Attachment 1

Queensland Government

Queensland Health

Statement of Reasons
Decision to issue health service directive QH-HSD-058

Order of Justice Muir dated 31 March 2025, paragraph [2]

1. I, David Rosengren, Director-General, Queensland Health provide this statement of reasons in relation to my decision on 28 January 2025 to issue a health service directive titled 'Treatment of gender dysphoria in children' (the **HSD**).

Relevant legislation

2. I exercised my power to issue the HSD in accordance with sections 47(1)(c) and (2)(b) of the *Hospital and Health Boards Act 2011* (Qld) (**HHB Act**). In doing so, I also considered human rights under the *Human Rights Act 2019* (Qld) (**HR Act**).

Evidence and other material relied upon:

3. I considered the following material in making my decision:

   (a) Cabinet Submission 25/SUB/245 (the **Cabinet Submission**);
   (b) Email from Queensland Health's Director and Cabinet Legislation and Liaison Officer (**CLLO**) dated 20 January 2025; and
   (c) Director-General Briefing Note C-ECTF-25/1416 including attachments (the **Briefing Note**).

Background

4. On 1 November 2024, I commenced in my role as Director-General of Queensland Health.

5. On or about 6 December 2024, I was notified of a clinical governance issue at Cairns and Hinterland HHS which indicated a paediatric gender clinic had been established without relevant approvals and concerns that children within that clinic had received stage 1 and stage 2 hormone therapy for gender dysphoria outside the Queensland Children's Gender Services' (**QCGS**) endorsed guidelines.[1]

[1] Those issues are now the subject of a clinical review and health service investigation, each commissioned under the HHB Act.

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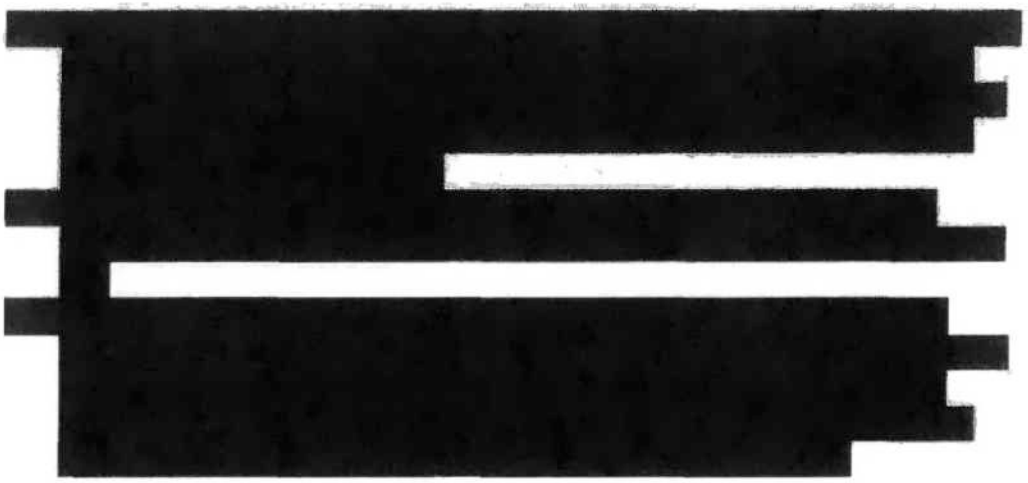
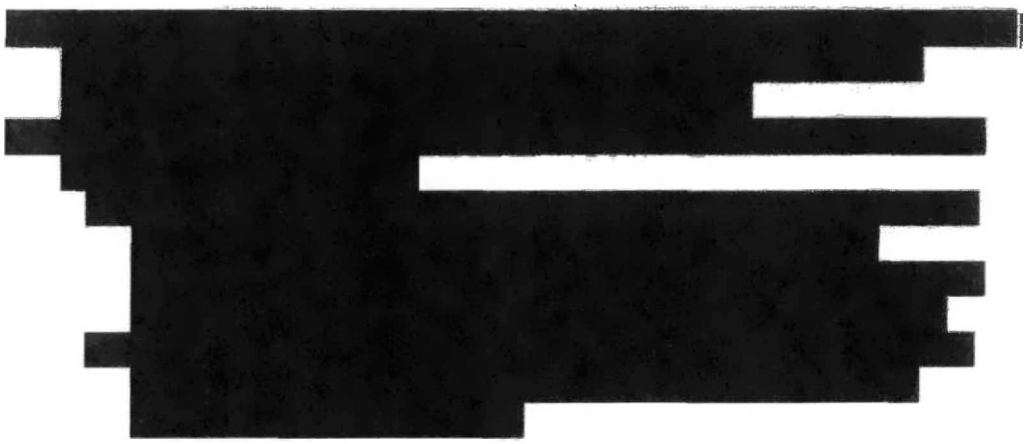
6. On or about 13 January 2025, the Minister for Health and Ambulance Services (the **Minister**) requested that Queensland Health prepare a Cabinet Submission [redacted]

