CCYP
Commissioner for Children and Young People Tasmania

Your Ref:
Our Ref: 832 / 348

3 September 2019

The Director
Tasmania Law Reform Institute
By email to: law.reform@utas.edu.au

Dear Director

Re: Legal Recognition of Sex and Gender Issues Paper No 29

Thank you for the opportunity to respond to the Issues Paper *Legal Recognition of Sex and Gender* and for agreeing to an extension of time in which to do so.

Role of the Commissioner for Children and Young People

The *Commissioner for Children and Young People Act 2016* (CCYP Act) outlines my functions and powers and provides guidance on the way in which I perform my legislated responsibilities. My comments below focus on matters discussed in the Issues Paper that are particularly relevant to promoting and protecting the rights, wellbeing and best interests of children and young people in Tasmania, noting the following requirement in the CCYP Act:

> **3. Principles to be observed**
>
> (1) The Commissioner or any other person performing a function, or exercising a power, under this Act, must –
>
> (a) do so according to the principle that the wellbeing and best interests of children and young people are paramount; and
>
> (b) observe any relevant provisions of the United Nations *Convention on the Rights of the Child* [CRC].

Preliminary Comments

Consistent with the terminology used in the Issues Paper, I have used the terms 'intersex', 'transgender' and 'gender diverse' in this submission. In doing so, I acknowledge that there is no clear consensus on the most appropriate terminology to describe gender identity and

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intersex variations, and that our language is constantly evolving to be more inclusive and respectful of individual experiences.[1]

In my November 2018 and February 2019 comments on amendments proposed to the *Birth, Deaths and Marriages Registration Act 1999* (BDMR Act),[2] I emphasised how it is important for us as a community to ensure that we do all we can to remove the unacceptable discrimination that children and young people can experience in their everyday lives because of their sex or gender identity. I also made it clear that, in my view, amendments to the BDMR Act to register a change of sex or gender without the need for sex reassignment surgery contributes to the removal of discriminatory practices against these children and young people.

I am deeply aware of recent public discussion and debate concerning the care and treatment of transgender and gender diverse children and young people. As I said in my February 2019 comment mentioned above, while public discussion and debate are critical elements of our democratic processes, there is a risk that debate may become highly politicised and expose children, young people and their families to harm and distress. It is imperative that we take every precaution to ensure that any such public debate is respectful and conducted in a manner which does no harm to those children and young people whose lives are affected by the issues being discussed.

Part 2 – Legal Recognition of Sex and Gender

I take this opportunity to convey my thanks to the Tasmania Law Reform Institute (TLRI) for setting out in a concise and informative way details around the changes introduced by the *Justice and Related Legislation (Marriage and Gender Amendments) Act 2019* (the *JRL Act*) and for including a discussion about the terms sex and gender and related terminology. By undertaking this work, the Issues Paper contributes to improved understanding of the amendments made and of their implications for children and young people affected by the legislative changes.

I make no comment in relation to the matters raised in Part 2 of the Issues Paper except to draw your attention to the following:

1. There may be implications for the interaction between the *JRL Act* and the search powers relating to children and young people detained under the *Youth Justice Act 1997* (YJA) (see section s131 of the YJA). In my May 2019 Advice to the Tasmanian Government on searches of children and young people held in custody in custodial facilities, I recommended that the legislative bases for all searches of children and young people in custody in Tasmania be clarified and consolidated. Relevantly, I also recommended that regulations clearly outline the way in which searches of children and young people in custody are to be conducted so as to promote the dignity and self-respect of the child or young person concerned and to minimise any associated

[1] Australian Human Rights Commission, https://www.humanrights.gov.au/our-work/lgbti/terminology. I note also that in its July 2018 Consultation Paper on *Protecting the Human Rights of People Born with Variations in Sex Characteristics in the context of Medical Interventions*, the Australian Human Rights Commission uses the term 'people born with variations of sex characteristics' rather than 'intersex' and has invited comments on whether there is a better way to describe people who are the subject of its consultation.
[2] https://www.childcomm.tas.gov.au/wp-content/uploads/2019-03-19-Comment-on-Proposed-Amendments-to-the-Justice-and-Related-Legislation-Marriage-Amendments-Bill.pdf and https://www.childcomm.tas.gov.au/wp-content/uploads/Submissions-2018-11-29-Comment-Justice-and-Related-Legislation-Marriage-Amendments-Bill-2018-.pdf.

trauma, distress or other harm.[3] I understand that relevant government agencies are progressing discussions to determine the best approach for a more consistent legal framework that applies to searches of children and young people in custody.

