peaceful and stable home environment with less emphasis on 'fixing' [the child], and visits to hospitals and health professionals to do the same;

i. a childhood which is not centred around pathologizing any behaviour [the child] may exhibit from time to time such as preferring to dress in traditionally feminine coloured clothing or allegedly 'self-harming';

j. a home environment in which [the child] is not the constant centre of attention;

k. an example of a loving and functioning relationship between two responsible and working adults (the father and [the child's] stepmother, Ms [V]); and

l. a meaningful relationship with [the child's] extended paternal family members including the paternal grandparents and cousins.

(Footnotes omitted).

231 Taking into account the evidence holistically, including not only his evidence in chief and in cross-examination, but also that of Ms LL in her Family Reports, I accept those submissions.

232 Having listened to, and observed, the father in the course of his oral evidence, I found him to be responsive, authentic and considered. He conveyed a caring personality, and his love for, and knowledge of, the child was manifest, notwithstanding the restrictions sought to be placed upon that knowledge by the mother. He was able to make appropriate concessions when challenged about past decisions, for example, his opposition to the child being immunised against COVID-19 in early 2022. He demonstrated that his application, the subject of this judgment, had been carefully considered. This was best emphasised when he was questioned about how he would approach the issue of a change of residence with the child. It was manifest that he had thought about the consequences of a change of residence at length and profoundly. He explained that the secondary school proposed by him for the child has a biology program which will be very appealing to the child, given the child's interests. He said that he would explain to the child that a change of primary school in grade six, to a local City K primary school, would be in preparation for the move to that secondary school, both located in the vicinity of where his partner and he reside. He said he hoped that this would be able to be conveyed to the child as a decision that both parents had decided would be best for the child. Unfortunately, I am not confident that the mother will be able to join with the father in so explaining a change of schools to the child.

233 In contrast to the mother, Dr BB reported of the father that:

> … At interview, I found [the father] to be a straightforward, direct man who impressed clearly as wanting to play a significant role in [the child's] life. spoke lovingly of [the child] throughout the interview, and was supportive of [the child's] relationship with [the mother], and from a psychiatric perspective, does not present with a psychiatric condition which would render him a risk to [the child], and accordingly, I consider [the child] would be safe with increased time with [the father].

234 Insofar as Dr BB reported, in September 2021, that the father "just wants [the child] to have a normal childhood and not have forced concepts such as 'gender diverse' and 'non-binary' forced upon him at such a young age", that is entirely consistent with his evidence in this regard at trial, which was unshaken, and which I find to be his genuine stance in this regard, and appropriately so.

235 In her first Family Report, Ms LL described the father as being "pleasant and co-operative" in the assessment and his narrative as being "child focussed, organised and thoughtful". Having listened to his oral evidence and observed him in cross-examination, I concur.

236 In her second Family Report, Ms LL reports, in her observations of the father and his partner, Ms V, that "[t]heir relationship presented as stable, nurturing and mutually respectful" and "[t]here was no clinical concern arising from their presentation" (at paragraph 14). Insofar as she reports the father saying to her: "We want [the child] to be [the child], we want to make good parenting decisions and our concerns are for his health" (at paragraph 17), that is consistent with his case before, and his evidence to, the Court, which I accept.

237 At paragraph 18, Ms LL refers to an instance when the child was referred to as the father's "son", a reference the father had not heard for some time. She continues:

> … [The father] explained that these occasions better reflect [the child's] lived experience. They are experiences that embrace [the child's] gender fluidity and a normalised childhood, one where they pursue developmentally normative interests, and have normative curiosities and encounters. [The father] regards exposure to these encounters as necessary for [the child] to enjoy their childhood.

238 Not only does Ms LL not express any concern about these sentiments, neither does the Court. They are entirely appropriate for a child of this child's age. That the mother is incapable of holding similar, open-minded views, is of concern.

239 The father's partner, Ms V, was cross-examined on behalf of the Independent Children's Lawyer but not on behalf of the mother. Accordingly, her evidence is unchallenged by the mother, including her evidence as to the relationship she enjoys with the father, free of any

violence. They have been in a committed relationship since in or about the first half of 2019. In her affidavit filed 14 March 2023, she describes their time together as being "full of wonderful experiences" and their relationship as being "very respectful, supportive, wonderfully communicative, caring, thoughtful, loving and joyful". She deposes that (at paragraph 6):

> … [The child] and I have built a lovely relationship … and I very much enjoy the time we spend together, playing games, talking about dancing, telling jokes, playing with [...] [the dog] and experiencing fun activities together with [the father]. We often catch up with family in [City K] and [the child] has met my family too.

240 Her evidence was that, in late 2023, the father and she discussed, at some length, his proposal to seek that the child live with him, in their household, and that she is supportive and welcoming thereof. In cross-examination, Ms LL agreed that her impression is that the father and Ms V have a "full three-dimensional life" and said that she considers Ms V, who she described as "vivacious", to be part of a potentially very healthy parenting team for the child.

241 Having heard Ms V's evidence tested in, and observed her in the course of, cross-examination, I found her to be a warm, open and, indeed, vivacious person. Not only do I not have any concerns whatsoever about Ms V, I consider that, together with the father, she can provide an environment for the child that is warm and loving, thoughtful and imaginative, and devoid of preconceptions, which will allow for the open exploration of all facets of the child's identity, as the child matures and develops, progressing to adulthood.

EVIDENCE OF THE FAMILY REPORT WRITER

242 Ms LL prepared two Family Reports in this matter. Prior to her cross-examination, by agreement, Senior Counsel for the Independent Children's Lawyers, summarised without any substantive objection, much of the evidence hitherto, particularly that of the expert witnesses, which caused Ms LL to contextualise, and reconsider, aspects of the matters in her Family Reports.

243 Much of Ms LL's evidence has been referred to above. Other aspects thereof include the following.

244 In relation to her observations of the child in her first Family Report, Ms LL reports at paragraph 30 that:

> [The child's] narrative was not free flowing and while [the child] could reference friendships and some other normative childhood experiences there was restraint around words chosen and information shared and they couldn't join in discussion

about family matters. This is developmentally unusual, more so for a child with [the child's] verbal skills and confidence. [The child] impressed as needing to control the process. [The child] made assertions such as "I don't want to be at Dad's" and "I prefer Mum, it's hard to explain" but when asked to add more detail to those statements [the child] would revert to a response of "it's hard to explain." There were long silences while the card game continued. The overall picture was one of incongruence and fragmentation.

245 In her evaluation, Ms LL reports at paragraph 31 that:

> … The dominant narrative in this dispute is that which has been told by [the mother] with [the father] as an unprotective parent from whom [the child] should be afforded some protection. The subjugated narrative of [the father], asserting [the mother] is the parent unable to support [the child's] relationship with their father is the emergent narrative presenting as more authentic, balanced and reflexive around [the child's] needs as a child.

246 She continues at paragraphs 32–34:

> 32. [The mother] wants the threat of [the father] to remain foreground [sic] despite there being no recent incident of family violence, she continues to define him as a perpetrator and uses this framework of understanding in her application of the risk [the father] allegedly poses to [the child]. At assessment, there was no current information to support that claim. [The father] was assessed as [an] emotionally attuned and protective parent who was responsive to [the child's] cues and at no time sought to impose his needs onto [the child]. There is a contested history of claims [that] he was violent in relation to [the mother] and a subsequent partner. [The father] has engaged in counselling and has been assessed as being psychologically well. [The father] impressed as having appropriate conflict resolution skills. In her report, Ms [DD] raised no concern about [the father's] conduct in that setting. While the determination of future risk will ultimately be a matter for the Court, there were no attitudinal or behavioural indicators on the part of [the father] that would give rise to concern about male privilege or that he has a binary view of gender.
>
> 33. The underlying reasons for [the mother's] beliefs are complex, not well understood and have likely developed over time in response to the separation. Her views may have been informed by her own parenting experience for [sic] which little is known, given her estrangement from family. [The mother's] acceptance into a marginalised and disempowered subculture probably provided her with the sense of belonging and family she craved. As [the child's] gender issues emerged as a point of difference developmentally, she and [the child] have felt embraced, empowered and understood in the gender diverse community. [The mother] has used this identity to emphasise [the] difference between herself and [the father] and in that process, she has either consciously or unconsciously [sic] marginalised [the father], and interprets and projects on to [the child], a belief that the world outside of their inner world, is unsafe. Her perception of herself and [the child] as victims has [sic] a currency she uses to trade with when threat is posed to the world she and [the child] inhabit.
>
> 34. Like most children subject to ongoing parental conflict and uncertainty [the child's] views and responses are shaped by the parental responses and their enmeshment and boundary diffusion between them and their preferred

> parent. [The mother] has sought to colonise [the child's] world and in the exclusivity of her parental role, a co-dependent relationship with [the child] has developed. [The child] takes their cues about [the father] from their mother and as [the mother's] stress escalates around changeover, [the child] mirrors that stress, separations from [the mother] become distressing and [the child] is not equipped with a level of independence or emotional support that allows transition without difficulty. [The child's] need to psychologically split off and display resistance to their father is best understood as arising in the context of sustained parental conflict. It is a maladaptive coping strategy that is supported and reinforced by parental behaviours.

247 At paragraph 36, Ms LL opines:

> [The mother] is a devoted mother and it is clear [the child] is the centre of her world. [The child] and their mother are strongly bonded and there are features of the relationship that are functional. However, the enmeshment is problematic and has resulted in [the mother] feeling entitled to manage and control [the child's] life. The psychological process of [the child] moving from dependence to independence is predicted to be difficult, not because of their gender identity, which was assessed as well managed, but because of [the mother's] cognitive rigidly and over protectiveness. Her lack of insight around this fundamental aspect of good parenting acts as a restraint to an understanding of the importance and value of [the child's] need to have relationships with others. This will have implications for [the child's] relationship with their father and for their ability to function capably and independently in the world.

248 Ms LL concludes at paragraph 37 that, whilst sole parental responsibility reposed in the mother (implicitly, if the child lives with her) may lead to fewer conflicts around parental decision-making, it "is also likely that [the child's] relationship with their father will diminish and erode in the process". Further, she reports that, and as I find to be the case, "[t]here was no evidence available at assessment to support claims [the father] was *imposing* a masculine construct on to [the child]" (emphasis added).