7. A Cabinet Submission was prepared by Queensland Health staff for the Minister to inform Cabinet about the following emerging issues:



8. The Cabinet Submission made fourteen recommendations in relation to the various matters, including:



9. On 18 January 2025, the Cabinet Submission was finalised by the Minister's Chief of Staff and lodged.

10. On 20 January 2025, I was provided with an email from the CLLO which confirmed the outcome of Cabinet's deliberations on each recommendation. [redacted]

11. On 21 January 2025 [redacted], I instructed Queensland Health staff to prepare a health service directive.

12. On 27 January 2025, I confirmed the final format for the draft health service directive.

13. On 28 January 2025, I received the Briefing Note from the Acting Executive Director of Patient Safety and Quality, which attached a final draft proposed health service directive, along with a human rights compatibility statement and memo to Health Service Chief Executives (**HSCEs**). I used the Briefing Note as the basis for my consultation with the HSCE's.

14. At 10.00am on 28 January 2025, I met with all the HSCEs via Microsoft Teams to consult on the HSD. In that meeting I discussed the background events that had escalated this issue for consideration.

15. HSCE's were provided a copy of the proposed HSD, which was read through in detail and discussed collectively.

16. During that meeting, I received feedback that the references to 'current patient' and 'new patient' in relation to the ongoing delivery of puberty blockers and sex hormones for medical conditions other than gender dysphoria be removed as it seemed unnecessary and apt to cause confusion.

17. Following the meeting, two minor refinements were made to the HSD to reflect the feedback of the HSCEs.

18. At 11.07 am on 28 January 2025, having incorporated the minor refinements as discussed with the HSCE's, I issued the HSD to all HHSs pursuant to sections 47(1)(c) and (2)(b) of the HHB Act.

19. The HSD was given the reference number: QH-HSD-058 and uploaded onto Queensland Health's website.

Key terms and concepts

20. In order to properly understand my reasons, it is necessary to first define some key terms and concepts.

21. *Stage 1 hormone therapy or treatment* means the provision of medication that suppresses the endogenous oestrogen and testosterone responsible for induction of secondary sexual characteristics, otherwise known as puberty-blockers.

22. *Stage 2 hormone therapy or treatment* means the provision of gender affirming treatment using oestrogen or testosterone, otherwise known as gender affirming hormone therapy.

23. *Puberty-blockers* are medications that suppress the endogenous oestrogen and testosterone responsible for induction of secondary sexual characteristics.

24. *Sex hormones* include oestrogen or testosterone.

Reasons for my decisions

25. As the Director-General of Queensland Health, I am responsible for the overall management of the public sector health system. In performing the system manager role, I am responsible for issuing binding health service directives to HHSs, which include setting standards and policies for the safe and high-quality delivery of health services.

26. As indicated above, on 20 January 2025 I was advised [redacted]

27. [redacted] In developing the HSD I ensured puberty blockers and sex hormones would remain available in the treatment of other medical conditions e.g., precocious puberty in children and young people.

28. I was cognisant that I could not issue the HSD unless it had been determined to be compatible with human rights. Accordingly, in arriving at my decision to issue the HSD, I considered a draft human rights compatibility assessment that had been prepared for me in relation to my instructions on the parameters of the proposed HSD. I agreed with the analysis of human rights in that document and adopted it as my own, as indicated by me approving the Briefing Note. A copy of the human rights compatibility assessment is attachment 1 to these reasons.

Dr David Rosengren
Director-General
Queensland Health
8 April 2025

Human Rights Compatibility Assessment – Proposed decision to pause delivery of certain public sector health services by way of a health service directive

1. The purpose of this assessment is to set out the consideration given to human rights for the proposed decision to give a directive requiring that, subject to the exceptions stated in paragraphs 3 and 4, persons under the age of 18 (children and adolescents) are not to be prescribed or receive *Stage 1 Treatment* or *Stage 2 Treatment* for gender dysphoria.

