FAMILY COURT OF AUSTRALIA

RE: SHANE (GENDER DYSPHORIA) ***[2013] FamCA 864***

FAMILY LAW – CHILDREN – MEDICAL PROCEDURES – where the applicants are parents of a child with gender dysphoria – where the applicants seek an order authorising them to consent to Stage 2 treatment for their child – where the Full Court has recently held that authorisation by this court is not required for Stage 1 treatment but is required for Stage 2 treatment (*Re: Jamie* [2013] FamCAFC 110) – whether the proposed treatment is in the child's best interests – where the child is 16½ years old – where the child has significant comorbidities including social isolation, anxiety and depression – where the expert evidence is unanimous in terms of diagnosis and proposed treatment – where the treatment is in accordance with international guidelines and practices adopted in other hospitals in Australia – orders made authorising the applicants to consent to the Stage 2 treatment proposed for the child.

Family Law Act 1975 (Cth)

Family Law Rules 2004 (Cth)

Gillick v West Norfolk A.H.A [1986] AC 11
Re: Jamie [2013] FamCAFC 110
Re: Lucy (Gender Dysphoria) [2013] FamCA 518
Re: Sam and Terry (Gender Dysphoria) [2013] FamCA 563
Secretary, Department of Health and Community Services v JWB and SMB ("Marion's Case") (1992) 175 CLR 218

APPLICANT: The Mother and the Father

INTERVENER: The Department

FILE NUMBER: By Court Order File Number is suppressed

DATE DELIVERED: 5 November 2013

JUDGMENT OF: Murphy J

HEARING DATE: 28 October 2013

REPRESENTATION

By Court Order the names of counsel and solicitors have been suppressed

ORDERS

IT IS DECLARED IN RESPECT OF THE CHILD HANNAH (now known as SHANE) BORN … 1997 (referred to in these Orders as "Shane") THAT:

1. By this Order, Shane's parents are authorised to consent to the administration of intramuscular primoteston TM (testosterone enanthate) ("Stage 2 treatment") in such dose, in such manner and with such frequency as determined by and under the guidance of Shane's treating medical practitioners including but not limited to his Endocrinologist, Professor X and his Psychiatrist, Dr Y.

IT IS FURTHER ORDERED THAT

2. So as to protect Shane:

   a. Shane's full name, his family members, his medical practitioners, this court's file number, the State of Australia in which the proceedings were initiated and any other fact or matter that may identify Shane shall not be published in any way;

   b. Only anonymised Reasons for Judgment and Orders (with coversheets excluding the registry, file name and number, and lawyers' names and details, as well as Shane's real name (both past and present)) shall be released by the court to non-parties without further contrary order of a judge;

   c. No person shall be permitted to search the court file in this matter without first obtaining the leave of a judge.

3. To the extent that the exception provided for in s 121(9)(g) of the *Family Law Act 1975* (Cth) or the other provisions of that subsection do not otherwise authorise same, the applicants shall have leave to publish to Shane's treating medical practitioners a version of these Reasons which does not encompass the restrictions set out in the preceding paragraph.

IT IS NOTED that publication of this judgment by this Court under the pseudonym *Re: Shane (Gender Dysphoria)* has been approved by the Chief Justice pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order the File Number is suppressed

The Mother and the Father
Applicants

REASONS FOR JUDGMENT

1. The child the subject of these proceedings, Shane (born in 1997)[1], has been diagnosed with gender dysphoria. His parents have brought these proceedings pursuant to r 4.08(1)(a) of the Family Law Rules 2004 (Cth) ("the Rules") and seek orders authorising them to consent to "Stage 2" treatment on Shane's behalf (being the administration of testosterone to induce male puberty).

2. The Director-General of the Department has intervened. No material was filed by the intervenor and oral submissions made on the Director-General's behalf supported the application.

3. Neither the applicants nor the intervenor sought the appointment of an Independent Children's Lawyer. I considered that the circumstances did not warrant such an appointment: some urgency attends the proposed treatment; there is unanimity amongst the experts and between Shane and his parents as to the treatment; and, the affidavit material both from the experts and Shane's parents contains consistent accounts of Shane's strong and thoughtful views.