249 Ms LL's observations of the child with the mother, and with the father and his partner, in her second Family Report are qualitatively different. Ms LL reports at paragraphs 23–25:

> 23. When observed with their mother [the child] and [the mother] were noted to maintain a low "footprint." They sat quietly looking at the writer saying very little. [The mother] was noted to make observations of the room's furnishings and [the child] often echoed her comments or added an inquiry or remark. There were periods of quiet, and both [the child] and their mother appeared content in each other's company with little need for dynamic or structured play. [The child] and their mother appeared at ease in their conversation. [The child] was noted to mirror their mother's verbal expression and tone. There was a high degree of co-regulating with mutual smiling and talk of their shared experiences in and around their home, e.g., fostering of pets and discussion with the writer about animal welfare. [The child] appeared entirely at ease in the company of their mother. At the session's conclusion, [the child's] mother wished [the child] well for the five-night period with [the father]. She asked that [the child] collect her bag which was in the room that

[the father] and [Ms V] were occupying. [The child] did so, willingly.

24. [The child] was observed with their father and [Ms V] at the commencement and conclusion of the assessment. [The child] engaged readily with [Ms V] in a game. The mood was light, and [the child] bantered with their father and [Ms V]. [Ms V] presented as vivacious in her approach to [the child]. She was playful and laughed easily and this conveyed warmth and endearment toward [the child]. [The father] chimed in, facilitating [the child's] interaction with the writer and promoting discussion about their shared experiences as a family. [The child] displayed confidence as they shared a card trick with the writer. [The child] was trusting in their engagement but impressed as needing to maintain a confident exterior and be in control of the play.

25. There was a noted absence of spontaneity and silliness that may accompany interactions between adults and an eight-year-old.

250 At the time of the preparation of Ms LL's second Family Report, the child was nearly, but not yet, 10 years of age. It is therefore of concern that, at that age, the child reported to her that the father makes the child feel "uncomfortable" because the child is "transgender" (at paragraph 28). Ms LL continues:

> … [The child] recalled the feeling of discomfort usually arose when their father "says some things, kind of criticises me about being transgender and I try to blank out what he says, I try to forget but it makes me kind of sad and angry". [The child] thought it was important to convey that point to the writer because "you and the other people help make the visitation times."…

251 Ms LL further reports that the child said: "I feel my Mum is more supportive of me … If he [the father] forgot about me, it would be easier, easier by myself with Mum" (at paragraph 28); and "It's like I'm in two different worlds and the worlds don't join up and I can only connect to Mum's world" (at paragraph 29). Notwithstanding the child's comments, Ms LL reported (at paragraph 30) that "[t]he interview concluded and there was no stress detected in [the child's] demeanour as they departed with their father and [Ms V]".

252 In her evaluation, Ms LL reports at paragraph 33:

> [The mother] continues to provide a consistent style of parenting to [the child] that is responsive to their needs and wishes. Her narrative reflects the primary role she has played in their care and she can impart knowledge about [the child's] inner world with richness and depth. When observed in [the child's] presence the more restricted aspects of [the mother's] affect fade and she presents as nurturing, patient and adoring. She cocoons [the child] and the enmeshed features of that relationship remain stable. Her unconventional approach to supporting [the child's] development places value on choice and emphasises a parental need to be guided by the child's lead. In her care, a female name is used for [the child] who determines that they sleep wherever "they are happy to." Given this parenting environment, it is understandable [the child] may be perplexed by the notion that others are determining how much time they spend with their other parent.

253 At paragraph 34, Ms LL opined (important it is to note, prior to cross-examination):

> … If [the child] continues to identify themselves as transgender and does not, as is asserted by their mother, want to experience male pubertal growth then [the mother] is the parent better placed to meet [the child's] unique developmental needs. She presents as engaged with [...]CH's Gender clinic [sic], aligned with the agency's values and commitments and will undoubtedly facilitate [the child's] participation in any assessment and treatments. With her as the primary parent [the child] is likely to feel secure and protected during that journey.

254 Ms LL (at paragraph 35) contrasts the mother's "unstructured or what is commonly referred to as a permissive parenting style" with that of the father and his partner, who she evaluated as having "authoritative parenting styles, where care and control functions are balanced" and where the child's views "would be sought for the purpose of informing rather than determining parental decisions and activities". She reports that the father's "exasperation with the issues of [the child's] gender expression and parenting preference was palpable"; that he stressed that the child "is a child with fluid gender preferences"; and that the relationship between the father and his partner "presented as stable, respectful, mutually supportive and sensitive to each other's needs and interests".

255 At paragraph 36, Ms LL reports that the father "emphasised a need to adopt a cautious view when interpreting [the child's] narrative", claiming that the child "uses language and terms they don't know the meaning of and conveys a level of emotional distress about their experience of their father that is not based in reality". In this regard, Ms LL reports that she shares some of the father's concern about the child's narrative.

256 At paragraphs 38–39, Ms LL concerningly opines:

> 38. As [the child] has consistently remarked, when they move between their parents, they transition between "worlds." The language is different, the rules and customs are different, and the people are different. When children are raised by parents who lack the ability to share their child, to cooperate and communicate around their child's every day and longer-term needs, differences are amplified and the messaging received by the child is frequently confusing, unsettling and often distressing. With age and in the absence of change on the part of their parents, children become adept at developing strategies that enable them to cope in ways that alleviate the pressure inevitably placed upon them in the transition.
>
> 39. [The child] presented as an anxious eight-year-old child, accustomed to being observed. Their need to control the interview's direction could be both a response to their anxious symptoms and their over empowered engagement style. During interview, [the child] made clear that choosing their mother over their father would make their life "easier" and it is an astute observation from a bright child. In what appeared to be somewhat of a choreographed account [the child] may be reporting accurately on their feelings, however,

> the topics raised and driven by [the child] portray his father in a light that seems at odds with a more fulsome picture of [the child's] experience with their father. [The child's] need to convey feelings of being rejected by their father for their transgender status may be taking on some urgency in light of [the father's] position on treatments and it's possible those views have been transmitted to [the child], inadvertently or deliberately. Of course, it is possible [the child's] account is informed by multiple sources and has strands of undue maternal influence and strands that accurately reflect their lived experience.

257 Whilst Ms LL predicted (at paragraph 40) that the child's rejecting behaviours toward the father would escalate and that the mother might "have grounds to adopt a more protective, gatekeeping approach to parenting [the child], particularly if [the child] becomes increasingly aware of their father's opposing views to interventions they seek out", that opinion must be considered in the context of all of the evidence tested at trial, including her evidence, and appropriate concessions, in cross-examination. That included the following matters:

- Ms LL opined that the mother has a "core belief" that the father is a threat to her safety and, by extension, to that of the child, which is transmitted to the child and which has implications for how the child perceives the father.
- Ms LL agreed with the proposition that the father ought not to be criticised for some expressions of concern regarding aspects of social transition for the child, including attending school in a dress. I would add that, no matter how supportive the child's current school may be, the father ought not to be criticised for concerns that the child might be teased at school. A court does not need to resort to evidentiary concepts such as judicial notice to express awareness, as a matter of common sense and from life experience, that children, as children, may be cruel, whether intentionally or innocently.
- Ms LL was supportive of the school proposed by the father for the child, close to his home in City K, and did not consider a change of school as an insurmountable issue for the child, especially in circumstances where her impression was that the child's current school was not a primary source of friendships for the child. To that, I would add that the child will, in any event, need to change schools at the conclusion of primary school at the end of this year.

258 In relation to the risks posed to the child by a change of primary care from the mother to the father, Ms LL said:

> Well, the most significant factor in my opinion, and probably the risk issue is how

> [the child] will adjust to living primarily with his [sic] father after living primarily with his [sic] mother. I've made some remarks in my report about the quality of the mother-child relationship. I've spoke [sic] about there being, you know, some enmeshed features to that. If that is accurate, then the – the – the process by which [the child] can transition from his [sic] mum's full-time care – sorry, to their – from their mum's full-time care to their father's full-time care will be made more difficult by that – by that enmeshed relationship, because what [the child] feels – [the child] feels what their mother feels. Whenever – when [the child] is away from their mum, as he [sic] – as they reported to me at interview, [the child] worries about their mum. Now, that's a classic feature – that's a classic scenario where you have degrees on enmeshment, so the sense of loss will probably be quite overwhelming for [the child]. We don't know what – we don't – we can only theorise about what the emotional and psychological impact of that will be – what that will look like, but I think it's reasonable to assume that there will be a significant period of – there will be a grief reaction, and what – how that grief reaction unfolds is the bit that I'm not sure about, and I don't know about the length of it, I don't know about the intensity of it, but I – I am of the view that there will be a fairly significant period of adjustment for [the child]. Whether that can be supported through the presence of other professionals, being surrounded by other family, I don't know. There's a possibility that he [sic] might – they might reject their father, hold the father responsible for being separated from their mother. There are a – a kind of a number of issues in my mind that sort of cascade from that scenario, and it's hard to be definitive, because we don't know how each child is going to react.
>
> (Transcript 6 June 2024, p.21 lines 23–46)

259 Further, she said that there was nothing in her observations of, and interactions with, the father, as well as her observations of the interactions between the child and him, which would give her any concern that he might not be able to deal appropriately with any grief or related reactions. She considers both the father to be a competent parent, and his partner also to be "part of a potentially very health[y] team", albeit that "if [the child's] reaction is going to be highly rejecting, and if [the child's] behaviour becomes incredibly difficult to manage", she considers that "the competency issue goes – becomes background, and … anybody would struggle to manage the intensity of … a response" (Transcript 6 June 2024, p.22 lines 10–15).

260 Ms LL opined, without any qualification thereto, that the child's enmeshment with the mother would not be a reason not to change the child's living arrangements. She also said that, whilst the father does not have a favourable view of the mother, "the subtle but importance [sic] differences" are that, unlike her, he may be able to put some better boundaries around his views of her and not necessarily project them onto the child (Transcript 6 June 2024, p.31 line 28).

261 A number of what was said to be positive attributes of the father were put to Ms LL in cross-examination, and agreed by her to be so, including:

- having engaged in education around gender issues to assist him in dealing with the child;
- creating, together with his partner, a warm, robust and full home;
- demonstrating signs of being child-centred;
- demonstrating that he is not transphobic or "anti-transgender";
- supporting aspects of the child's care proposed by the mother, even when he was sceptical about, or did not agree with, them, such as the administration of a blood type diet; and
- pursuing counselling and support, with Mr Y (who was not required for cross-examination, in particular, by the mother), in contrast to the mother who has not accessed counselling support.