2. *Stage 1 Treatment* for gender dysphoria is treatment by way of medication for puberty suppression. *Stage 2 Treatment* is treatment by way of gender affirming hormone therapy.

3. The directive described in paragraph 1 would not apply in relation to children and adolescents who require medication for puberty suppression or hormone therapy for a medical reason other than gender dysphoria.

4. Also, the directive described in paragraph 1 would not apply to children and adolescents receiving gender health services that include Stage 1 Treatment or Stage 2 Treatment as at the date of this directive. It is intended that these children and adolescents can continue to receive the health services including Stage 1 Treatment and/or Stage 2 Treatment, including moving from Stage 1 Treatment to Stage 2 Treatment where such progression is considered clinically appropriate by treating practitioners.

5. To avoid doubt, it is intended that all children and adolescents can continue to receive paediatric gender health services from a Hospital and Health Service (HHS). The proposed directive will only limit the provision of Stage 1 Treatment or Stage 2 Treatment to children and adolescents who have not yet started those treatments.

Background

6. Medical intervention for children and adolescents/young people experiencing gender dysphoria was considered by Dr Hilary Cass in her 2024 final report of the *Independent review of gender identity services for children and young people* (Cass Review), which Dr Cass undertook for NHS England and NHS Improvement's Quality and Innovation Committee.

7. The Cass Review recommended, among other things, that:

   a) the 'evidence based underpinning medical and non-medical interventions in this clinical area must be improved' and '[f]ollowing

our earlier recommendation to establish a puberty blocker trial, which has been taken forward by NHS England, we further recommend a full programme of research be established'; and

b) NHS England 'should review the policy on masculinising/feminising hormones. The option to provide masculinising/feminising hormones from age 16 is available, but the Review would recommend extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18.'

8. The Cass Review has prompted fresh consideration of medical interventions for trans and gender diverse young people internationally. Concerns include the potentially irreversible effects of gender affirming hormone therapy (Stage 2 Treatment) and uncertainty about long term effects of puberty blocking medication (Stage 1 Treatment).

9. Given the concerns that have been identified about the potential harmful effects of Stage 1 Treatment and Stage 2 Treatment to children and adolescents, and the importance of preserving public confidence in Queensland public health care sector, particularly in relation to medical services provided to children, Queensland Health proposes to 'pause' the provision of Stage 1 Treatment and Stage 2 Treatment by HHSs to children and adolescents while further research/investigations are undertaken into those treatments.

Which human rights are engaged or limited?

10. The proposed directive is designed to protect children in their best interests, which is a right enshrined in section 26(2) of the *Human Rights Act 2019* (Qld) (HR Act).

a) However, by restricting access to Stage 1 and Stage 2 Treatment for some people, particularly transgender children and adolescents, the proposed directive may also engage and limit the following human rights: The right to non-discrimination – Section 15(2) of the HR Act protects the right to enjoy other human rights without discrimination and section 15(4) protects the right to equal and effective protection against discrimination. These rights are relevant because the decision will have a greater impact on children and adolescents, on transgender people, and possibly on intersex people. However, the decision will not indirectly discriminate on those grounds if it is reasonable.

b) Right to life – Section 16 of the HR Act protects the right to life. It could be argued that preventing access to Stage 1 and Stage 2 Treatment may cause emotional distress and an increased risk of suicide. However, it should be emphasised that the decision is only to pause delivery of that treatment and will not affect any children or adolescents who are already receiving that treatment. Further,

the recent Cass Review in the United Kingdom found that the evidence does not support a conclusion that hormone treatment reduced the elevated risk of suicide: at [15.36]-[15.43]. I will proceed on the basis that this right is not limited.

c) Right to privacy – Section 25(a) of the HR Act protects the right not to have one's privacy unlawfully or arbitrarily interfered with. In a human rights context, the right to privacy protects a person's mental and physical integrity. On that basis, in human rights cases overseas, courts have found that preventing access to hormone therapy for a transgender person engages this right. However, this right will only be limited if the interference is 'unlawful' or 'arbitrary' (meaning disproportionate to a legitimate aim). I will consider whether the interference is unlawful or arbitrary below when considering the proportionality of the directive.

