



FAMILY COURT OF AUSTRALIA

CHAMBERS OF THE HONOURABLE DIANA BRYANT AO  
CHIEF JUSTICE

Commonwealth Law Courts  
305 William Street  
Melbourne VIC 3000  
Mail: GPO Box 9991  
Melbourne VIC 3001

22 February 2013

Committee Secretary  
Senate Standing Committee on Community Affairs  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600

Dear Committee Secretary

This letter constitutes my submission to the Senate Community Affairs Committee's ("the Committee") Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia ("the inquiry").

I make this submission in my role as Chief Justice of the Family Court of Australia ("the Court"), in consultation with the Court's Law Reform Committee. I wish to emphasise that the views contained herein are my own and may not necessarily reflect the views of all of the other members of the Court.

I understand that the Senate referred the inquiry to the Committee on 20 September 2012. Unfortunately however, as I was not informed that the matter of involuntary sterilisation was before the Committee, the existence of the inquiry only recently came to my attention. This occurred as a result of media reporting around the comments made by Ms Carolyn Frohmader, Executive Director, Women with Disabilities Australia, about a Family Court decision, *Re: Angela* (2010) 43 Fam LR 98, which involved an application for sterilisation of an 11 year old girl with a severe medical condition. The judge in that case granted the application. Ms Frohmader was reported as saying that she found the case "very problematic for a whole range of reasons."<sup>1</sup>

---

<sup>1</sup> Vince Chadwick, 'Sterilisation the First Option for the Disabled', *The Age*, Melbourne, 2 January 2013 <http://www.theage.com.au/national/sterilisation-first-option-for-the-disabled-20130101-2c48m.html> (accessed 8 February 2013).

Upon undertaking further enquiries, I learned that the Committee held a public hearing on 11 December 2012 which was attended by Ms Frohmader, Ms Colleen Pearce and Mr John Chesterman from the Office of the Public Advocate Victoria, Associate Professor Sonia Grover from the Royal Children's Hospital, Melbourne, and Mr Jim Simpson from the New South Wales Council for Intellectual Disability. I have reviewed the transcript of that hearing and it is apparent that Ms Frohmader and other witnesses are critical of that decision and believe it to be misconceived.

You would appreciate that it is not appropriate for me to comment on individual cases. Nevertheless, it seems to me that the discussion that occurred at the public hearing was in many respects ill-informed insofar as it pertained to the process of hearing and determining applications to sterilise children with disabilities. I therefore thought it would be of assistance for me to briefly outline the jurisdiction exercised by the Court with respect to special medical procedure applications (including but not limited to sterilisation of minors), the legal test to be applied, and the process for hearing and determining such applications.

I note too from the transcript that certain witnesses have queried whether judges are appropriately or best qualified to preside over special medical procedure applications (see for example at page 2 of the transcript). Some witnesses have proposed that the jurisdiction instead be exercised by a multi-member tribunal. That is of course a matter of policy and one upon which it would be inappropriate for me to trespass, as it is the province of government. I do however wish to speak briefly to the issue of the competence and suitability of the Court's judges to deal with special medical procedure applications.

I would also like to respond to assertions again made at the public hearing that the Court operates in a way that is unduly formal and adversarial, which is inimical to the interests of parties and particularly young people who are the subject of special medical procedure applications. As the Head of Jurisdiction I am naturally discomfited that the Court is perceived in such a way and I wish to point out various features of the Court's case management system that belie the truth of those assertions.

I understand that the Committee's terms of reference were expanded on 7 February 2013 to include reference to "intersex people". I will make some concluding comments about the sterilisation of people with disorders of sexual development, which in my view differs materially from the sterilisation of people with intellectual disabilities. The most significant point of departure concerns the concept of voluntariness, which in turn invokes consideration of the views of the child and the weight to be accorded to those views.