4. Prior to the hearing, the legal representatives for the applicants approached the court seeking permission for Shane to be present during the hearing. In light of Shane's age, his maturity, the nature of the disorder he is suffering from, his erstwhile involvement in discussions about his treatment and the absence of conflict with his parents, I allowed him to be present during the hearing.

IS AUTHORISATION REQUIRED?

5. As the recent decision of the Full Court in *Re: Jamie* [2013] FamCAFC 110 makes plain (see, also, *Re: Lucy (Gender Dysphoria)* [2013] FamCA 518 and *Re: Sam and Terry (Gender Dysphoria)* [2013] FamCA 563), children can give informed consent to Stage 2 treatment if they are Gillick-competent. If, however, a child is not Gillick-competent, Stage 2 treatment falls within a narrow band of "special cases" consent to which does not come within the ambit of parental responsibility. In those "special cases", authorisation of the

[1] Shane was born Hannah. In April 2013, a Change of Name Certificate was registered, and Hannah's name was formally changed to Shane. For reasons which will appear, he will be referred to by the male pronoun and as Shane in these reasons.

treatment by this court pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act") is required.

6. However, as I discussed in *Re: Lucy*, s 67ZC does not, in and of itself, confer jurisdiction upon the court to make the order sought in the instant application. In order to validly exercise the jurisdiction contained within s 67ZC, that section must "attach" to a "matter" contained in Part VII of the Act. Given the applicants in this case are Shane's parents and Shane is a child of a marriage, the power provided for in s 67ZC can "attach" to the jurisdiction conferred upon the court in Part VII in respect of parental responsibility. Consequently, s 67ZC provides jurisdiction in this case to make the order sought by Shane's parents.

7. Having determined that the court has jurisdiction to authorise the proposed treatment, two further questions arise: is Shane Gillick-competent and, is the proposed treatment of the nature and type for which authorisation of the court is required?

Is Shane Gillick-competent?

8. Each of Dr Y and Professor X state that whilst Shane is an intelligent and thoughtful adolescent who has substantial insight into his condition and the proposed treatment, they do not consider him to be presently Gillick-competent. Further, each considers that he will not attain such competency whilst he is a minor. The application filed by Shane's parents is an indication that they agree. The legal representative for the Director-General did not contend otherwise; indeed, it was submitted that authorisation by the court was required.

9. Whilst I accept that Shane has the capacity to intelligently and thoughtfully consider his condition, the proposed treatment and its consequences, there is no evidence before me to suggest that Shane has "achieve[d] a sufficient understanding and intelligence to enable him … to understand fully what is proposed", being the test of Gillick-competency accepted by the High Court as law in this country (*Gillick v West Norfolk A.H.A* [1986] AC 11; *Secretary, Department of Health and Community Services v JWB and SMB ("Marion's Case")* (1992) 175 CLR 218). I do not, then, consider Shane to be Gillick-competent.

Does the proposed treatment require authorisation?

10. Having so found, the next issue is whether the proposed Stage 2 treatment is of a nature and type to require authorisation by the court.

11. As noted earlier, in *Re: Jamie* the Full Court of this court unanimously held that Stage 2 treatment for gender dysphoria (comprising the administration of either oestrogen or testosterone to instigate the onset of female or male puberty respectively) *is* treatment falling within the narrow band of "special cases"

requiring this court's authorisation (see, also, the discussion in *Re: Lucy* and *Re: Sam and Terry*).

12. That being the case, the criterion for permitting authorisation is that the proposed Stage 2 treatment is in Shane's best interests.

THE NATURE OF SHANE'S CONDITION

13. Shane was born genetically and anatomically female. He has, however, legally changed his name to Shane and identifies exclusively as a male.