262 Ms LL agreed that certain aspects of the child's life, whilst in the mother's care, were suggestive of "splitting" for the child, such as the use of a secret female name, co-sleeping, diet and food restrictions and the use of a secret mobile phone, creating "a small closed world with the mother" (Transcript 6 June 2024, p.41 line 25). Ms LL explained splitting to be a psychological defence mechanism more present in children who live in a conflicted parenting environment, being a "mal-adaptive coping strategy where they start to segment their world, so there is the world at Mum's, there is the world at Dad's. There is good mum, and bad dad, and so you get these really polarised views" (Transcript 6 June 2024, p.42 lines 1–3). Ms LL said that splitting can be the pre-cursor to difficulties in the formation of personality and is a risk factor, because "really on a day-to-day basis … none of us can live in two worlds. Certainly not children, and so … [in] their day-to-day lives, they operate at a stress level much higher than children who are not subject to this [sic] conflicted parenting arrangements and adopt these kinds of strategies" (Transcript 6 June 2024, p.42 lines 6–10).

263 Ms LL explained that the child's description of it being "easier" to be with the mother, rather than the father, was merely reflective of the child's experience, rather than a rejection of the father or the child's life with him. She agreed that one of the determining factors in the parties' competing residence applications is who can, and will, support the relationship with the other parent, thereby providing a more secure base for the child "to live in and venture out from" (Transcript 7 June 2024, p.3 lines 41–42).

264 Further, and importantly, Ms LL's evidence confirmed that the decision regarding the pathway forward for the child, namely, whether solely gender affirming treatment, as contended by the mother and her experts, or more holistically and open-mindedly, as proposed by the father and his experts, is crucial to the determination of the question of the child's living arrangements. This is because, if the child were to receive gender affirming treatment, it would be best supported in the mother's home, where she wholeheartedly supports it. However, conversely, if the child is not to receive such treatment, or even is to be further assessed before such a decision is made, the child would need to be in the predominant environment of the father, because the mother would not be able to support this.

265 I am greatly assisted by, accept and place weight upon, the evidence of Ms LL in the determination of the parents' competing applications.

STATUTORY PRINCIPLES

266 As observed above, the trial having commenced prior to 6 May 2024, these proceedings are to be determined in accordance with the provisions of Pt VII of the FLA before the amendments thereto by the Family Law Amendment Act, which commenced operation on that date.

267 Section 64B(1)(a) of the FLA provided (and continues to provide) that a parenting order is an order made under Pt VII of the FLA dealing with a matter mentioned in subsection (2).

268 Section 64B(2) of the FLA provided (and continues to provide) that a parenting order may deal with, *inter alia*:

> (a) the person or persons with whom a child is to live;
>
> (b) the time a child is to spend with another person or other persons;
>
> (c) the allocation of parental responsibility for a child;
>
> …
>
> (e) the communication a child is to have with another person or other persons;
>
> …
>
> (i) any aspect of the care, welfare or development of the child or any other aspect of parental responsibility for a child.
>
> …

269 Section 61B of the FLA provided (and continues to provide) that "parental responsibility" in relation to a child means "all the duties, powers, responsibilities and authority which, by law, parents have in relation to children".

270 Section 65D(1) of the FLA provided (and, for the purposes of these proceedings, provides) that in proceedings for a parenting order, the court may, subject to, *inter alia*, s 65DA(1), make such parenting order as it thinks proper.

271 In relation to the allocation of parental responsibility for a child (referred to in s 64B(2)(c)), s 61DA provided (and, for the purposes of these proceedings, provides):

> (1) When making a parenting order in relation to a child, the court must apply a presumption that it is in the best interests of the child for the child's parents to have equal shared parental responsibility for the child.
>
> (2) The presumption does not apply if there are reasonable grounds to believe that a parent of the child (or a person who lives with a parent of the child) has engaged in:
>
> (a) abuse of the child or another child who, at the time, was a member of the parent's family (or that other person's family); or
>
> (b) family violence.
>
> …
>
> (4) The presumption may be rebutted by evidence that satisfies the court that it would not be in the best interests of the child for the child's parents to have equal shared parental responsibility for the child.

272 Section 65DAA(1) and s 65DAA(2) required (and, for the purposes of these proceedings, requires), *inter alia*, that, if a parenting order provides (or is to provide) that a child's parents are to have equal shared parental responsibility for the child, the court consider whether the child spending equal time with each of the parents would be in the best interests of the child and reasonably practicable and, if not, whether the child spending substantial and significant time with each of the parents would be in the best interests of the child and reasonably practicable.

273 In the present case, each of the mother and the father (together with the Independent Children's Lawyer) seeks an order for, or for aspects of, sole parental responsibility for the child, such that it is not necessary for the court to consider the matters prescribed in s 61DA and s 65DAA. No party (including the Independent Children's Lawyer) contends that it is in the best interests of the child for the child's parents to have equal shared parental responsibility for the child, without qualification, or for the child to spend equal time with

each of them. Indeed, they explicitly contend to the contrary. In any event, by reason of the geographic distance between them, that would not be reasonably practicable.

274 See *Doherty & Doherty* [2016] FamCAFC 182 and, subsequently, *Pruchnik & Pruchnik (No 2)* (2018) 58 Fam LR 458 at [52], where the Court said at [52]:

> … As *Doherty* makes plain, had orders for parental responsibility as proposed by the father been made s 65DAA would not have been triggered.

275 In *Pruchnik (No 2)*, the father sought orders for sole parental responsibility for education and medical and that, otherwise, the parents have equal shared parental responsibility for the children.

276 Section 60CA of the FLA provided (and continues to provide) that, in deciding whether to make a particular parenting order in relation to a child, the Court must consider the best interests of the child.

277 Section 60CC(1) of the FLA relevantly provided (and, for the purposes of these proceedings, relevantly provides) that, in determining what is in the child's best interests, the Court must consider the matters set out in subsections (2) and (3) thereof.

278 Section 60CC(2) of the FLA set out (and, for the purposes of these proceedings, sets out) the primary considerations I must consider, being:

> (a) the benefit to the child of having a meaningful relationship with both of the child's parents; and
>
> (b) the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence.

279 The former requirement will often be subject to the latter (cf. *Mallory & Mallory* [2019] FamCAFC 221; *M v M* (1988) 166 CLR 69). In the former case, Ainslie-Wallace J said at [77]:

> In *M v M* at 78 the plurality of the High Court considered the assessment of the existence and magnitude of a risk in the context of sexual abuse of a child and said:
>
> > … In devising these tests the courts have endeavoured, in their efforts to protect the child's paramount interests, to achieve a balance between the risk of detriment to the child from sexual abuse and the possibility of benefit to the child from parental access. To achieve a proper balance, the test is best expressed by saying that a court will not grant custody or access to a parent if that custody or access would expose the child to an unacceptable risk of sexual abuse.

280 As to the first of those two primary considerations, in *Mazorski v Albright* (2007) 37 Fam LR 518 at [26], Brown J held that "meaningful", when used in the context of "meaningful relationship", is synonymous with "significant", "important", "of consequence" and "valuable to the child" and is a qualitative adjective, and not a strictly quantitative one.

281 In *Goode v Goode* (2006) 206 FLR 212 at [44], the Full Court said:

> The importance of s 61DA is that if the Court applies the presumption of equal shared parental responsibility when making parenting orders, then that presumption is the starting point for a consideration of the practicality of the child spending equal time with each of the parents and, if it is consistent with the best interests of the child and not impracticable, the Court must consider making an order that the child spend equal time with each of the parents. If the Court does not make such an order, it must consider whether making an order that the child spend substantial and significant time with each of the parents would be in the best interests of the child and not reasonably impracticable and, if so, must consider making such an order (see s 65DAA). Section 65DAA(3) explains the meaning of "substantial and significant time".

282 As observed above, neither parent seeks (nor does the Independent Children's Lawyer propose) an order for unqualified, equal shared parental responsibility for, or equal time with, the child.

283 The Full Court in *Goode* said at [72]:

> In our view, it can be fairly said there is a legislative intent evinced in favour of substantial involvement of both parents in their children's lives, both as to parental responsibility and as to time spent with children, subject to the need to protect children from harm, from abuse and family violence and provided it is in their best interests and reasonably practicable. This means where there is a status quo or well settled environment, instead of simply preserving it, unless there are protective or other significant best interests concerns for the child, the Court must follow the structure of the Act and consider accepting, where applicable, equal or significant involvement by both parents in the care arrangements for the child.

284 I am cognisant of the objects of Pt VII of the FLA, and the principles underlying it, specified in s 60B of the FLA.

285 Section 60CC(3) of the FLA set out (and, relevantly, sets out) the additional considerations to the primary considerations.

286 Many of the matters set out in s 60CC(2) and s 60CC(3), which are required to be considered, have been considered at length elsewhere in these reasons for judgment. Given what the parties agree to be the largely *sui generis* nature of these proceedings, and the way they have conducted them, including the evidence adduced and submissions made by each of them, that

has been necessarily so. I do not propose to repeat slavishly matters considered and/or findings made elsewhere in these reasons for judgment.

Section 60CC(2) Factors

287 For the purposes of s 60CC(2)(a), each of the mother and the father (supported by the Independent Children's Lawyer) concedes the benefit to the child of having a meaningful relationship with the other parent. So much is apparent from the mirroring orders sought by each of them, irrespective of with which parent the child is to live. Having heard and considered the evidence of the parents and Ms LL, I find that the father has a greater capacity to support and enable the child to have a meaningful relationship with the mother, than that of the mother conversely.

288 Whilst each parent seeks that the child live with them, it is agreed between them that the child spend time with the other parent during school term periods, each alternate weekend from the conclusion of school (or like time), on Friday until the commencement of school (or like time), on Monday (or Tuesday, if Monday not be a school day). In circumstances where the mother lives in Town G, in Region H, and the father lives in Suburb J in City K, which are located approximately 85 kilometres from each other, the reality is, and is conceded by the parties to be, that, no matter the benefit to the child of having a meaningful relationship with the parent with whom the child does not live, the child will not be able to spend more than alternate weekends with that parent during school terms. Further, it is proposed by all parties that, during school term and long summer holidays, the child spend time with the parent with whom the child does not live, for one half of such holidays.