## Background

Non-therapeutic sterilisation of minors is one of a species of cases known as ‘special medical procedures’. They are so described because they concern medical treatment that is both invasive and irreversible, and thus falls outside the ambit of the type of medical treatment to which parents can consent on their children’s behalf. As the High Court in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (‘*Marion’s Case*’) observed, there is no clear dividing line between those cases that require court authorisation and those that do not. However, it is clear from the High Court’s decision that non-therapeutic sterilisation of children and young people under the age of 18 requires court authorisation. The High Court said (at 249):

*There are, in our opinion, features of a sterilisation procedure or, more accurately, factors involved in a decision to authorise sterilisation of another person, which indicate that, in order to ensure the best protection of a child, such decision should not come within the ordinary scope of parental power to consent to medical treatment. Court authorisation is necessary and is, in essence, a procedural safeguard.*

As compared with applications concerning children generally, special medical procedure applications are infrequent. Applications to sterilise children and young people with disabilities, and particularly applications to perform hysterectomies, are increasingly rare. In her article entitled ‘Making sense of the Family Court’s decisions on the non-therapeutic sterilisation of girls with intellectual disability’, Linda Steele states:

*There are 11 publicly available decisions of the court where the welfare jurisdiction has been exercised in relation to sterilisation. These 11 decisions were made during 1988–1995 and the writer is not aware of any decisions of the Family Court that have been made since 1995.<sup>2</sup>*

Although I appreciate it is a somewhat crude measure, I caused a search of the Court’s internal judgments database to be undertaken. That search revealed that there are 27 judgments in respect of applications to perform hysterectomies on young people with disabilities. 22 of these were delivered in the 1990s. Since the year 2000, reasons have been delivered in only two such cases; one in 2004 and one in 2010, that being the decision in *Re: Angela* (supra).

Of course, there are other medical procedures that cause children and young people to be rendered infertile. For example, in two instances the Court granted permission for gonadectomies to be performed on children (*Re: Lesley (Special Medical Procedure)* [2008] FamCA 1226 and *Re: Sean and Russell (Special Medical Procedures)* (2010) 44 Fam LR 210). Although these were technically sterilisations, the applications were brought in whole or in part because the gonads were at significant risk of becoming diseased. As far as the decision in *Re: Sean and Russell* is concerned, the trial judge

---

<sup>2</sup> (2008) 22 *Australian Journal of Family Law* 1, p. 3

found that in the circumstances of the case the parents in fact had the capacity to consent themselves to the procedure being performed and that court authorisation was not required (although the trial judge went on to find that the Court had jurisdiction to make the orders sought). *Re: Lesley* involved a four year old child who suffered from a very rare disorder of sexual development. She had been raised as and identified as female but nevertheless had bilateral gonads in the labial area, which presented the risk of virilisation during puberty. In addition, given the location of the gonads, there was a heightened risk of their becoming cancerous (26%), which the trial judge found to be a “further important factor.”

Insofar as it is possible to detect trends in such a small number of special medical procedure cases, it appears to me that there has been a significant decline in the number of applications for sterilisations since the 1990s. Concomitantly, it would seem that the most special medical procedure applications now concern children and young people who have been diagnosed with gender identity disorder/dysphoria. Indeed, I note that judgment in such a matter was delivered as recently as 14 February 2013 (*Re: Jodie* [2013] FamCA 62).

#### *Jurisdiction and relevant law*

Jurisdiction to make orders in relation to non-therapeutic sterilisation of children, and to make orders with respect to special medical procedure applications generally, is found in section 67ZC of the *Family Law Act 1975* (Cth) (“the Act”). Sub-section 67ZC(1) provides that courts exercising jurisdiction pursuant to Part VII of the Act have, in addition to any other jurisdiction courts have under Part VII, jurisdiction to make orders relating to the welfare of children. This is colloquially referred to as the ‘welfare jurisdiction’ and is the equivalent of the *parens patriae* jurisdiction exercised by State Supreme Courts. As the High Court in *Marion’s Case* explained, it is by virtue of this section that the Court can make orders in respect of the non-therapeutic sterilisation of minors.

Sub-section 67ZC(2) states that in deciding whether to make an order pursuant to the welfare power, the Court must regard the best interests of the child as the paramount consideration. The matters the Court must have regard to in determining what is in the best interests of the child are contained in sub-sections 60CC(2) (primary considerations) and 60CC(3) (additional considerations). These relevantly include the capacity of each parent to provide for the child, parental attitudes and responsibility, and “any other relevant fact or circumstance”. It is important to remember that although the best interests of the child is the paramount consideration, it is not the sole determinant. It is well established at law that all relevant facts and circumstances in each individual case should be taken into account in arriving at an outcome that is in the child’s best interests. In some sterilisation cases, the appreciable easing of the burden on the parents as primary carers has been found to be a relevant factor (see for example *Re: Katie* (1996) FLC 92-659).