2. It is stated in the Issues Paper that any application to register a change of gender made by or on behalf of a minor under the new Part 4A of the BDMR Act must be supported by evidence that the child has received counselling regarding the consequences of registering a change of gender (eg paragraph 2.1.143). This is not quite as I understand the situation. On my reading of the relevant provision (see the new section 28C of the BDMR Act), there is no obligation for an application to be accompanied by evidence of counselling, although an applicant may choose to provide that evidence with their application, or the Registrar may require that evidence in the circumstances outlined in the provision. It would be useful to clarify this aspect of the changes in any final report.

Part 3 - Consent to medical treatment to alter a person's sex or gender:

Introductory comments

At 3.3.1 of the Issues Paper it is stated that, "[b]ecause the *JRL Act* has removed the requirement for reassignment surgery as a prerequisite to registering a change of gender, the *BDM Act* no longer plays a role in regulating consent to medical procedures in relation to minors". I should point out that it was not my understanding that the BDMR Act has historically played a role in regulating consent to medical procedures in relation to minors. It would therefore be useful for the TLRI to clarify this matter in its final report.

As the Issues Paper notes, other than in exceptional cases, informed consent is required before medical treatment can lawfully be provided to a child or young person who has not yet attained the age of 18 years ('child'). Generally, where medical practitioners are satisfied that a child is '*Gillick* competent', the child may provide consent to their own medical treatment.[4]

Gillick competence is achieved where a child 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[5] Where a child is not *Gillick* competent, decisions about their treatment are generally made by their parent or guardian.[6]

However, some decisions about medical treatment for children fall outside the normal authority of a parent or person with parental responsibility and, even where a *Gillick* competent child consents to the treatment, such decisions may require authority of a court.[7] In the family law context, these types of decisions relate to what are known as 'special

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[3] https://www.childcomm.tas.gov.au/wp-content/uploads/2019-05-06-FINAL-Advice-to-Ministers-Searches-of-children-and-young-people-in-custody-in-custodial-facilities.pdf

[4] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (*Gillick*); see also *Secretary of the Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 189 (*Marion's case*).

[5] *Gillick*, ibid.

[6] Pursuant to section 61C of the *Family Law Act 1975* (Cth), subject to any order of the court, each of the parents of a child who has not turned 18 years of age has the "parental responsibility" for that child, an aspect of which is the right and obligation to make decisions around medical treatment for the child.

[7] *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218 (*Marion's case*); *Family Law Act 1975* (Cth), s67ZC. Note also the requirement to seek authorisation for 'special treatment' under the *Guardianship and Administration Act 1996* (Tas), Part 6.

medical procedures.' While this term has no fixed definition, court authorisation is required for proposed treatment that is non-therapeutic, invasive, irreversible and where there is a significant risk of making an incorrect decision about the best interests of the child and the consequences of doing so are particularly grave.[8]

Decision-making is guided by what is in the best interests of the child which includes giving due consideration to the views of the child having regard to their age and maturity.[9] I think it is important to note the below comment of the Committee on the Rights of the Child in relation to best interests:

> 22. The right of the child to have his or her best interests taken into account as a primary consideration is a substantive right, an interpretative legal principle and a rule of procedure, and it applies to children both as individuals and as a group. All measures of implementation of the Convention, including legislation, policies, economic and social planning, decision-making and budgetary decisions, should follow procedures that ensure that the best interests of the child, including adolescents, are taken as a primary consideration in all actions concerning them. In the light of its general comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration, the Committee stresses that, when determining best interests, the child's views should be taken into account, consistent with their evolving capacities and taking into consideration the child's characteristics. States parties need to ensure that appropriate weight is afforded to the views of adolescents as they acquire understanding and maturity [footnotes omitted].[10]

A number of legal and rights-based considerations arise in relation to consent to medical procedures for transgender and intersex children.

Consent to medical treatment for intersex children

Where a child is born with ambiguous genitalia, medical interventions are sometimes undertaken in order to bring their external physical appearance more in line with their assigned gender. These interventions can include hormone treatment or surgery.