289 For the purposes of s 60CC(2)(b), namely, the need to protect the child from physical or psychological harm from being subjected to, or exposed to "abuse, neglect or family violence", I observe as follows.

290 As to "abuse", that term is defined in s 4(1) of the FLA to mean, in relation to a child:

> (a) an assault, including a sexual assault, of the child; or
>
> (b) a person (the first person) involving the child in a sexual activity with the first person or another person in which the child is used, directly or indirectly, as a sexual object by the first person or the other person, and where there is unequal power in the relationship between the child and the first person; or
>
> (c) causing the child to suffer serious psychological harm, including (but not limited to) when that harm is caused by the child being subjected to, or

exposed to, family violence; or

(d) serious neglect of the child.

291 It is not suggested by either the father or the Independent Children's Lawyer that, for the purposes of s 60CC(2)(b), there is a "need to protect the child from physical … harm from being subjected to … abuse", within the definition of "abuse" contained in paragraph (a) of the definition thereof, namely, "an assault … of the child" in the form of medical gender affirming treatment, in particular, Stage 1 puberty blockers. I make no finding, and express no view, in relation thereto.

292 In this case, only the definition of "abuse" in s 4(1)(c) could be relevant, namely, causing the child to suffer "serious psychological harm": on the mother's case, conceivably by reason of her allegation that the child has been exposed to family violence; and, on the father's case (supported by the Independent Children's Lawyer), conceivably by reason of the mother's approach to, and influence over, the child's gender identity, including her adoption of gender affirming treatment. I consider this issue below.

293 As to "neglect", there is no suggestion by any of the parties, nor any evidence, that the child has been subjected or exposed thereto.

294 As to "family violence", that term is defined in s 4AB(1) of the FLA to mean "violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the ***family member***), or causes the family member to be fearful" (emphasis in original). Section 4AB(2) provides non-exclusive examples of behaviour that may constitute family violence. Section 4AB(3) provides that "a child is ***exposed*** to family violence if the child sees or hears family violence or otherwise experiences the effects of family violence" (emphasis in original). Section 4AB(4) provides non-exclusive examples of situations that may constitute a child being exposed to family violence.

295 The issue of family violence, and what constitutes same, was recently considered by the Full Court in *Pickford & Pickford* [2024] FedCFamC1A 249, in separate judgments by McClelland DCJ, Aldridge and Carew JJ, and Austin and Williams JJ.

296 In relation to the definition of "family violence" in s 4AB(1) of the FLA, Austin and Williams JJ observed at [109] that:

> The definition is exclusive, not inclusive. Notwithstanding the obvious breadth of the definition, it is disjunctive and admits of "violent, threatening or other behaviour" amounting to "family violence" in only one of two ways …

297 Their Honours continued at [112]:

> If it be the case that, on the whole of the available evidence, the judge is unable to find the perpetrator's conduct does amount to family violence in the form of coercion or control, such unsatisfactory conduct will still likely be relevant in other ways. If the conduct induced the victim's fear, then it will be family violence under the second limb of the definition. Alternatively, the unsatisfactory conduct might not amount to family violence at all, but will still influence the overall exercise of discretion under Pt VII of the Act if, for example, it demonstrates lack of insight or stunted parenting capacity.

298 Aldridge and Carew JJ "largely agree[d] with the reasons of Austin and Williams JJ, save in relation to their Honours' interpretation of the definition of family violence which seeks to limit family violence to only two types of behaviour, namely, that which coerces or controls and that which causes fear" (at [41]). Their Honours said at [44]:

> The definition identifies certain behaviour that may fall within the definition, namely, violent, threatening or other behaviour that coerces or controls a member of the person's family or causes the family member to be fearful. Violent behaviour or threatening behaviour are stand-alone behaviours that fall within the definition of family violence. Such behaviours may coerce or control or cause fear, but it is not essential. It might be, for instance, that a female punches her male partner but the punch neither coerces nor controls nor causes the male to be fearful. The behaviour may nevertheless be an act of family violence.

299 With respect, it is difficult to reconcile the suggestion by Aldridge and Carew JJ that the definition of family violence in s 4AB, which is expressed therein to be "[f]or the purposes of this Act", merely identifies certain behaviour that *may* fall within the definition, with the exclusive, disjunctive wording of that definition. Family violence is exclusively defined to mean violent, threatening or other behaviour by a person that:

- "coerces or controls a member of the person's family"; or
- "causes that family member to be fearful".

300 McClelland DCJ (at [3]) agreed with the judgment of Aldridge and Carew JJ –

> … in so far as their Honours take a more expansive view of the concept of family violence and, in particular that the interpretation of the definition of family violence should not be limited to only two types of behaviour, namely, that which coerces or controls and that which causes fear.

301 Although, at first blush, possibly difficult to reconcile, I consider the separate judgments of Aldridge and Carew JJ and of McClelland DCJ, are reconcilable with that of Austin and Williams JJ, by reason of [112] in the latter judgment. Even if conduct is found to be unsatisfactory but not to constitute family violence, as defined, it will still likely be relevant in other ways and will still likely influence the overall exercise of discretion under Pt VII of

the Act. Indeed, conduct may be found to constitute violence, in the ordinary usage of that term, but merely not "family violence" as defined in, and for the purposes of, the FLA. In many cases, the distinction may be one without a difference, more apparent than real. It is unlikely that an act of violence, such as that postulated by Aldridge and Carew JJ at [44], even if it did not constitute "family violence", would be any less relevant or irrelevant. It must be recalled that many of the provisions in Part VII of the FLA are not an end in themselves, but a means to an end, namely, the determination of what is in a child's best interests.

302 In written closing submissions on the mother's behalf, it is conceded that "the issue of the Mother's *perception* as to family violence ought to be viewed in light of the opinion of [Ms LL] as to the Mother's (it may be inferred authentically) 'fading global narrative' as to the Father as a perpetrator of family violence" (emphasis added).

303 In *Pickford & Pickford*, Austin and Williams JJ observed at [87] that "judges need not make findings to resolve contested facts unless the findings authentically influence the outcome". Their Honours continues at [90] that, in that case:

> Implicitly, the mother's case was posited on the basis that neither she nor the children were at any risk of harm from family violence committed by the father provided the children only spend four nights per fortnight with him in school terms, so it is entirely unclear how she could have conversely contended the children were at risk of such harm if they instead spend five, six or seven nights per fortnight with him in school terms. It may be wondered: what danger could emerge on the fifth night to threaten the children's safety which danger would be absent on the previous four nights? The question is incapable of a rational answer. The curious paradox was accentuated by the mother's satisfaction the children could safely spend one-half of all school holidays with the father, which would certainly entail them staying with him for no less than seven contiguous nights in each holiday stint.

304 So too, in the present case, it is difficult to reconcile the mother's historical allegations of family violence by the father, albeit her 'fading global narrative' thereof, with her proposal that he spend each alternate weekend, from Friday afternoon until Monday morning, and half of all school term and long summer holidays, with the child, unsupervised. I infer that she does not hold, or invite the Court to hold, any relevant protective concerns for the child in the father's care for the purposes of s 60CC(2)(b). Orders sought by consent will ensure that face-to-face interactions between the parents will be minimal, including changeover in public locations and separate attendances at parent-teacher meetings. It is not suggested that any orders the Court is asked to make by any of the parties would, contrary to s 60CG(1)(b) of the

FLA "expose a person to an unacceptable risk of family violence", in particular the mother or the child.

305 In relation to the need to protect the child from being subjected to abuse, within paragraph (c) of the definition of that term in s 4(1), namely, "causing the child to suffer *serious* psychological harm" (emphasis added), there is no evidence to suggest, and I do not find, that the mother, to date, has caused the child to suffer serious psychological harm in her approach to the child's gender identity and her pursuit of gender affirming treatment. However, moving forward, I find that there is a need to protect the child from potential psychological (and, indeed, physical) harm, were the mother to continue (as she seeks to do) in her pursuit of gender affirming treatment for the child, including, in particular, by the administration of puberty blockers to the child.

Section 60CC(3) Factors

306 I turn to the additional considerations to the primary considerations prescribed by s 60CC(3) of the FLA.

307 As to paragraph (a) thereof, namely, any views expressed by the child and any factors (such as the child's maturity or level of understanding) that the Court thinks are relevant to the weight it should give to the child's views, I find as follows. By reason of the child's nature (namely, the child's relatively young age) and the child's nurture (namely, the mother's gender affirming approach to the child's gender identity, which identity I have found to have been substantially influenced in, and by, the mother's care), I give no weight to the child's expressed desire for puberty blockers. Insofar as the child generally expressed to Ms LL, in their meetings, a preference for the mother and her care, over the father and time with him, I take same into account. However, I accord little weight to such wishes, given Ms LL's subsequent evidence in cross-examination, as well as by reason of the fact that, if the child continues to live with, and be in the care of, the mother, the child will, on the balance of probabilities, progress to medical gender affirming treatment, in circumstances where I do not accept the diagnoses of gender incongruence/dysphoria, and where I have found that such treatment would pose an unacceptable risk of harm to the child.

308 As to paragraph (b), namely, the nature of the relationship of the child with each of the parents, the mother's contention is that the child has demonstrated reluctance to spend time with the father. Reported difficulties in the time that has been spent with the father have been a feature of her narrative since the first proceedings in the Court, as adverted to by Ms LL in

her first Family Report. Whilst the mother represented the father to Ms LL as posing a risk to the child, and the child exhibiting resistance to spending time with the father arising from "lived experience" of him, that was significantly rejected in the first Family Report.