I am aware that one witness, Professor Grover, submitted the following in evidence:

*The question really is: is this a procedure you would do on a non-disabled person? That is the question when we are dealing with these sorts of procedures, not whether it is therapeutic or not therapeutic. We should not be doing a sterilising procedure if we would not be doing it in somebody who did not have a disability.*

As I have explained, that is not the applicable legal test. The test is whether or not it would be in the best interests of the child to have the procedure performed, taking into account all relevant facts and circumstances. Professor Grover is effectively advancing what has been described as the “but for” test. That test has been rejected by the Full Court of the Family Court. In *P & P & Legal Aid Commission of New South Wales & Human Rights and Equal Opportunity Commission* (1995) FLC 92-615 the Full Court said the following:

*We disagree with the concept of such a test in these cases. While it may be superficially attractive to impose this sort of a test upon the basis that it is non discriminatory and equates the intellectually handicapped person with the non intellectually handicapped, we think that upon analysis it has the opposite effect.*

*To apply it is, in our view, conceptually incorrect. We consider it is both unrealistic and contrary to the intention of the majority judgment in Marion's case to deal with a particular aspect of the child's needs and capacities as though it existed in isolation from other needs and capacities.*

*We are unconvinced that there is any relevant conclusion to be drawn with regard to the best interests of a particular child by an artificial exercise which compartmentalises a finding of fact about an immutable characteristic and then hypothesises that it were not so. [The child's] intellectual disability cannot be isolated as a factor and then "subtracted" from the constellation of facts about her, any more than one can simply imagine that she no longer suffers from epilepsy, or that she is infertile, or that she is not a female. Realistically, the effect of each of these factors is interactive and cumulative and it is their combined presence in the child which has led to the application before the Court.*

As far as special medical procedure applications specifically are concerned, Nicholson CJ in *Re Marion* (No. 2) (1994) FLC 92-448 proposed a number of discrete factors to be considered when the Court is faced with an application of that type. They are:

- (i) the particular condition of the child which requires the procedure or treatment;
- (ii) the nature of the procedure or treatment proposed;
- (iii) the reasons for which it is proposed that the procedure or treatment be carried out;

- (iv) the alternative courses of treatment that are available in relation to that condition;
- (v) the desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives;
- (vi) the physical effects on the child and the psychological and social implications for the child of:
  - (a) authorising the proposed procedure or treatment
  - (b) not authorising the proposed procedure or treatment
- (vii) the nature and degree of any risk to the child of:
  - (a) authorising the proposed procedure or treatment
  - (b) not authorising the proposed procedure or treatment
- (viii) the views (if any) expressed by:
  - (a) the guardian(s) of the child;
  - (b) a person who is entitled to the custody of the child;
  - (c) person who is responsible for the daily care and control of the child;
  - (d) the child;to the proposed procedure or treatment and to any alternative procedure or treatment.

In addition to the relevant provisions of the Act, including Division 12A and sections 67ZC and 60CC, special medical procedure applications are also governed by the *Family Law Rules 2004* (Cth) ("the Rules"); in particular Division 4.2.3. The Rules govern who may make a special medical procedure application, service of the application, and fixing of the hearing date, which is required to be as soon as possible after the date of filing and if practicable, within 14 days. Relevantly, rule 4.09 concerns expert evidence. Sub-rule 4.09(1) states that if a special medical procedure application is filed, evidence must be given to satisfy the court that the proposed medical procedure is in the best interests of the child. Sub-rule 4.09(2) specifies that the evidence must include evidence from a medical, psychological or other relevant expert that establishes a number of matters.

These include:

- the exact nature and purpose of the proposed procedure;
- the particular condition of the child for which the procedure is required;
- the likely long-term physical, social and psychological effects on the child if the procedure is carried out and if it is not carried out;
- the nature and degree of any risk to the child from the procedure;
- if an alternative and less invasive treatment is available, the reason the procedure is recommended instead of the alternative treatment;



- if the child is incapable of making an informed decision about the procedure, that the child:
  - is currently incapable of making an informed decision;
  - is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;
- whether the child's parents or carer agree to the procedure.

Practice Direction No. 9 of 2004 took effect on the same day that the Rules commenced (29 March 2004) and sets out the practice and procedure related to the conduct of special medical procedure applications for children living in Victoria and Queensland. The guidelines and protocols contained in the Practice Direction aim to, inter alia:

- promote positive outcomes for children and young persons;
- promote the care, welfare and development of children and young persons;
- ensure consistent and timely management of applications for a medical procedure for a child; and
- ensure that a Court hearing is of 'last resort' after all other options have been tested or considered and failed to or been assessed as unable to produce a satisfactory outcome.