14. There is unanimous expert evidence, which will be referred to in detail later in these reasons, that Shane meets the DSM-5 diagnostic criteria for gender dysphoria in both adolescents/adults and children (previously called "gender identity disorder" in the superseded DSM-IV). It is appropriate to set out the former (noting that the unanimous medical opinion is that he also satisfies the latter):

> **Gender Dysphoria in Adolescents and Adults**
>
> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
>
> 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
>
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
>
> 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
>
> 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
>
> 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
>
> B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
>
> *Specify* if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Shane's Circumstances

15. Shane, who has also been diagnosed with Asperger's Spectrum Disorder, has, according to his mother, "always perceived himself as a boy." Shane's father deposes that "[a]s far back as I can recall, [Shane] was not a typical girl. He had no interest in the usual things that girls like doing (for example, playing with dolls). His behaviour was more than just being a tom-boy." Shane's mother deposes to him being "very different" to his older sister; "[h]e never owned any typical girl toys such as dolls. He preferred big trucks."

16. Both of Shane's parents depose to Shane asking them when he was "a toddler" when he "could be a boy". His father describes "[t]hings bec[oming] very difficult when Shane entered puberty…" and he "…recall[s] a particular occasion when [Shane] became very distressed about having to purchase a bra."

17. Shane's treating psychiatrist, Dr Y, whose evidence will be referred to in greater detail shortly, annexes to his report (attached to an affidavit filed 17 October 2013) "written material summarising [Shane's] gender variant behaviours since early childhood" provided to him by Shane's parents. In that "material" Shane's mother states that as a child, Shane "…had very few friends, but of those he had, all were boys" and describes Shane as selecting male clothes whenever he was given the opportunity to choose his outfit. Shane's father describes puberty as "…being a very awkward time and [Shane] refused to talk about the changes that were happening, buying underwear was a particular challenge as [Shane] refused to come shopping with either me or my wife and absolutely no frills or lace was the order of the day."

18. The "written material" also contains photographs of Shane from childhood through to adolescence, which are accompanied by commentary by Shane. In all bar two of the photographs, Shane is wearing a t-shirt and shorts/pants. In one photograph, Shane is wearing a life jacket and comments 'I used to love

wearing life jackets because you could not see my chest…" In respect of a photograph of him in a female school uniform, Shane describes being physically bullied by female classmates. Shane has since changed schools and attends his present school as a male.

19. Each of Shane's parents depose to being told by Shane in about 2012 that he was gay. Shortly thereafter, as a result of his own research, Shane informed them that he was transgender. Shane's older sister (who is studying a health science) arranged for him and his family to attend a support group for transgender people, after which Shane and his mother saw his General Practitioner who tentatively diagnosed Shane with Gender Dysphoria and referred him to Dr Y, a consultant child and adolescent psychiatrist at a children's hospital and clinical director of a State children's mental health agency. (Shane had previously met Dr Y in 2011 when he was diagnosed with Asperger's Spectrum Disorder).

20. Since the referral, Shane and his father have seen Dr Y on two occasions (Shane's mother has not physically met with Dr Y as she has been working overseas, however she has communicated with him via telephone and email). In his report (referred to earlier), Dr Y notes that:

> 10. [Shane] advised that he recalls wishing he were a male since early childhood…
>
> 11. [Shane] reported feeling "mortified" about wearing the female school uniform of dresses and skirts during primary and early high school…Although he always attended the girls' toilets, [Shane] feels uncomfortable with this and prefers to "hang on"…
>
> 12. In retrospect, [Shane] admits that his gender dysphoria significantly contributed to his longstanding social problems, which ultimately lead [sic] to the diagnosis of Asperger's Disorder. [Shane] reported that his same-aged peers "hated me because I was different and didn't want to fit in". He retaliated by refusing to interact with them ("what was the point?"), and engaging in gender non-conforming behaviours, such as wearing male clothing. [Shane] reported that this resulted in "pack mentality" from peers, causing him to be the subject of verbal abuse and bullying. This initially occurred in primary school, but escalated in years 8 and 9 … As "[Hannah]" [[Shane's] former name], [Shane] reported that he was subjected to much rumour and innuendo, even to the point of others querying whether he was a male-to-female transsexual. [Shane] recalls that his peers would try to watch him when he undressed in the changing rooms to see what "parts" he had.
>
> 13. [Shane] reported that he found early puberty to be an uncomfortable, confusing and difficult time. [Shane's] gender dysphoria escalated during this time, complicated by social isolation and emerging symptoms of depression. He disliked menses, breast

development, bras, female underwear and the emergence of other secondary female characteristics…

