



July 2019

Shadow Report submission to the Committee on the Rights of Persons with Disabilities: Australia

Submitted by Intersex Human Rights Australia (IHRA)

Endorsed by the AIS Support Group Australia (AISSGA), Disabled People's Organisations Australia (DPOA), and People with Disability Australia (PWDA)



This Report is submitted by **Intersex Human Rights Australia** (“IHRA”), a national charitable organisation run by and for people born with intersex variations, formerly known as Organisation Intersex International Australia. The submission was written by co-executive director Morgan Carpenter, M.Bioeth. (Sydney), with input from the board and members of IHRA and endorsing organisations.

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Organisations endorsing this submission:

- [AIS Support Group Australia](#) (“AISSGA”), an intersex-led peer support organisation for people with all intersex variations, including Androgen Insensitivity Syndrome (“AIS”).
- [Disabled People’s Organisations Australia](#) (“DPO Australia”) is a national coalition of Disabled People’s Organisations, which are run by and for people with disability and grounded in a normative human rights framework.
- [People with Disability Australia](#) (“PWDA”) is a national disability rights and advocacy organisation, and member of DPO Australia. PWDA’s primary membership is made up of people with disability and organisations primarily constituted by people with disability.

1 Summary

A pattern of human rights abuses on infants, children, adolescents and adults born with intersex variations occurs in Australia, without effective, independent oversight, often based on gender stereotypes, and lacking a scientific basis. Evidence includes a Family Court of Australia case *Re: Carla (Medical procedure)* (2016) which facilitated the unnecessary “therapeutic” sterilisation of a 5-year old child. Incidental disclosure in that child’s medical history of an unnecessary clitorrectomy and labioplasty (a “vulvoplasty”) was described by the judge as follows:

Surgery already performed on Carla has enhanced the appearance of her female genitalia (at [2])

In 2014, Carla underwent two operations. In March that year, Dr B, performed a ‘clitoral’ recession and labioplasty to feminise Carla’s external appearance. (at [16])

The case is notable for presenting gender stereotypes in support of her sterilisation, including her toys and attire: Carla wore a “floral skirt and shirt with glittery sandals and Minnie Mouse underwear and had her long blond hair tied in braids”. The clinical evidence in support of her sterilisation was obsolete and incomplete. These interventions took place with parental substitute consent. The Court found that parties to the case supported surgery as in the best interests of the child, judicial oversight was not required.

As we show in this report, it appears likely that around 70 similar “vulvoplasties” take place each year. Additional types of medical intervention also occur. In 2018, a urology committee has sought to increase fees payable for the performance of paediatric vaginoplasties (construction of a vagina in a child) (Medicare Benefits Schedule Review Taskforce 2018, 127). Larger numbers of “masculinising” genital surgeries also take place (Carpenter 2018b, 471–73). CEDAW has described these as “harmful practices” in concluding observations on Australia (2018, para. 26). These harmful practices occur despite rhetoric by Australian governments that denies them or asserts changes to clinical practices (for example, Department of Communities 2012, 14), and that asserts recognition and valuing of intersex people (Carpenter 2016b).

A 2013 Senate committee inquiry made recommendations for change to clinical practice (Community Affairs References Committee, Senate of Australia 2013). The Australian government has rejected those recommendations (Attorney General's Department 2015); federal and State governments have failed to implement them. The Family Court has been unable to perform an independent role that protects children's rights.

A 2017 intersex community consensus statement defines a set of demands, the *Darlington Statement*, in response to this situation (AIS Support Group Australia et al. 2017). The UN Human Rights Committee (2017, para. 26) and CEDAW (2018, para. 26) have published recommendations for protections for intersex children. The Australian Human Rights Commission and Tasmanian Law Reform Institute have commenced studies (Australian Human Rights Commission 2018a); despite limited resources for community-led organising including an absence of core funding by governments, we are optimistic of helpful findings. However, as with the 2013 Senate inquiry, 2017 Human Rights Committee recommendations, and 2018 CEDAW recommendations, implementation is not assured.