d) Right to family – Section 25(a) of the HR Act protects against unlawful or arbitrary interference with family, and section 26(1) protects the family as the fundamental group unit. The ability of parents to consent to medical treatment for their children is engaged by these rights.

e) Protection of children – Section 26(2) of the HR Act enshrines the right of children to protection in their best interests. This includes a right of children to have their views taken into account about what is in their best interests for decisions made about their health: UN Committee on the Rights of the Child, General Comment No 14 (2013) 9.

f) Right to health – Section 37(1) of the HR Act protects the right to access health services without discrimination. This includes a right of access to sexual health care for transgender and intersex persons: UN Committee on Economic, Social and Cultural Rights, General Comment No 22 (2016) [23].

11. Accordingly, the proposed decision may limit the right of children to protection in their best interests as well as their right of access to health services. Subject to a proportionality analysis, the rights to non-discrimination, privacy and family may also be limited.

Are any limits on human rights reasonable and justified?

12. As the proposed decision may limit human rights, the question is whether those limits are nonetheless justified in accordance with the proportionality test in sections 8 and 13 of the HR Act. In broad terms, a limit on a human right will be justified if:

- it is 'under law' or authorised by law;
- it has a proper purpose;

- it actually helps to achieve that purpose;
- there is no less restrictive way of achieving that purpose; and
- it strikes a fair balance between the need to achieve the purpose and the impact on human rights.

13. That test may be applied as follows:

a) Lawful – The decision is to be implemented as a health service directive under section 47 of the *Hospital and Health Boards Act 2011* (Qld).

b) Proper purpose – The purpose of the pause is to protect the health of children and adolescents, and to maintain confidence in public health services, while appropriate investigations are conducted into the evidence-base for Stage 1 and Stage 2 treatment for gender dysphoria.

c) Suitable – Pausing the delivery of Stage 1 and Stage 2 Treatment while appropriate investigations are carried out will help to achieve those purposes.

d) Necessary – The proposed directive is tailored to try reduce the impact on human rights in several ways.

(i) The proposed directive would not apply to children or adolescents who have already commenced Stage 1 Treatment or Stage 2 Treatment (and children/adolescents who have commenced Stage 1 Treatment will be able to progress to Stage 2 Treatment). This will avoid any distress for children and adolescents who have begun treatment, which may include adverse psychological impact of treatment withdrawal on those currently being treated.

(ii) The proposed directive would not apply to children or adolescents who require medication for puberty suppression or hormone therapy for a medical reason other than gender dysphoria.

(iii) The proposed decision will not apply to adults who will still be able to make decisions for themselves.

(iv) The proposed decision will not prevent access to Stage 1 or Stage 2 Treatment from private health services.

The only real alternative is to allow Queensland public sector health services to continue to deliver Stage 1 and Stage 2 Treatment pending the outcome of appropriate investigations. However, that would not achieve the purpose of protecting children and adolescents in the meantime. As the proposed decision

represents the least restrictive way of achieving its purpose, any limits it imposes on human rights are necessary to achieve the purpose of protecting children and adolescents.

e) Fair balance –Pausing the delivery of Stage 1 and Stage 2 Treatment will have an impact on children and adolescents, particularly transgender children and adolescents. However, the pause is needed in order to protect that vulnerable cohort while appropriate investigations are made. That ultimately serves to promote the right of children to protection in their best interests as well as the right of access to health services that are medically appropriate and of good quality: UN Committee on Economic, Social and Cultural Rights, General Comment No 14 (2000) [12]. It is open to the Director-General to consider that the potential negative impacts of the proposed pause would be outweighed by the positive impacts.

14. Accordingly, the proposed directive imposes a justified limit on human rights. This also means that the impacts on privacy and family are not arbitrary, such that those rights are not limited. The greater impact on transgender children and adolescents is also reasonable, such that the right to non-discrimination is not limited.

15. For these reasons, the Director-General may be satisfied that the proposed directive would be compatible with human rights.

16. It is noted that this conclusion aligns with consideration of the issue overseas. In July 2024, the English High Court concluded that the temporary pause on access to puberty suppression medication in the UK would be very unlikely to breach the right to privacy: *R (TransActual CIC) v Secretary of State for Health and Social Care* [2024] EWHC 1936 (Admin) [250]. The UN Special Rapporteur on Violence against Women and Girls also welcomed the Commitment by the UK Government to implement the Cass Review.