309 At paragraphs 34–36 of the first Family Report, Ms LL reported:

> 34. Like most children subject to ongoing parental conflict and uncertainty [the child's] views and responses are shaped by the parental responses and their enmeshment and boundary diffusion between them and their preferred parent. [The mother] has sought to colonise [the child's] world and in the exclusivity of her parental role, a co-dependent relationship with [the child] has developed. [The child] takes their cues about [the father] from their mother and as [the mother's] stress escalates around changeover, [the child] mirrors that stress, separations from [the mother] become distressing and [the child] is not equipped with a level of independence or emotional support that allows transition without difficulty. [The child's] need to psychologically split off and display resistance to their father is best understood as arising in the context of sustained parental conflict. It is a maladaptive coping strategy that is supported and reinforced by parental behaviours.
>
> 35. As [the child] settles into the developmental stage of middle childhood there are important social and emotional milestones to be reached and mastered. One is the capacity to perspective take and empathise (the theory of mind). [The child] will learn to infer mental states, read non-verbal cues and moods and recognise that others may feel and think differently to them. Children of [the child's] age don't necessarily have the psychological competence to fully understand those processes and are susceptible to covert pressure that may influence their views and behaviours on a range of matters. While children of this age have moved out of an ego-based phase of development where they may see themselves as responsible for the conflict, they move into a phase where they can perceive themselves as responsible for finding solutions. Therefore it is no coincidence that in this developmental phase, children are at greater risk of developing unhealthy parental alignments when subject to conflicted and confusing parenting arrangements. The writer would therefore signal caution around interpreting [the child's] remarks as an authentic expression of their lived experience.
>
> 36. [The mother] is a devoted mother and it is clear [the child] is the centre of her world. [The child] and their mother are strongly bonded and there are features of the relationship that are functional. However, the enmeshment is problematic and has resulted in [the mother] feeling entitled to manage and control [the child's] life. The psychological process of [the child] moving from dependence to independence is predicted to be difficult, not because of their gender identity, which was assessed as well managed, but because of [the mother's] cognitive rigidly and over protectiveness. Her lack of insight around this fundamental aspect of good parenting acts as a restraint to an understanding of the importance and value of [the child's] need to have relationships with others. This will have implications for [the child's] relationship with their father and for their ability to function capably and independently in the world.

310 Further, the mother's contentions in this regard are undermined by her own proposal that the child spend time with the father each alternate weekend and for one half of all school term or long summer holidays.

311 Unlike the mother, who has sought to marginalise and denigrate the father and his ability to care for the child, including to Dr N, who proceeded on these assumptions, the father, to his credit, has not retaliated in kind and, on the evidence and for the reasons herein, I find that of the two parents, he is the parent who will more likely support a meaningful relationship with the other parent.

312 As to paragraph (c), namely, the extent to which each of the parents has taken, or failed to take, the opportunity to participate in making decisions about major long-term issues in relation to the child and to spend time and communicate with the child, neither party alleges that the other party has failed to take such opportunities. Rather, the father's case, which I accept on the evidence, is that the mother has, in many respects, prevented him from having, and therefore taking, such opportunities. That is in relation to both participation in making decisions about major long-term issues in relation to the child, in particular in relation to the issue of the child's gender identity and attendance at, and involvement with, the CHGS, as well as spending time and communicating with the child, which has been unnecessarily and unreasonably restricted by her.

313 As to paragraph (ca), namely, the extent to which each of the parents has fulfilled, or failed to fulfil, that parent's obligations to maintain the child, no submissions have been made in this regard.

314 As to paragraph (d), namely, the likely effect of any changes in the child's circumstances including, particularly, the likely effect on the child of any separation from either of the parents, I accept that a change of residence, and therefore care, from the mother to the father, and the inevitably consequential change of schools, as well as the change in approach to, and treatment of, the child's gender identity, may well be difficult initially for the child. However, I find that the numerous long-term benefits to the child of such changes, identified herein, far outweigh those difficulties. In the mother's care, the child would continue to live a relatively socially and geographically isolated existence, in which the child's gender identity will not be able to be freely and genuinely explored and addressed, as opposed to channelled through one-directional gender affirming treatment, including medical treatment. In the father's care, the horizon for the exploration of the child's gender identity will be broader than, principally,

the CHGS in City K, and HH Service and the local LGBTQI+ community in Region H if the child were to remain living with the mother. Having heard the evidence of the father and Ms V, and observed them in the course thereof, and taking into account my findings in relation to their evidence and to them herein, as well as the evidence of Ms LL, I am satisfied that the father, with both the support of Ms V and the professional support of Dr R (or a like-qualified practitioner) will be able to deal appropriately, sensitively, thoughtfully and broad-mindedly with any difficulties the child may encounter, including in relation to a change of residence (and care) from the mother to him, and the change in approach to, and treatment of, the child's gender identity. In relation to a consequentially necessary change of schools, the child would, in any event, need to change schools at the end of primary school this year. If the child commences at B School in grade six at the commencement of Term 2, as is envisaged, the child's primary education will be completed there this year, as a precursor to the commencement of the child's secondary education at another school (C School) which would be necessary in any event. In the result, I accept that C School, with its program in biology, which is of interest to the child, is appropriate.

315 As to paragraph (e), namely, any practical difficulty and expense of the child spending time and communicating with either parent and whether any such difficulty or expense will substantially affect the children's rights to maintain personal relations and direct contact with both parents on a regular basis, in circumstances where the geographical distance between the parents is such as it is, they each recognise by their competing applications that, during school terms, the child will only practicably be able to spend time with the parent with whom the child does not live in alternate weekends, from Friday afternoon until Monday (and, occasionally, Tuesday) morning.

316 As to paragraph (f), namely, the capacity of each of the parents to provide for the needs of the child, including the child's emotional and intellectual needs, I refer to and take into account my extensive findings in relation thereto in these reasons for judgment. It will be clear therefrom that whilst I have no concerns about the father's capacity, I have considerable concerns regarding the mother's capacity to provide, in particular, for the child's needs in relation to gender identity and the exploration and resolution thereof.

317 As to paragraph (g), the maturity, sex, lifestyle and background (including lifestyle, culture and traditions) of the children and of either of their parents, and any other relevant characteristics of the child, the issue of the child's gender identity has predominated these

proceedings and these reasons for judgment. It has manifestly been taken into account and my findings in relation thereto do not bear repetition.

318 Paragraph (h) is inapplicable in this case; the child is not an Aboriginal or Torres Strait Islander child.

319 As to paragraph (i), namely, the attitude to the child, and to the responsibilities of parenthood, demonstrated by each of the child's parents, I note as follows. The mother's case is that the father has been oppositional to, and unsupportive of, any exploration or affirmation of the child having a diverse/questioning approach to gender identity. I do not find that to be the case. Insofar as the father did not unquestioningly accept that the child is gender incongruent or dysphoric, from my findings in relation thereto, I conclude that was appropriate and, in the result, correct. The father's case, which I accept, is that the child is gender fluid and expansive but not, on the evidence, on the balance of probabilities, taking into account the gravity of the mater, gender incongruent or dysphoric. Actively or passively, correctly or otherwise, the father has supported a degree of gender affirmation by the child, instigated in the mother's care, namely, social affirmation. He opposes and, I find on the evidence, correctly so, any medical affirmation, including Stage 1 puberty blockers.

320 The mother has also presented the father as being unreasonable in his position, out of "anti-transgender" bigotry, a wish to be oppositional to her or, simply, a refusal to accept the child as the child is. However, I find that the father has not been unsupportive in his response to the child's gender diversity but, rather, only with respect to the gender affirming treatment pathway and, in particular, medical treatment. Further, based on my findings as to that treatment pathway, I find that his questions and objections have been, and are, reasonably held by him, given the risks inherent in that proposed pathway, especially with respect to the prescription of puberty blockers for the child. Far from refusing to accept the child as the child is, I find that is precisely what the father has sought, seeks and proposes for the child to do – to grow and develop into whatever person the child does become, with the passage of time and the acquisition of maturity.

321 Insofar as the mother relies upon the father's opposition to the child receiving a COVID-19 vaccination, in support of her contention that he has non-traditional views in relation to the medical profession, that is not supported by the tested evidence. Rather, the evidence was, and it is the case, that the father's concerns related only to the COVID-19 vaccination, and not, more broadly, to vaccination or medicine. Indeed, somewhat like the mother, but in a

much more discrete and limited fashion, and without long-term implications, it appears that the father came under the influence of other people who had their own agendas, rather than he himself having fixed and opposing views to vaccination and the medical profession generally. Whilst discrete orders were required to be made by the Court in 2022 for the child to be vaccinated, the broader contention urged by, and on behalf of, the mother cannot be extrapolated therefrom.

322 As to paragraph (j), namely, any family violence involving the child or a member of the child's family, I have referred to this issue elsewhere in these reasons for judgment. The evidence of the mother in relation to family violence was lacking in detail, was largely historical and, even taken at its highest, suggests that the mother's reporting of it, and seeking of intervention orders (and subsequent reporting of alleged breaches resulting in criminal charges against the father) was not a proportionate or reasonable response. For example, her description of being "verbally abused" and not feeling "safe", even in professionally supervised interactions with the father, is not supported by the evidence of the parenting coordinator, Ms DD. The description by Ms DD of the parenting coordination sessions is contained in her report annexed to her affidavit filed on 22 June 2021 at paragraph 41. Ms DD was not required for cross-examination and her direct evidence is therefore unchallenged.

323 I also refer to the mother's evidence in relation to what I consider to be her wholly disproportionate, if not confected, response to the alleged distress surreptitiously reported by the child to her in June 2019, whilst spending alternate weekend time with the father, and her subsequent application for a variation of an intervention order and admission of the child and herself to a women's refuge.

324 Further, Ms LL, in her first Family Report, noted allegations by the mother of verbal abuse, "horrible emails" and unnecessary aggression by the father, and opined (at paragraph 25 thereof) that "[f]rom this [the mother] *extrapolated* that [the father] *may* perpetrate family violence against [the child] because [the father's] violence is 'gender based'" (emphasis added). I do not accept that any actions by, or attitudes of, the father have been based on, or in opposition to, the gender of the mother or the child.

325 In her January 2024 report, at paragraph 71(g), Dr N reports that, whilst family violence, at or about the time of separation, when the child was aged three to four years, was described implicitly by the mother, "there is no evidence to indicate [the child] is affected by trauma due to this". Whilst I do not accept the mother's allegations generally in relation to family

violence, even if it did occur, to some extent lesser than that alleged by her, I place weight upon this opinion of Dr N.

326 The mother has made family violence allegations, and has alleged breaches of intervention orders, against the father, in support of her position that the father has exposed the child to violence and that the child's primary residence should remain with her to protect the child from such violence. However, I infer from the fact that the mother proposes that the father spend regular, unsupervised overnight blocks of time with the child, each alternate weekend and for half of all school holidays, that her professed concerns regarding family violence are not such as genuinely give her, or would give the Court, any real concerns regarding the father and the child.