21. Dr Y also records that:

> 16. [Shane] now reports strong and persistent cross-gender identification; he identifies strongly as male. I find no evidence of any cultural or personal advantage for this cross-gender identification. [Shane] has repeatedly stated a desire to be male. He now exclusively wears male clothing, binds his breasts, lives as a male and has a desire to be treated as a male…

22. Under the heading "My diagnosis…" Dr Y reports:

> 17. …I am of the opinion that [Shane] has had a longstanding history of gender dysphoria, which condition emerged in early childhood. His gender dysphoria escalated during early adolescence, complicated by a range of social problems and emerging symptoms of Asperger's Spectrum Disorder and depression.
>
> 18. I concur with [[Shane's] General Practitioner]. I have formed an opinion that [Shane] fulfils the DSM 1V Diagnostic Criteria for Gender Identity Disorder (GID). Based on his current age, [Shane] would fulfil the criteria for Gender Identity Disorder in Adolescents or Adults (F302.85), although his history indicates that he had symptoms as a child (F302.6). He would also meet the new DSM-5 Diagnostic Criteria for Gender Dysphoria.

23. Dr Y considers the proposed Stage 2 treatment "…to be in [Shane's] best interests"; "[g]iven the improvement in [Shane's] mental health issues since he began living as a male, it is my view that [Stage 2] treatment will further reduce the risk of future mental health problems." According to Dr Y, the treatment "…is likely to reduce the short and long term risks of psychiatric co-morbidity and mental health problems associated with gender dysphoria."

24. Delaying treatment would not "…serve any purpose…" Rather, Dr Y considers that delay would "…significantly exacerbate symptoms of social isolation and anxiety, and increase the risks of depression, [which is] currently in remission."

25. Whilst Dr Y notes that "treatment with testosterone is known to cause affective lability (characterised by mood swings and low mood) and increases the risk of agitation and aggression" he also reports that "[Shane] does not have a pre morbid history of aggression or violence" and notes that "[a]ppropriate psychological assessments are planned to monitor Shane's mental state" during the treatment. Further, Dr Y states that "[m]ental health support to [Shane] and his family will be provided by and co-ordinated through me."

26. Shane has also consulted with another child and adolescent psychiatrist, Dr Z. In a letter to the legal representatives for Shane's parents dated 25 August 2013 and attached to an affidavit filed 17 October 2013, Dr Z records:

> [Shane] reported he wanted "to feel more comfortable in myself. I want to be the 16 year old guy I feel I am. I want to look like I feel … I feel uncomfortable in my body, my hips and my face and my breasts." [Shane] has been binding his breasts since the beginning of 2013 to appear more male like. [Shane] told me he disliked his menstrual cycle "intensely" and had sought medical treatment to stop his periods.

27. Dr Z confirms the diagnosis of Gender Dypshoria and notes that "[Shane] reports a classical history of Gender Dysphoria." Dr Z also records that that "[w]hile [Shane] has previously received a diagnosis at the age of 14 of [Asperger's Spectrum Disorder] upon my interview today … there was no evidence [Shane] was suffering from [Asperger's Spectrum Disorder]…" This is consistent with the evidence of both of Shane's parents and Shane's self-reports, as detailed by Dr Y, which refer to a marked amelioration of the symptoms previously attributed to Shane's Asperger's Spectrum Disorder subsequent upon Shane living exclusively as a male and commencing Stage 1 treatment.

28. As with Dr Y, Dr Z considers that delaying Stage 2 treatment would be deleterious to Shane's psychological wellbeing:

> If the proposed treatment was not provided more than likely [Shane's] psychological health would decline. He would be unable to involve himself in social and recreational activities that he enjoys. He would remain socially anxious…
>
> …
>
> … [Shane's] feelings have been consistent since a young child and have remained consistent through middle childhood, puberty and early adolescence and now middle to late adolescence. He has never had periods where he has considered himself to be female. Social pressure at 15 forced him to trial female clothes and behaviours however this was uncomfortable and he chose to stop pretending.
>
> [Shane] continues to be unhappy with his current gender and these feelings will only increase with time if treatment is not undertaken…
>
> …
>
> …There is no reason to delay treatment in the hope [Shane] will change his mind. This will only lead to a further 18 months of physical discomfort, social anxiety and unhappiness.