Special medical procedure applications are sensitive and often involve complex ethical issues around which experts may disagree. I am familiar with the judgments delivered by Family Court judges in respect of special medical procedure applications and I have no hesitation in recording that judges treat these cases with the utmost sensitivity and gravity, and according to their obligations as judges appointed under Chapter III of the *Constitution*. This is not only because of the nature of the applications themselves and the consequences that flow from deciding to make or not make a certain order. It is also because there is usually no contradictor to the application and judges must tread particularly carefully in such circumstances.

### *Qualifications*

As an adjunct to the above, I wish to now turn to the qualifications, skills and experience of Family Court judges in the context of their suitability to determine special medical procedure applications.

An issue that was raised during the public hearing was whether judges are the best qualified people to make decisions about sterilisation of children and young people with disabilities. Whether jurisdiction to authorise sterilisation of children should continue to be vested in Family Court and State Supreme Court judges or whether it should be exercised by members of a Tribunal is a matter for government, with due regard to

Constitutional limitations. To the extent however that the Court retains jurisdiction pursuant to section 67ZC, Committee members may wish to note that sub-section 22(2) of the Act requires that a person shall only be appointed as a judge of that court if he or she has been a judge of another court or enrolled as a legal practitioner for not less than five years and specifically that he or she, by reason of training, experience and personality, is suitable to deal with matters of family law. That of course includes matters arising under the 'welfare jurisdiction'.

Appointees to the bench have, without exception, extensive experience in practising family law and have long negotiated the difficulties and complexities that attend this particular jurisdiction. It is an area of law which demands consideration of a multitude of factors, the attribution of weight to those factors, and the judicious exercise of discretion.

Family law is by its nature inter-sectoral and judges are experienced in dealing with evidence from a variety of disciplines, including medical evidence. Such evidence assumes particular importance in special medical procedure applications. In the case of *Re: Angela* for example, the trial judge had before him evidence from Dr T, an obstetrician and gynaecologist, whose expertise was found to be "beyond question", evidence of Dr C, from whom Dr T obtained a second opinion, and evidence from a third doctor, Dr M, a consultant paediatrician. All medical experts supported the application to have a hysterectomy performed. As recorded by him, the trial judge also had the benefit of the mother's evidence, submissions from the mother's solicitor and those of counsel appearing on behalf of the Director General of the Department of Communities.

As I will discuss shortly, judges are able to make appropriate and necessary directions as to the evidence to be filed. They are empowered to invite the Attorney-General and a state welfare officer to intervene in the proceedings and can grant an application for a non-party to intervene. As to the latter, the Australian Human Rights Commission and/or the Office of the Public Advocate or equivalent have often been granted permission to intervene when a sterilisation is being proposed (see for example *P & P & Legal Aid Commission of New South Wales & Human Rights and Equal Opportunity Commission* (supra)). Where appropriate, judges may also be assisted by an independent children's lawyer and by amicus curiae (a 'friend of the court'). Therefore, it is my personal view that Family Court judges are optimally placed to make informed and responsible decisions about individual special medical procedure applications and to arrive at a decision that is in the best interests of the child in all the circumstances.

#### *Decision making process*

In this section I will respond to criticisms of the Court made at the public hearing as being "very...adversarial", which I trust will build upon what I have already said about the use of expert evidence. I also intend to discuss the appointment of independent children's lawyers. I do so in order to correct the misapprehension that at least one witness was labouring under that their appointment is "part of special medical procedures



legislation” and that the trial judge in *Re: Angela* should be “rapped over the knuckles” for not appointing an independent children’s lawyer. I say that meaning no disrespect to the witnesses, who is not a lawyer and who does not purport to be, but as a matter of record.

In 2006, the Act was substantially amended. This included the insertion of Division 12A, which contains principles for the conduct of children’s cases. It provides that all children’s cases (including special medical procedure applications) are required to be conducted without undue delay and with as little formality, and legal technicality and form, as possible. Judges are required to consider the needs of the child concerned and the impact that the conduct of the proceedings will have on the child in determining the conduct of the proceedings. Further, judges are required to actively direct, control and manage the conduct of the proceedings.

Division 12A contains specific provisions relating to evidence, which detail the Court’s duties and powers. These include:

- giving directions and making orders about who is to give evidence;
- giving directions and making orders about expert evidence, including:
  - the matters in relation to which the expert is to provide evidence
  - the number of experts who may provide evidence in relation to a matter
  - how an expert is to provide the expert’s evidence
  - asking questions of, and seeking evidence or the production of documents or other things from parties, witnesses and experts on matters relevant to the proceedings
- giving directions and making orders about how particular evidence is to be given.