327 Conversely, however, I do not accept any contention that there has been (as opposed to that there may hereafter be) abuse of the child in the care of the mother. As referred to above, in relation to s 60CC(2)(b), the term "abuse", in relation to a child, is defined in s 4(1) of the FLA to mean, *inter alia*, "causing the child to suffer *serious* psychological harm" (emphasis added). Notwithstanding my concerns regarding the mother's care of the child, by reason of her unwavering belief that the child suffers from gender incongruence or dysphoria which requires medicalisation, and her gatekeeping measures to exclude the father from, or at least minimise his involvement in, the child's life, I do not understand the evidence of Ms LL to suggest that the child has suffered "serious" psychological harm to date. However, I do find, on the evidence, that, if the mother were to have, as she seeks (at paragraphs 2 and 3 of her proposed orders), sole parental responsibility for the child for –

> … all major long-term issues in relation to the care, welfare and development of the Child of a long-term nature concerning the Child's health, including in relation to the Child's gender identity … [and] including to give informed consent on behalf of the Child, for any therapeutic treatment that is in the Child's best interests concerning the Child's diagnosis and treatment for gender dysphoria, limited to "Stage 1" treatment for gender dysphoria

and the child were to live with her, there would hereafter be an unacceptable risk of serious psychological and, indeed, physical harm to the child by her single-minded pursuit of gender affirming treatment, including medically, for the child.

328 Returning to the mother's allegations, I also take into account the submission, in the written closing submissions on her behalf (at paragraph 31(a)) that –

> … the issue of the Mother's perception as to family violence ought to be viewed in light of the opinion of [Ms LL] as to the Mother's (it may be inferred authentically)

> "fading global narrative" as to the Father as a perpetrator of family violence …
>
> (Footnotes omitted)

329 What Ms LL relevantly said at paragraph 41 of her second Family Report is:

> … While claims of [the father] as a perpetrator family violence fade from her narrative her global view of [the father] is negative, and this is undoubtedly transmitted to [the child]. …

330 In the mother's written closing submissions, only two paragraphs directly address the issue of family violence (paragraphs 64 and 65). I do not understand the submission at paragraph 64 that "she has not had the opportunity to fully respond to the more specific criticisms that are minimising of the characterisation of her evidence in this regard", referencing in a footnote paragraphs 27.1.1–27.1.4 of the Independent Children's Lawyer's written closing submissions. After the conclusion of the mother's evidence, on the sixth day of the trial, there was no application over the ensuing 12 days of evidence to recall her, for example, after the evidence of the father or Ms LL. Further, the Independent Children's Lawyer's written submissions were filed first in time, on 2 August 2024, and those of the mother were filed last in time, on 26 August 2024, such that she had ample opportunity to make submissions in reply in relation thereto.

331 Insofar as the mother's evidence is that she was contacted by the father's former partner, Ms PP, in or about 2019, who allegedly reported to her what she asserts to be similar experiences of family violence by him, whilst admissible under s 69ZT of the FLA, I give no weight thereto. No explanation was proffered as to why she did not adduce evidence directly from Ms PP, whose allegations she had been aware of for nearly five years at the time of trial. In circumstances where it has not been submitted by the father that a *Jones v Dunkel* (1959) 101 CLR 298 inference should be drawn against the mother, I do not need to, and I do not, draw such a specific inference. However, conversely, I give the mother's hearsay evidence in relation to Ms PP no weight, whilst giving weight to the unchallenged evidence of Ms V as to the loving and violence-free nature of her relationship with the father.

332 I also take into account the evidence that, on 27 March 2024, during the adjourned period between 21 February 2024, when the trial was adjourned part-heard, and 27 May 2024, when the trial resumed, of 11 pending charges brought by Police against the father relating to alleged breaches of an intervention order, seven were dropped. In respect of the remaining four charges, the nature of which appears to have been *de minimis*, such as calling for court-ordered telephone communication with the child a minute or two late, the father pleaded

guilty. However, no conviction was entered against him and only a six-month bond not to commit family violence was imposed upon him. At no time thereafter, including until the evidence closed on 7 June 2024, in written closing submissions filed in the course of August 2024, in oral closing submissions on 12 September 2024 or at the mention on 20 December 2024, was it remotely suggested that there have been any further breaches by him, substantive or technical.

333 As to paragraph (k), namely, any inferences that can be drawn from a family violence order that applies, or has applied, to the child or a member of the child's family, there are no further inferences to be drawn beyond any referred to elsewhere herein, nor have I been invited to do so.

334 As to paragraph (l), namely, whether it would be preferable to make an order that would be least likely to lead to the institution of further proceedings in relation to the child, the parenting dispute between the parents should have been quelled by the 2018 final parenting orders. However, it was not. Within eight months thereof, a Contravention Application was filed by the father on 25 July 2019 and, less than two months thereafter, an Initiating Application was filed by the mother, seeking the discharge of several of those final parenting orders, including orders:

- in relation to time to be spent between the father and the child;
- requiring the parents to appoint a general medical practitioner at a nominated medical practice to treat the child, other than in cases of emergency; providing that, if the agreed practitioner was unavailable, the parents were to take the child to another general medical practitioner in that same practice, or another agreed practitioner for that occasion; and requiring both parents to authorise that agreed practitioner, or any other general medical practitioner in that practice, to speak to the other parent about the condition and treatment of the child; and
- restraining both parents "from taking the child to a medical practitioner, dentist, allied professional, counsellor/psychologist or the like without the other parent's prior written consent except in an emergency or in accordance with order 16 herein or as recommended by the agreed GP".

335 In lieu thereof, the mother relevantly sought orders:

> 2. That the father spend time with and communicate with the child at such times

and on such conditions as determined by this Honourable Court.

3. That the mother be permitted to cause the child to attended upon Dr [JJ], General Practitioner of the [AA] Medical Centre together with any medical professional (including a psychologist or counsellor) as may be recommended by [Dr JJ] from time to time.

4. That the mother authorise [Dr JJ] (together with any other health professional as recommended by her) to communicate with the father in relation to the child's physical and mental health.

336 Accordingly, in all the circumstances of this case, for the reasons herein, I consider that the orders sought by the father and supported by the Independent Children's Lawyer, particularly those that provide for:

- the father to have sole parental responsibility for the child;
- for the child to live with the father;
- for the parents (by themselves, their servants and agents) to be restrained, *inter alia*, from consenting to or otherwise facilitating the child attending upon a paediatrician at the CHGS and commencing the administration of Stage 1 puberty blockers and Stage 2 cross-sex hormones; and
- the father to do all necessary things to obtain a referral for the child for an assessment and treatment, if required, by a paediatrician and/or child and adolescent psychiatrist or psychologist, and to provide the mother with the name and contact details of such treating health professionals –

would be least likely to lead to the institution of further proceedings in relation to the child and that this would be in the child's best interests.

337 As to paragraph (m), namely, any other relevant facts or circumstances, counsel for the mother, in the written closing submissions filed on her behalf, point to the issue of and treatment for the child's gender identity. However, in circumstances where that has overshadowed both the 20 hearing days, between 12 February and 20 December 2024, as well as therefore these reasons for judgment, there are no further relevant facts or circumstances to be taken into account.

PARENTAL RESPONSIBILITY

338 The father, supported by the Independent Children's Lawyer, in his minute of orders tendered in closing submissions (Exhibit F-19), seeks, without qualification, sole parental responsibility for the child –

… save that prior to making any significant long-term decision for the child, he will:

a. Provide the mother with not less than 28 days' notice of the decision that needs to be made and his proposal;

b. Provide the mother with sufficient information to enable the mother to consider his proposal;

c. Give due consideration to the views of the mother;

d. In the event of a disagreement between the parents, make the final decision for the child and notify the mother of the same in writing within 48 hours of having made the decision.

339 Further, he seeks injunctions in relation to the child attending upon a paediatrician at the CHGS, commencing the administration of Stage 1 puberty blockers and Stage 2 cross-sex hormones and any changes to the child's name and recorded sex and gender with the Registrar of Briths, Deaths and Marriages. He also seeks an order (albeit unnecessarily if he be granted sole parental responsibility) for him to obtain a referral for the child for an assessment and treatment, if required, by a paediatrician and/or child and adolescent psychiatrist or psychologist (with him to provide the mother with the name and contact details thereof and the mother to be authorised to communicate and liaise therewith).

340 The mother, in her minute of orders tendered in closing submissions (Exhibit M-38), relevantly seeks the following orders:

2. Subject to Order 3, the Mother have sole parental responsibility for all major long-term issues in relation to the care, welfare and development of the Child of a long-term nature concerning the Child's health, including in relation to the Child's gender identity ("**Health Decisions about the Child**").

3 To the extent it is necessary to do so, the Court declares that the Mother is authorised and has sole parental responsibility to make decisions, including to give informed consent on behalf of the Child, for any therapeutic treatment that is in the Child's best interests concerning the Child's diagnosis and treatment for gender dysphoria, limited to "Stage 1" treatment for gender dysphoria.

NOTING THAT to the extent the Mother might later propose any Stage 2 treatment for the Child in relation to their gender identity, and the Father disputes such treatment,

then the Mother undertakes to make an application to this Court for and on behalf of the Child to determine the issue.

4. As to all matters concerning Health Decisions about the Child:

(a) The Mother is to provide to the Father in writing details of and information in relation to any significant proposed Health Decision not less than 14 days prior thereto and provide the Father with all relevant information in relation to any proposed decision, save in the case of emergency;

(b) The Father be at liberty to provide a response and any feedback to the Mother in writing in relation thereto, for her consideration, within 7 days thereafter;

(c) The Mother is required to give due consideration to the views of the Father; and

(d) The Mother thereafter notify the Father in writing of her decision within 7 days thereof, save that, in the event of emergency, she advise him of any decision made and provide him with details thereof and information in relation thereto, as soon as reasonably practicable after making such decision.

NOTING THAT in the event of disagreement between the parties, the Mother shall be at liberty to make the final decision for the Child.

5. The Mother be at liberty, in the exercise of her sole parental responsibility for Health Decisions about the Child, to facilitate and provide her consent to the Child's attendance upon a paediatrician as referred by the Gender Service at the [Children's Hospital] at [City K], or such other paediatrician as she determines is appropriate to treat the Child.

6. Subject to [3] to [5] of the Orders above, the Mother and the Father have equal shared parental responsibility for the Child.