There is increasing awareness of the potential harmful effects of undertaking medical interventions, especially "gender normalisation surgery", on intersex infants and children who are not able to provide informed consent. Courts have also been criticised for failing to adequately consider the human rights and autonomy of children born with variations of sex characteristics, and the repercussions of medical interventions on individuals and their families.[11]

A 2016 decision of the Family Court in *Re: Carla (Medical Procedure)* [2016] FamCA 7 ('*Re: Carla*') suggests that surgical procedures on intersex children may now fall within the normal authority of a parent or person with parental responsibility and no longer require Court authorisation. This decision has been criticised and it has been noted that 'this withdrawal of the need for external scrutiny of an invasive and potentially non-therapeutic

[8] *Marion's Case*, ibid; Australian Human Rights Commission, *Protection the Human Rights of People Born with Variations of Sex Characteristics in the context of Medical Interventions*, July 2018, [79].
[9] *Convention on the Rights of the Child*, Articles 3 and 12.
[10] Committee on the Rights of the Child, *General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1).*
[11] Australia and Aotearoa/New Zealand intersex community organisations and independent advocates (March 2017), *Darlington Statement*, 4. See https://ihra.org.au/wp-content/uploads/key/Darlington-Statement.pdf

medical procedure signalled a retreat by the judiciary from any meaningful engagement with the child's future preferences'.[12]

It is acknowledged that arriving at a decision in the best interests of an infant or child in these types of matters can be extremely difficult. In its General Comment on the right of children to have their best interests considered, the Committee on the Rights of the Child has acknowledged that there is room for manipulation:

> 34. The flexibility of the concept of the child's best interests allows it to be responsive to the situation of individual children and to evolve knowledge about child development. However, it may also leave room for manipulation; the concept of the child's best interests has been abused by Governments and other State authorities to justify racist policies, for example; by parents to defend their own interests in custody disputes; by professionals who could not be bothered, and who dismiss the assessment of the child's best interests as irrelevant or unimportant.[13]

A recent paper in the QUT Law Review notes as follows:

> It has been suggested that with respect to the medical intervention of intersex children, 'it is time to stand back and rethink every aspect of its management', and the same holds true for the legal test of how to determine the best interests of intersex children.[14]

Appropriately, in its discussion of the human rights issues of relevance to intersex children, the Issues Paper notes Article 24.3 of the CRC which obliges states parties to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children. As the TLRI states, 'this is relevant to medical practices that are based on conventional medical practice and social considerations rather than established physiological need' (para 3.2.5). There is also a comprehensive discussion regarding the rights relevant to medical intervention for intersex children, in a July 2018 Australian Human Rights Commission consultation paper.[15]

The question of surgical intervention for intersex children, and particularly those who are not yet *Gillick* competent, has been the subject of a number of inquiries, reports, and statements.[16] In its concluding observation on Australia's sixth periodic report under the *International Covenant on Civil and Political Rights*, the United Nations Human Rights Committee expressed concern that 'infants and children born with intersex variations are sometimes subject to irreversible and invasive medical interventions for purposes of gender assignment, which are often based on stereotyped gender roles and are performed before they are able to provide fully informed and free consent (arts. 3, 7, 9, 17, 24 and 26)'.[17] The Human Rights Committee has explicitly recommended that Australia 'move to end irreversible medical treatment, especially surgery, of intersex infants and children, who are

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[12] Richards, Bernadette J; Wisdom, Travis Leal Couto. Re Carla: An Error in Judgment. *QUT Law Review,* [S.l.], v. 18, n. 2, p. 77 - 92, Jan. 2019. ISSN 2201-7275. Available at: <https://lr.law.qut.edu.au/article/view/760>

[13] Committee on the Rights of the Child, *General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)* [34].

[14] Richards, Bernadette J; Wisdom, Travis Leal Couto. Re Carla: An Error in Judgment. *QUT Law Review,* [S.l.], v. 18, n. 2, p. 77 - 92, Jan. 2019. ISSN 2201-7275. Available at: <https://lr.law.qut.edu.au/article/view/760>

[15] Australian Human Rights Commission (July 2018), *Protecting the Human Rights of People Born with Variations in Sex Characteristics in the context of Medical Interventions.*

[16] Australian Human Rights Commission, ibid, [5.3].