Presumptively, many of the rules of evidence, such as the rule against hearsay, do not apply in children’s proceedings unless the Court finds there are exceptional circumstances that warrant their application. The Court is able to give such weight as it thinks fit to evidence admitted as a product of the rules of evidence not being applied.

The Court gives effect to the principles for conducting child-related proceedings contained in Division 12A through the ‘less adversarial trial’. The less adversarial trial is more closely directed by the judge than a traditional trial and is designed to encourage the parties to focus on arrangements that are in the best interests of the children. A less adversarial trial is focused on the children and their future, flexible to meet the needs of particular situations, expected to cost less and reduce the time spent in court, and is less formal and less adversarial than a traditional trial.

It may be instructive for Committee members to have regard to the former Chief Justice Nicholson’s description of the hearing process his Honour instituted when dealing with a special medical procedure application concerning a young person who had been

diagnosed with gender identity dysphoria and who, through his carer, was seeking permission for the administration of hormone therapy and testosterone (*Re: Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] FamCA 297). In his judgment, Nicholson CJ recorded the following:

- 41 *The evidence in these proceedings was adduced through a hearing process that differed in a number of respects from the traditional form of trial of children's issues in this Court. I think it is fair to say that the court record indicates that the legal representatives and witnesses shared my view that the procedural modifications to the hearing process enhanced the depth and richness of the evidence, and thereby better served the aim of an outcome which will be in Alex's best interests. I consider that a format such as this is usually to be preferred, at least in relation to special medical procedure cases.*
- 42 *The hearing process was conventional in so far as the evidence in chief was mostly in affidavit form. At the request of the parties, I ordered that all documents including affidavits and exhibits in these proceedings be available to the parties and that the parties be at liberty to provide such material to their expert witnesses.*
- 43 *The hearing process was, however, different in the following major ways:*
- *The hearing was conducted in an inquisitorial rather than adversarial format. In substance, I indicated the type of evidence that I required and what further evidence was needed, after discussions with the parties' legal representatives and some of the witnesses;*
  - *The hearing was conducted in a private conference room setting around a table using portable recording equipment. Official transcription services were used to ensure a formal record;*
  - *I did not require the aunt and the school principals to give their evidence in chief by affidavit and took such evidence viva voce;*
  - *It was agreed that the hearing would not necessarily follow the traditional course of each party having a single sequential opportunity to cross-examine witnesses one by one but rather that the questioning of witnesses may alternate between the legal representatives, other witnesses and myself as evidence was proffered. Thus, the hearing often took the form of an orderly discussion between witnesses and legal representatives (including, sometimes, instructing solicitors) and myself;*
  - *A distinct benefit of the discussion format from my perspective was hearing witnesses engage in a dialogue in respect of each other's evidence. For example, observations made by Alex's primary school principal were commented upon by his secondary school principal and, on another occasion, there was a very illuminating discussion among medical experts concerning*



*the recommended nature and timing of hormonal treatment in which each commented upon the evidence given by others during the course of a telephone link up;*

- *The nature of the proceedings lent themselves to more than one hearing date rather than a single continuous fixture. This enabled parties to provide further expert material and for witnesses to consider the evidence of other witnesses and to respond in a considered way to material points of difference. The time taken in hearings was considerably less than would have been the case if a traditional format had been employed;*
- *I was informed that Alex wished to meet with me in private and without objection, indeed with the encouragement of the parties, I did so;*
- *So far as the discussion with Alex was concerned, he requested that aspects of it remain confidential. I have honoured that request and insofar as I have acted upon any of the contents of that discussion, I have only done so after referring relevant aspects of it to the witnesses; and*
- *Given the intricacies of the evidence, I arranged for the production of transcripts following each hearing session. A copy was provided to the parties through my chambers as soon as it became available.*

I adopted the same process in *Re: Alex* (2009) 42 Fam LR 645, which involved an application on Alex's behalf to have bilateral mastectomies performed.

In my view the Court is alert and responsive to the needs of people involved in special medical procedure applications, and particularly affected children. Accordingly, I must reject assertions that the Court operates with undue formality and maintains an adversarial model for hearing and determining such cases.