(Emphasis in original)

341 Paragraph 2 seeks that the mother have "sole parental responsibility for all major long-term issues in relation to the care, welfare and development of the Child of a long-term nature concerning the Child's health, including … gender identity", subject to paragraph 3. However, paragraph 3 is, in fact, no qualification to the aspect of sole parental responsibility sought in paragraph 2; rather, it buttresses it, by seeking a declaration, "[t]o the extent it is necessary", that the mother "is authorised and has sole parental responsibility to make decisions, including to give informed consent on behalf of the Child, for any therapeutic treatment that is in the Child's best interests concerning the Child's diagnosis and treatment for gender dysphoria", albeit limited only to Stage 1 / puberty blocker treatment. Paragraph 4 does not derogate in any way from the aspect of sole parental responsibility sought by the mother; it merely requires her to provide the father with information and details in relation to "health decisions" about the child (relevantly defined in paragraph 2 to include decisions in relation to the child's gender identity), to give "due consideration" to any views expressed by the father in relation thereto and thereafter to notify him of her decision, noting that, "in the event of disagreement between the parties, the Mother shall be at liberty to make the final decision for the Child ". Paragraph 5 further buttresses the sole parental responsibility that the mother seeks in relation to health decisions about the child, providing liberty to her, in the exercise thereof, "to facilitate and provide her consent to the Child's attendance upon a

paediatrician as referred by the Gender Service at the [Children's Hospital] at [City K], or such other paediatrician as she determines is appropriate to treat the Child". So analysed, it becomes apparent that, in the particular circumstances of this case, the mother's proposal that, "[s]ubject to [3] to [5] of the Orders above, the Mother and the Father have equal shared parental responsibility for the Child", is largely meaningless, especially given the parents' competing schooling applications (albeit that they implicitly conceded that the issue of schooling will be resolved by the determination of whether the child lives with the mother in Town G or with the father in Suburb J). Other than health and education, no other possible major long-term issues in relation to the child were identified.

342 In any event, it will be apparent from these reasons for judgment, and it cannot be gainsaid, that the parents have a fractious history. I find that there is little to no prospect of them being able to communicate in such a way that they can make co-parenting decisions. This is especially, and importantly so, in relation to the overwhelming issue of the child's gender identity, and how it is to be managed. The evidence establishes that the mother has perceived and/or alleged much of the father's behaviour to constitute family violence and many of his views in relation to the child's gender identity to be "anti-transgender", even though not found to be so.

343 The mother's view is that the child *is* a transgender girl and, as such, she is the better parent to have parental responsibility for the child, as she is the affirming parent of the child's fixed transgender identity, whilst the father is not accepting of the child being transgender. Indeed, notwithstanding being in Court and hearing the evidence of many of the expert witnesses of the father and the Independent Children's Lawyer, much of which was persuasive and substantially unshaken in cross-examination, the mother's case has remained as immutable as she considers the child's gender identity to be.

344 The father does not dispute that the child is experiencing equivocation regarding gender identity but asserts that, at the age of 11 years, the child does not have a fixed gender identity and that he is the parent most capable of supporting and protecting the child, by letting the child simply be a child. I have found above that, in the circumstances of this case, including the deficiencies in the diagnostic processes undertaken in relation to the child, I do not accept the diagnoses by Dr N of the child to be gender incongruent or gender dysphoric.

345 Accordingly, the father's questioning of the gender affirming treatment pathway, including medically, proposed by the mother, and advocated for, and endorsed by, the CHGS, is

reasonable in all the circumstances. The contents of the Conference of Experts document illustrates that there is no clinical consensus amongst the professional expert witnesses called by each of the parents and the Independent Children's Lawyer. However, the Conference of Experts document also illustrates that the experts called by the father and the Independent Children's Lawyer, who are independent of each other, are generally in alignment and their evidence was not substantially shaken in cross-examination. I stress that it is not the greater quantity of those experts but, rather, the greater quality of their evidence, as well as the supporting evidence tendered, upon which I rely. That evidence includes the Cass Report which was tendered on behalf of the mother, and forms part of the evidence in her case, notwithstanding that it does not support her case. If the medical experts cannot agree on the best way forward for the child, then great caution should be exercised when the treatment proposed by the mother and her experts is potentially life altering and irreversible.

346 In the circumstances, inter-related with the issue of parental responsibility, I consider the injunctions the father seeks preventing continued attendance by the child at the CHGS and administration to the child of Stage 1 and Stage 2 hormonal treatment, to be in the child's best interests. Rather, I consider the father's proposal, that the child be permitted to attend upon Dr R, or a like clinical psychologist, for general therapy and support, including to address the child's anxiety, to be in the child's best interests.

347 Dr R was measured and balanced in her views generally and, in particular, her explanation of how she would approach treating the child. Her evidence, which was not challenged to any substantial degree, was that she is qualified to, and could, assess and manage any treatment for the child, if required, for anxiety, trauma, neurodiversity, grief and gender-related questions. I do not consider the fact that she is based in State T to pose any insurmountable hurdles. She is able to use remote technology to work with the child, and the father gave evidence, which I accept, that he would be committed to travelling with the child to attend upon her from time to time, including for the initial sessions when rapport-building is important.

348 Having heard and observed each of the parents in cross-examination, I find that the mother holds a severely distorted, inaccurate and negative view of the father and, as such, she cannot, and will not, view anything that he proposes in a positive light. Whilst I find that the father has considerable concerns regarding proposals for the child that emanate from the mother, and sees these in a jaundiced light, he demonstrates a greater capacity to focus upon the

child's needs, rather than on simply opposing the mother *per se*. Further, on the evidence, I find that these concerns on the part of the father are not necessarily misplaced, especially in relation to the child's gender-related issues.

349 In circumstances where no party, including the Independent Children's Lawyer, suggests that, in light of the history of the parents, they can make joint decisions in relation to the child's gender identity, the evidence provides considerably more support for the father holding sole decision-making authority in relation thereto.

350 Given my findings regarding the child's engagement at the CHGS, both to date and in the future, if it were to be allowed, and the benefits to the child of being assessed and treated neutrally, by a clinical child psychologist such as Dr R, as the father proposes, rather than in accordance with the gender affirming treatment model (including medical treatment) advocated by, and on behalf of, the mother, the child will require a supported living environment which I find the mother will be unable to provide. I am comfortably satisfied, on the evidence, that the mother will not respond well to the cessation of the child's involvement at the CHGS, in which she places her belief and faith, and the fact that the child will not undertake gender affirming treatment, including medical treatment. I consider that she will, unfortunately, likely again blame the father and communicate this to the child, as she has done in the past, with negative effects on the relationship between the father and the child.

351 I accept the submission by the Independent Children's Lawyer, and find, that if the mother were to have sole parental responsibility for decisions in relation to the child's gender identity, and to live with her, as I address further below, this would be highly likely to result in the child receiving potentially life-altering and damaging medical intervention for which there may not be a proper underlying basis.

352 As referred to above, albeit in the context of the s 60CC(3) considerations, I am cognisant of the fact that, on 9 March 2022, during or in the aftermath of the COVID-19 pandemic in City K, I made an order for the mother to have sole parental responsibility for the child for all decisions relating to immunisation and vaccination against COVID-19. This was in circumstances where the father had opposed such vaccinations at that time. However, when cross-examined about this, the father said that he is not opposed to medical intervention generally and I accept that this was otherwise an aberration on his part. Indeed, I am fortified in so finding by his actions in seeking ongoing information from the CHGS, notwithstanding

his reservations in relation thereto, as well as evidence more broadly from other health experts in relation to the child's gender exploration.

353 More broadly, given the mother's inability or unpreparedness to work collaboratively with the father where he disagrees with and/or will not comply with her opinions and wishes, even with good reason, I consider it to be in the child's best interests for the father to have sole parental responsibility for the child, subject to the provisos proposed by him.

RESIDENCE

354 Given the evidence generally, and my findings in relation to parental responsibility, I conclude that it would be extremely difficult for the mother and, therefore, for the child, if she were to retain primary residence in the face of the father having sole parental responsibility for the child, with gender affirming treatment, including medical treatment, being restrained by injunctive orders. Indeed, it is almost inconceivable, in the circumstances of this case, that the father could practicably have sole parental responsibility for the child, as I have determined should occur, whilst the child is living with the mother. I find the mother so entrenched, convinced and fixated in her unwavering belief that the child is, beyond doubt in her mind, a transgender girl, that for her to primarily care for the child without following the gender affirming treatment pathway offered at CHGS would be very difficult, if not impossible, in practice.

355 In her written closing submissions, the mother complains that she "was given no real opportunity to address in her evidence how [the child] may respond to the alternative 'time spent' arrangements, including as to displacement from [the child's] current school and more particularly a change of residence" (at paragraph 68). It is correctly observed by her that "the Father did not seek Orders in his Court materials filed in this proceeding for what is in effect a reversal of the long-standing residence from the Father to the Mother [sic] until he filed his Case Outline on 7 February 2024" (at paragraph 69). It is manifest that this is a typographical error and that reference is intended to be made to a reversal of the long-standing residence of the child from the mother to the father. However, that complaint is misplaced; it overlooks the fact that in the father's updating/responding affidavit filed five days earlier, on 2 February 2024, he deposed at paragraph 62: "I seek that [the child] live primarily with me" and listed several of the benefits that he contended would flow therefrom for the child.

356 Further, the trial did not commence until 12 February 2024, and there was no application by the mother to adduce further evidence, either by affidavit or *viva voce* in evidence in chief.

Therefore, insofar as it is also submitted that "there was no further opportunity of the Mother to file a further affidavit" and that "there was no opportunity for the Mother to be heard in relation to the question of change of residence", that is incorrect; there was opportunity, but it was not sought. Accordingly, I do not accept the submission that it is "procedurally unfair in the circumstances for the Court to make such significant orders for a reversal of residence". Similarly, I do not accept the attempted criticism of counsel for the father and the Independent Children's Lawyer for not putting any questions to Dr N with respect to the impact on the child of a change of residence; that was a matter more within the province of Ms LL, and I take her evidence in this regard into account. Dr N gave evidence on 19, 20 and 21 February 2024 and 27 and 28 May 2024. The mother and her lawyers were on notice of the father's application for a change of residence since 7 February 2024, foreshadowed five days earlier, and yet there was no application to lead any further evidence from Dr N in relation thereto.