[17] Human Rights Committee (2017), *Concluding observations on the sixth periodic report of Australia*, 1 CCPR/C/AUS/CO/6, 25-26.

not yet able to provide fully informed and free consent, unless such procedures constitute an absolute medical necessity'. [18]

The Committee on the Rights of the Child has also emphasised 'the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy.' The Committee has condemned forced surgeries or treatments on intersex adolescents and called upon States to eliminate such practices.[19]

In my opinion, and consistent with the views of human rights bodies discussed above, irreversible and invasive medical treatment for intersex children, particularly gender normalisation surgery, should be deferred until such time as the child becomes *Gillick* competent, unless there is an absolute medical necessity for the treatment to occur.

There is a degree of complexity however around how this could best be achieved in Tasmania noting that Tasmania does not have legislation which governs consent to medical treatment for children generally. It is also necessary to take account of the jurisdiction of the Family Court regarding special medical procedures – a jurisdiction based on an assessment of medical treatment as essentially non-therapeutic. For the sake of completeness, I note also that authorisation is required from the Guardianship and Administration Board for interventions for children with disability which come within the term 'special treatment'.[20]

Furthermore, there are differing views as to what form such a regulatory framework should take. This is demonstrated by the range of options canvassed in the Issues Paper which include criminalisation of certain surgical procedures on children, establishment of a specialist tribunal or board to provide oversight and authorisation, specialised legislation to address the normalisation or reassignment surgery of children and/or a civil liability approach.

In my opinion, consideration of possible reforms around consent to medical interventions for children who are intersex could appropriately occur in the context of discussions about whether Tasmania should introduce specific legislation governing consent to medical treatment for children in Tasmania generally.

Further, my preliminary view is that I would be generally supportive of the establishment of a specialist multi-disciplinary body which could provide child-centred oversight, authorisation and advice to parents and clinicians on 'the ethically, legally and, at times, clinically, complex question of how to appropriately support the medical and social needs of intersex children'.[21] In saying this I acknowledge that the introduction of this type of body may raise some jurisdictional issues which would require careful consideration.[22]

I note also that, once finalised, the work of the Australian Human Rights Commission to consider and make recommendations on how best to protect the rights of people born with

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[18] Human Rights Committee (2017), ibid.
[19] Committee on the Rights of the Child, *General Comment No 20 (2016) on the implementation of the rights of the child during adolescence*, CRC/C/GC/20, para 34.
[20] *Guardianship and Administration Act 1996* (Tas), Part 6. See also the Tasmania Law Reform Institute, *Review of the Guardianship and Administration Act 1995 (Tas)*, Final Report No 26, 13.2.
[21] Richards, Bernadette J; Wisdom, Travis Leal Couto. Re Carla: An Error in Judgment. *QUT Law Review*, [S.l.], v. 18, n. 2, p. 77 - 92, Jan. 2019. ISSN 2201-7275. Available at: <https://lr.law.qut.edu.au/article/view/760>
[22] Richards, Bernadette J; Wisdom, Travis Leal Couto. Ibid.

variations in sex characteristics in the context of non-consensual medical interventions is likely be of significant assistance.

Consent to medical treatment for transgender minors

As the Issues Paper notes at 3.5.1, the effect of the *JRL Act* is to remove sex reassignment surgery as a pre-condition to registering a change of sex or gender. This is a welcome change. I note however that there may be circumstances in which a transgender young person wishes to undergo treatment including reassignment surgery to align their appearance with their affirmed gender before they attain the age of 18. For example, chest reconstructive surgery (known as 'top surgery') may be a treatment option for adolescent transgender males with gender dysphoria in the circumstances of their individual case, although I understand that genital surgery is generally delayed until adulthood.[23]

In relation to surgery the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* relevantly provide as follow:

> A decision as to whether the surgery is in the adolescent's best interest should be made jointly, with consensus reached between the adolescent, their parents/ guardians and the clinicians involved in their care. Ideally, this would include the members of the multidisciplinary team taking a holistic approach with the paediatrician or endocrinologist, the mental health clinicians and the surgeon in agreement regarding best interest. [24]

There is no doubt that the situation in relation to consent for a transgender child or a young person to access treatment can be complicated and there is a degree of uncertainty about the law. This is particularly the case where a child's parent or guardian does not support the wishes of the child or where there is a dispute as to whether the child is *Gillick* competent or whether the treatment proposed is therapeutic.

As I understand the situation, the Family Court has held that where all parties agree that a child is *Gillick* competent, and there is no dispute between the child and their parents or with or between the parents and medical practitioners regarding the therapeutic nature of the treatment proposed (ie there is no "controversy"), its authorisation is not required for puberty suppression treatment (Stage 1 treatment) or gender affirming hormone treatment (Stage 2 treatment) for gender dysphoria.