I also wish to explain for the Committee's benefit how independent children's lawyers are appointed. Such appointments do not occur as of right or by agreement between the parties. Sub-section 68L(1) of the Act states that the court may order that the child's interest in the proceedings be independently represented by a lawyer if it appears to the court that the child's interests ought to be independently represented.

Section 68LA of the Act defines the role of the independent children's lawyer. Principally, an independent lawyer is required to form an independent view, based on the evidence available to him or her, of what is in the best interests of the child, and must then act in what the independent children's lawyer believes to be in the child's best interests in relation to the proceedings.

Although there are some types of cases in which one would expect an independent children's lawyer to be appointed – for example, cases involving allegations of sexual or serious physical abuse of children – the decision as to whether to appoint an independent children's lawyer is made on a case by case basis. There is no 'special medical procedures legislation' that compels the appointment of an independent children's lawyer when such proceedings have been initiated.

Further, independent children's lawyers are funded by the State or Territory legal aid agencies and those agencies are operating within severe budgetary constraints. It would be a profligate use of a valuable resource to appoint an independent children's lawyer where that appointment would serve no purpose or would otherwise not assist the court in deciding what orders would be in a child's best interests. In special medical procedure applications, it may be the case that there is already sufficient evidence before the Court, or that another party (such as the Australian Human Rights Commission, state child welfare agency or public advocate) is serving as contradictor, so that the appointment of an independent children's lawyer would be superfluous. In addition to the decision in *Re: Angela* at paragraphs 36 to 42, where the trial judge clearly explains why he decided not to make an appointment, I also refer the Committee to the decision of *Re: Sally* [2010] FamCA 237, where a similar conclusion was reached.

I also wish to point out that a decision not to appoint an independent children's lawyer is one that is capable of being appealed to the Full Court of the Family Court by any of the parties to the proceedings.

#### *"Intersex people"*

I note the extension of the Committee's terms of reference to include "intersex people" and bring to the Committee's attention three Family Court decisions concerning applications for permission to perform surgery on young people born with disorders of sexual development. They are, in date order:

*In the Matter of the Welfare of a child A* (1993) FLC 92-402 (per Mushin J)

*Re: Lesley* [2008] FamCA 1226 (per Barry J)

*Re: Sally* (supra) (per Murphy J)

In all three cases, a by-product of the surgery was to render the child infertile (although in *Re: Lesley* the trial judge found that the child was already incapable of having children). The cases involved children and young people aged respectively 14 years, 4 years and 14.5 years.

I have discussed *Re: Lesley* earlier in this submission. In that case it was agreed that the child in question was not capable of consenting to the procedure, given that she was only four years old. It is apparent from the decisions involving teenagers however that their views assume considerable significance as compared with matters involving young



children and children and young people with intellectual disabilities (the “views of the child” being a relevant matter as part of the court’s ‘best interests’ inquiry). The concept of ‘involuntary’ or ‘coerced’ sterilisation thus sits uncomfortably with these cases as, although neither young person was found to be competent to consent to the procedure themselves, in both instances the young people wanted the surgery to be performed, despite being aware that one of its effects would be to render them incapable of bearing children.

In *Child A*, the trial judge found that A had “an overwhelming expectation and desire to have the operations referred to so that he may assume what he regards as being his right and expectation, that is to become a male in all possible respects.” In *Re: Sally*, the trial judge made an order permitting Sally to file an affidavit in which she deposed to her thoughts about the procedure and explained why she wanted to have it performed. The trial judge found that:

*...[t]here are signs within the material...that Sally is a mature young woman who has carefully and thoughtfully considered the issues relevant to this application in consultation with her parents and her medical practitioners. She would appear to understand the reasons why the procedure is recommended and also appears to understand that there might be risks associated with it, in both the physical and psychological sense.*

I appreciate that the Committee may be contemplating scenarios whereby permission is sought to perform surgery on a young child to give them the appearance of one sex or another, without the child being of sufficient age and maturity to express a view as to the procedure. I am not aware though of judgment having been delivered in any such case before the Family Court.

I trust the foregoing has been of assistance. I would be pleased to elaborate on any aspect of my submission, although I reiterate that I cannot discuss individual cases, beyond explaining published reasons for judgment where it appears to me that the decision has been misunderstood. Should you wish to contact me, you may do so through my Executive Assistant, Ms Helen Grist,

Alternatively, you are welcome to contact my Senior Legal Research Advisor, Ms Kristen Murray, who assisted in the preparation of this submission.

Yours sincerely

Diana Bryant AO  
Chief Justice