357 I do not accept the mother's submission (at paragraph 82 of her written closing submissions) that the father appears to have given little thought as to the significant impact on the child's well-being, should there be a change of residence. He is cognisant of the potential challenges, both for the child and for him. He has researched and identified a primary school and a secondary school that, by all accounts, will be appropriate for the child. The evidence is, and the father accepts that, in addition (and possibly related) to the child's exploration of gender identity, the child also suffers from (at least) anxiety. I have no concerns that the father, both personally and with the support of Ms V, is well equipped and able to be the primary carer for the child. He has identified a clinical psychologist, Dr R, who will provide any necessary therapy and support for the child. He will take the child to State T, from time to time, to attend upon Dr R in person. He is in a stable and loving relationship with Ms V, in respect of whom it is submitted on behalf of the mother that: "It is pleasing that the Father has the support of [Ms V] and that she appears to have a positive relationship with [the child]" (paragraph 84 of the mother's written closing submissions).

358 The mother submits, under the rubric of the impact on the child of a change of residence, that if the Court accedes to the father's application, the child "will not have the option of receiving medically affirming care". However, I have concluded that, at this stage in the child's life, the child should not have that option. As the child progresses and develops, including in age and maturity (and becomes *Gillick* competent), as well as in diagnosis (if any, hereafter), that may change.

359 In all the circumstances, including by reason of my determination that the father should have sole parental responsibility for the child, I conclude that it is in the child's best interests to live with the father hereafter, notwithstanding (and having taken into account) the potential initial distress to the child of such change.

360 In relation to how the child should be told of the change of residence, Ms LL said that, ideally, both parents should be involved but that, if this is not possible, the primary carer (whom I conclude to be the father hereafter) should do so. She opined that the father could do so in a thoughtful manner and, having had the singular benefit of hearing his evidence and observing him in the course thereof, I do not disagree.

361 Subsequently, in oral closing submissions, Senior Counsel for the Independent Children's Lawyer proposed that, if a change of residence were ordered, the Independent Children's Lawyer and/or Ms LL, if available, should meet with the child for this purpose. However, the child last saw Ms LL in January 2023, over two years ago. The mother proposes a Court Child Expert do so, rather than Ms LL. In the circumstances, given the timing of the delivery of these reasons for judgment (namely, the penultimate day of Term 1), and the uncertainty as to the availability of Ms LL at this time, I consider the involvement of a Court Child Expert, together with the Independent Children's Lawyer, to be appropriate.

362 Whilst a change of residence is contrary to the child's currently overtly expressed wishes, and the child will need to be supported to adjust to these changes, I find that the child's best interests, including the need to protect the child from potential significant harm, require this and I am confident that the father and his partner have, and will exercise, the capacity to sensitively support the child through this adjustment, including with the assistance of Dr R or a like expert.

363 I have, in recent days, in anticipation of the delivery of this judgment, ordered the child to be brought to the Court's child-minding service this morning. The child will leave Court today with the father. I am cognisant that Term 1 concludes tomorrow. The father may wish to give consideration to taking the child to school tomorrow to farewell friends and teachers, but I shall not order him to do so. The child will commence Term 2 at B School and secondary school in 2026 at C School.

TIME TO BE SPENT

364 Each parent and the Independent Children's Lawyer agree that the child spend time with the other parent, during school term periods, each alternate weekend from the conclusion of school, or 3.30 pm if a non-school day, on Friday, until the commencement of school, or 9.00 am if a non-school day, on Monday (or Tuesday, if Monday be a student-free/curriculum day or a public holiday).

365 As I have observed above, in circumstances where the mother lives in Town G, in Region H in State S and the father lives in Suburb J, in City K, which are located approximately 85 kilometres one from the other, the reality is, and is conceded by the parties to be, that the child will not be able to spend more than alternate weekends with that other parent during school terms.

366 A minute of proposed orders by consent has been provided by the parties and orders will be made substantially in the terms thereof, amended only to give effect to these reasons for judgment (and as to matters of form, grammar and syntax). The consent orders deal, *inter alia*, with the time to be spent by the child with the parents during school term and long summer holidays (other than at Easter, which I consider below), and on special occasions.

367 The minute of consent orders also contains provisions in relation to school and extra-curricular enrolments, changeover, communication between the child and each of the parents, the provision/obtaining of information in relation to the child, travel by each of the parents with the child and other miscellaneous issues.

368 Neither the father, nor the Independent Children's Lawyer, seek any moratorium of any specified length on the child's time with the mother. However, in circumstances where the child will be changing residence and schools, I consider it to be in the child's best interests for the child not to spend any time with the mother during the immediately forthcoming Term 1 school holidays (which include Easter) this year. This will allow the child to settle into both the father's care, as well as the prospect of a new school in about a fortnight's time, at the commencement of Term 2 and, accordingly, the mother's time will commence on the first Friday of Term 2.

369 The only outstanding issue in relation to time to be spent by the child with each of the parents, not the subject of consent, is at Easter which, by reason of the timing thereof, is inter-related with the time to be spent in the Term 1 holidays.

370 The mother seeks that:

i. In the event that Easter does not fall during the first weekend of the Term 1 holidays, then from the conclusion of school on the last day of term to 5:00pm on the Saturday of the middle weekend;

ii. In the event that Easter does fall during the first weekend of the Term 1 holidays, then for eight consecutive nights commencing at 10:00am Easter Sunday and concluding at 10:00am the following Monday;

…

371 Thus, the mother seeks to divide the Easter weekend.

372 The father seeks that, at Easter, the child spend time with the parents as follows:

i. In odd numbered years with the father from the conclusion of school or 3.30pm on the Thursday preceding the Easter weekend, until the commencement of school on Tuesday, or 9.00am if a non-school day.

ii. In even numbered years with the mother from the conclusion of school or 3.30pm on the Thursday preceding the Easter weekend, until the commencement of school on the following Tuesday, or 9.00am on a non-school day.

373 Thus, the father seeks to alternate the Easter weekend.

374 The Independent Children's Lawyer proposes that, in respect of the Term 1 school holidays, so as to incorporate Easter, changeover take place at 12 noon on the middle Saturday, and that the child spend "the week containing the Easter weekend" with each of the parents in alternating years.

375 Neither parent adduced any evidence, nor made any submissions, in relation to Easter, yet they seek that the Court determine this apparently important issue, albeit in a vacuum. I consider that the proposal put forward by the Independent Children's Lawyer to be in the child's best interests as it incorporates Easter into the time to be spent by the child with each of the parents in the Term 1 school holidays in each alternate year, providing for certainty and removing an area of potential dispute between them. Accordingly, I shall make orders to the effect of those proposed by the Independent Children's Lawyer.

OTHER ISSUES

376 Notwithstanding that the father is seeking sole parental responsibility for the child, subject to the provisos proposed by him, namely, for the provision of notice and information by him to the mother and the consideration by him of her views in relation to "any significant long-term decision for the child", which orders shall effectively be made, he nevertheless proposes that

the parents do all acts and things to enrol the child in and facilitate the child attending B School until the conclusion of primary school and C School, for the child's secondary education. The orders for sole parental responsibility would ordinarily confer upon him the authority to do so. Whilst the mother seeks an order for the enrolment of the child at QQ School for the child's secondary education, that is clearly predicated upon the order she seeks, but which will not be made, for the child to live with her. I have considered above the father's evidence in relation to his reasons for his proposal of the named schools and found them to be in the child's best interests. No submissions, or alternative proposals, were made by the mother in the event of a change of residence.

377 However, insofar as the father seeks an order that "any enrolment and tuition fees and compulsory levies … be shared equally" between the parents, there is no application before the Court for departure from administrative assessment of child support or for the provision of child support otherwise than in the form of periodic amounts and, therefore, there is no jurisdiction for such an order to be made.

378 The parties are in agreement that each of the parents personally and by their servants and agents be restrained from:

> a. doing or saying anything to the child or in the presence or hearing of the child that is derogatory of the other parent; or
>
> b. denigrating, abusing or belittling each other in the presence or hearing of the child.

379 Such an order will be made by consent. However, the mother seeks a further order, which is apparently, but inexplicably, opposed by the father and the Independent Children's Lawyer, albeit without any submissions in relation thereto. The mother seeks, similarly without any submissions, there also be a restraint in relation to:

> … discussing any court proceedings or the contents of any documents filed with any court that relate to the parents or the child, with or in the presence of or hearing distance of the child.

380 It is entirely unclear why such a restraint would be opposed. Notwithstanding the absence of submissions, it is manifest that it would not be in the child's best interests for there to be any discussions of any court proceedings, or the contents of any documents filed in any court, that relate to the parents or the child, with, or in the presence or hearing, of the child, and I shall order accordingly.

CONCLUSION

381 This has been a difficult case in which the Court has been greatly assisted by counsel for the parties and, in particular, their detailed written closing submissions. The Court has also been assisted by much of the expert evidence in this case, both in reports filed and in oral evidence in cross-examination, as well as many of the documents tendered, such as, but certainly not limited to, the Cass Report. The Court, in particular, acknowledges the role of the Independent Children's Lawyer in this case, especially her assumption of the role of effective "contradictor" to garner evidence at a time when the father was self-represented in the face of the mother's application. The Court is not unaware that, in the immediate future, the orders to be made may cause some initial distress to the child but has concluded that, notwithstanding, they are indubitably in the child's overall best interests. The Court is also cognisant that the orders for the father to have sole parental responsibility for the child, in particular in relation (but not limited) to the child's gender identity, and for the child to live with the father, will be difficult for the mother to accept and will be distressing for her. Nevertheless, it is to be hoped that she will come to accept what has been determined to be in the child's best interests and to support the child accordingly.

382 I conclude by returning to my introductory observations. This is a case about a child, and a relatively young one at that; not one about the cause of transgender people. As this child grows, develops and matures, and explores and experiences life, the child might, with the related benefits of the passage of time and the acquisition of balanced understanding, come to identify as a transgender female and might elect to undergo some form of medical treatment, to affirm and/or align with that identity. But, similarly, with those benefits, the child might not do so, and for a variety of reasons. At this stage in the child's life, all options should be left open, without any unacceptable risk of harm to the child. That, I have concluded, will most likely occur if the father has sole parental responsibility for the child and the child lives with him, whilst nevertheless spending regular and frequent time with the mother.

I certify that the preceding three hundred and eighty-two (382) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice Strum.

Associate:

Dated: 3 April 2025