29. Significantly, both Drs Y and Z state that there is no alternate treatment available to Shane; the proposed Stage 2 treatment is consistent with internationally recognised guidelines and has been utilised in other hospitals in Australia to treat Gender Dysphoria.

30. Shane has also consulted with Professor X, an endocrinologist and Professor of Paediatrics, whose treatment proposal founds the present application and is set out in an affidavit filed 17 October 2013. Professor X deposes to having

consulted with Shane on two occasions. As with both Drs Z and Y, Professor X has met with Shane's father but has not met with Shane's mother.

31. Professor X states that baseline investigations and chromosome analysis have revealed no "…abnormal medical or endocrine reason for [Shane's] condition" and refers to the fact that Shane has already commenced Stage 1 treatment, comprising the administration of Depot Lucrin to "suppress [Shane's] female puberty and menstruation."

32. The Stage 2 treatment proposed by Professor X for Shane will entail the intramuscular administration of testosterone esters "…with the aim of inducing male puberty." Professor X confirms that "[t]he proposed treatment is based on the Endocrine Treatment of Transsexual Persons: an Endocrine Society Clinical Practice Guideline…" and is "…consistent with the recommendations in the American Endocrine Society Clinical Practice Guideline" and is similar to the practice adopted in other Australian hospitals.

33. According to Professor X, the proposed treatment will "…induce irreversible changes" including:

> …increased muscle mass and decreased fat mass, increased facial hair and acne, the potential for male pattern baldness and increased libido. Testosterone will also result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice and usually, cessation of menses.

34. If the treatment is not provided "… [Shane's] body habitus would continue to be female, including breast development and body fat distribution…" Consistent with the evidence of Drs Y and Z, Professor X opines that "…the proposed treatment is necessary for [Shane's] welfare, as his mental state is being adversely affected by his current physical and hormonal status." Professor X also notes the risk that Shane might seek to illicitly source testosterone and self-administer which "…could result in significant, adverse physical effects…"

35. Whilst Stage 1 treatment, which Shane is currently undergoing, is "…completely reversible and has no long-term negative impact on fertility or reproductive health", the Stage 2 treatment proposed for Shane:

> …is associated with high, long-term risk of serious adverse outcomes, including breast or uterine cancer and erythrocytosis (elevated red blood cell count) with a haematocrit greater than 50%, with increased stroke and myocardial infarction risk. There is also the moderate to high risk of severe liver dysfunction and temporary or permanent decreased fertility…

IS AUTHORISATION IN SHANE'S BEST INTERESTS?

36. A number of the factors relevant to a consideration of whether or not authorisation of the proposed Stage 2 treatment is in Shane's best interests have

been canvassed earlier in these reasons. In particular, the evidence plainly reveals that:

- There is unanimity amongst two highly qualified child and adolescent psychiatrists and Shane's General Practitioner as to his diagnosis and the unlikelihood of Shane's feelings dissipating or subsiding;
- Shane's desire to "be a boy" has been present since he was a toddler and that desire has not waivered and, indeed, has increased significantly with the onset of puberty;
- Shane's Gender Dysphoria has exacerbated (or may have been mistaken for) his Asperger's Spectrum Disorder, the symptoms of which have ameliorated significantly since he was diagnosed with Gender Dysphoria and commenced living exclusively as a male and Stage 1 treatment;
- Both of Shane's parents plainly love Shane and, I have no doubt, are genuinely committed to acting in his best interests, with the guidance of highly qualified specialists. They have no reason other than what they perceive to be Shane's best interests to seek authorisation to consent to the proposed Stage 2 treatment. All of the evidence before me suggests they are entirely supportive of Shane;
- Whilst there was no direct evidence from Shane's older sister, it was she who sourced a support group for Shane and his family to attend and Shane's parents advised the court, through their counsel, that Shane's sister is supportive of him;
- Shane has access to highly qualified specialists with particular expertise in this sub-speciality, in particular Professor X who will oversee Shane's treatment and Dr Y who will provide ongoing "mental health support" to Shane and his family;
- Each of Shane's parents and the experts describe Shane as a highly intelligent, thoughtful young man who, notwithstanding his not being Gillick-competent, has a thorough appreciation for and insight into his condition, the treatment proposed, its risks and consequences.