Where there is a dispute about whether a child is *Gillick* competent, or where there is a dispute between the child and their parents, or between the parents and/or the medical practitioners about the appropriateness of the treatment proposed, it appears that 'it is the role of the Family Court to hear and determine that controversy'.[25]

It appears that the situation regarding gender affirming surgery (Stage 3 treatment) is less clear. In *Re Matthew* [2018] FamCA 161 (*Re: Matthew*) Justice Rees of the Family Court made the following declaration:

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[23] Telfer, M.M., Tollit, M.A., Pace, C.C., & Pang, K.C. *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.1*. Melbourne: The Royal Children's Hospital; 2018.
[24] Ibid, 25.
[25] *Re Matthew* [2018] FamCA 161, 40.

That in the circumstances of this case, where the subject child has been diagnosed as suffering from Gender Dysphoria, where treating practitioners have agreed that the subject child is Gillick competent, where it is agreed that the proposed treatment is therapeutic and where there is no controversy, no application to the Family Court is necessary before Stage 3 treatment for Gender Dysphoria can proceed.[26]

The case of *Re: Matthew* was a decision of a single judge limited to the circumstances of the case in question and my understanding is that the decision is not binding on other judges.

Given that it is already the law that children who are *Gillick* competent can consent to medical treatment, as long as the treatment proposed is not of the sort within the meaning of a special medical procedure for the purposes of the *Family Law Act 1975*, the question remains whether there is a need for legislative or other guidance for decision-making regarding medical treatment for transgender children. This is particularly so given the evolving view of the Family Court in relation to these types of treatments.

It appears to me that the options for legislative reform put forward in the Issues Paper raise potential implications for consent to medical treatment for children and young people in Tasmania generally (ie not just treatment for transgender children).

As I understand the situation, even in the event of legislative reform in Tasmania, where there is a controversy of the relevant type, an application could still be made to the Family Court to resolve that controversy. It is not entirely clear to me how or in what way the options for legislative reform such as those proposed in paragraphs 3.5.12 - 3.5.16 of the Issues Paper, would operate in the context of this family law jurisdiction.

I am of the opinion that the circumstances of transgender children who wish to undergo (or whose parents may wish them to undergo) medical treatment to alter their sex characteristics could properly be considered in the context of discussions about the possible development of specific legislation governing consent to medical treatment for children in Tasmania generally.

Conclusion

As should be apparent from the above, the main recommendation that I make is that consideration be given to the development of legislation governing consent to medical treatment for children generally in Tasmania. Within that framework, consideration could be given to consent to medical treatment for intersex and transgender children. Such an approach is consistent with that proposed by Interim Commissioner Clements in his March 2018 submission to the TLRI review of the *Guardianship and Administration Act 1995,* [27] for children who come within the special treatment jurisdiction of the Guardianship and Administration Board.

Given the range and complexity of the legal issues in question, any contemplated legislative reform should be informed by those with relevant expertise in family, medical and constitutional law in order to avoid the potential for any unintended adverse consequences

[26] *Re Matthew* [2018] FamCA 161. 1.

[27] https://www.childcomm.tas.gov.au/wp-content/uploads/2018/06/TLRI-Review-of-the-GA-Act-1995-27-March-2018.pdf

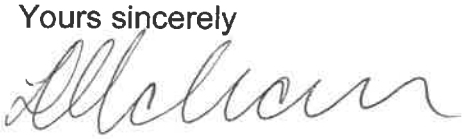
for children and their families. Any reforms should also be informed by the lived experiences of children, young people and adults who are intersex, transgender or gender diverse.

Finally, regardless of any legislative or regulatory approach adopted for intersex or transgender children in relation to consent to medical treatment, there should be a concerted effort to promote improved awareness and understanding in the community of the unique needs and experiences of transgender and intersex children.

I look forward to seeing the final report and recommendations of the TLRI in relation to this important area of policy and law.

Please do not hesitate to contact me if you would like to clarify or discuss in more detail any aspect of my submission.

Yours sincerely



Leanne McLean
Commissioner for Children and Young People

cc *The Hon. Elise Archer MP, Attorney General*
The Hon. Sarah Courtney MP, Minister for Health
The Hon. Roger Jaensch MP, Minister for Human Services
The Hon. Jeremy Rockcliff MP, Minister for Mental Health and Wellbeing