37. There are very significant risks associated with the proposed treatment, which have been outlined above. The treatment will also have irreversible effects on Shane's physical appearance. Yet, on the evidence before me, including the research annexed to Professor X's and Dr Y's affidavits which, they depose, represents international best practice, it is the only treatment available for Shane's Gender Dysphoria.

38. All three experts agree that the treatment is consistent with those international guidelines and practice and has been utilised in other hospitals in Australia. Further, the treatment proposed is consistent with that which has been the

subject of a number of cases in this court concerning treatment of Gender Dysphoria (formerly Gender Identity Disorder) (most recently, for example, *Re: Jamie*; *Re: Sam and Terry*; *Re: Lucy*; *Re: Rosie (Special Medical Procedure)* [2011] FamCA 63; *Re: Bernadette (Special Medical Procedure)* [2010] FamCA 94).

39. In terms of the risk to Shane's fertility, Professor X suggested that Shane and his parents consider harvesting Shane's ovarian tissue. Counsel for Shane's parents advised the court that Shane and his parents had carefully considered this issue and decided not to harvest Shane's ovarian tissue. As noted earlier, Shane is described by the experts and his parents as being a highly intelligent young man who has approached his condition and its treatment in an insightful and considered manner. I have no doubt that the same approach has been adopted in respect of the decision regarding the harvesting of his ovarian tissue. I am similarly satisfied that Shane's parents have approached that option in the same way they have approached the proposed treatment more generally; that is, from the perspective of what they consider to be in Shane's best interests after informed, intelligent and thoughtful discussion with him, with medical professionals and between themselves. I have no reason to doubt that the decision reached reflects those best interests and Shane's wishes.

40. Further, whilst the risks associated with the treatment cannot be mitigated, Professor X will be overseeing Shane's treatment and will monitor those risks; security which will not be available to Shane should the proposed treatment be delayed and he were to seek the hormones illicitly and self-administer (or, indeed, be administered by a professional without the qualifications and expertise of Professor X).

41. As noted, there are no alternatives to the proposed Stage 2 treatment and the consequences of delaying that treatment have been referred to in detail by each of Drs Y and Z and Professor X. Of most concern is the risk that delay will cause a regression in the significant improvement in Shane's Asperger's Spectrum Disorder and may result in a resurgence of Shane's depression, which is presently in remission and which carries the attendant risks of self-harm and suicidal ideation.

42. The evidence of Shane's parents and the experts reveal that Shane's aversion to "girly" things and desire to "be a boy" has been apparent since he was a toddler. On the evidence before me, it has never abated; indeed it has intensified. Neither Dr Y nor Dr Z considers there to be any likelihood that Shane's symptoms, and the attendant psychological distress, will dissipate without the proposed treatment.

43. Shane attends school as a male (he wears a binder to flatten his chest and a male school uniform) and is, on all accounts, completely committed to living his life as a male. He commenced Stage 1 treatment for his condition in August

this year which has suppressed further female pubertal development and menstruation which has resulted in significant relief for Shane.

44. The evidence is unequivocal in terms of the acceptance by Shane's family of his condition and their support of his transition. Shane's parents are plainly supportive of the treatment proposed for Shane.

45. The unanimous expert evidence, together with the evidence of Shane's parents and Shane's own reports satisfy me that the proposed Stage 2 treatment is in Shane's best interests.

PRIVACY AND ANONYMISATION

46. In matters such as this, orders tend to be made with a view to preserving the anonymity of the child. I consider it appropriate to make such orders, protecting not only Shane's name, but also other information (including the names of Shane's parents, the identities of the experts and the applicants' legal representatives) to ensure that Shane's identity is protected.

I certify that the preceding forty-six (46) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Murphy delivered on 5 November 2013.

Associate:

Date: 5 November 2013