In 2019 the Australian government cited *Re: Carla (Medical procedure)*, in its submission to the Committee on the Rights of Persons with Disabilities to illustrate a claim that the Family Court has "affirmed that any medical procedure resulting in sterilisation of a child must be therapeutic in nature for it to be within the bounds of permissible parental authority and not require court authorisation" (Australian Government 2019, para. 229), implying that Carla's sterilisation was "therapeutic", and omitting mention of serious human rights concerns about the circumstances of the case (Carpenter 2018b, 2018c; M. Jones 2018; Kelly and Smith 2017; Richards and Pope 2017).

2 Recommendations

We respectfully urge the Committee to make strong recommendations in line with recommendations of other Treaty Bodies, such as CEDAW:

1. "Adopt clear legislative provisions that explicitly prohibit the performance of deferrable surgical or other medical procedures" without personal informed consent, "provide adequate counselling and support for the families of intersex children and provide redress to intersex persons having undergone such medical procedures" (based on Committee on the Elimination of Discrimination against Women 2018, para. 26)
2. Ensure that all necessary medical interventions to modify the sex characteristics of children with disabilities and variations of sex characteristics are subject to independent human rights-based oversight.
3. Ensure that medical and psychological professionals, and parents, are educated on bodily and sexual diversity, on human rights norms, and on the consequences of unnecessary interventions for children born with variations of sex characteristics (based on Committee against Torture 2011, para. 20; Committee on the Rights of the Child 2016, para. 40).
4. Ensure that adults with variations of sex characteristics are able to freely access healthcare to manage consequences of iatrogenic (medically induced) changes to sex characteristics.

3 Intersex people

IHRA defines intersex people in line with a 2016 statement by human rights experts, published by the OHCHR:

Intersex people are born with physical or biological sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that

do not fit the typical definitions for male or female bodies (Public statement of UN and regional human rights experts 2016).

We acknowledge the diversity of people born with variations of sex characteristics, including our identities, legal sex classifications, genders, gender identities, and the words we use to describe our bodies. At least 40 different intersex variations are known (Hiort 2013) most genetically determined. Clinicians frequently use a stigmatising term, “Disorders of Sex Development” (“DSD”), to refer to intersex variations; this nomenclature presupposes and justifies unnecessary cosmetic medical interventions to make intersex bodies more typically female or male (Carpenter 2018a; Davis 2011).

4 Human rights framework

In General Comment 3, the Committee on the Rights of Persons with Disabilities identifies as “cruel, inhuman or degrading treatment or punishment”

forced, coerced and otherwise involuntary pregnancy or sterilization; any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion; invasive and irreversible surgical practices such as psychosurgery, female genital mutilation and surgery or treatment performed on intersex children without their informed consent (2016, para. 32)

The Committee states that this can occur through “Restricting or removing legal capacity”. In 2018, the Special Rapporteur on the rights of persons with disabilities remarked that there “are a growing number of treatments and interventions whose effectiveness is uncertain or deemed controversial” which “are invasive, painful and irreversible, and therefore may amount to torture or ill-treatment if applied involuntarily” (2018, para. 41). Possible outcomes include incontinence, insensitivity, a need for repeat surgeries, and reinforcement of incorrect gender (Carpenter 2018a). Similar remarks were made by the Committee in General Comment 6 (2018, para. 7).

The Committee states that disability or “the existence of an impairment (including a physical or sensory impairment) must never be grounds for denying legal capacity or any of the rights provided for in article 12” (2014, para. 8) on equal recognition before the law:

The denial of legal capacity to persons with disabilities has, in many cases, led to their being deprived of many fundamental rights ... reproductive rights, parental rights, the right to give consent for intimate relationships and medical treatment, and the right to liberty (2014, para. 9)

Further: “Support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision- making” (2014, para. 17). Supported decision- making must be free of “undue influence”, including where there may be signs of fear, deception or manipulation. General Comment 1 of the Committee also reflects on the importance of autonomy, preservation of children’s identities, and of respect for difference “as part of human diversity and humanity (2014, para. 4). Human rights issues engaged by medical interventions on persons born with variations in sex characteristics also relate to article 17 on “protecting the integrity of the person”. Intersex and disability representative organisations have made submissions (including jointly endorsed submissions) to the Committee on the Rights of Persons with Disabilities, which raised this issue in its 2017 list of issues prior to reporting issued to Australia (Committee on the Rights of Persons with Disabilities 2017, para. 20).

In 2017 the UN Human Rights Committee responded to concerns regarding practices in Australia, concluding the government should:

...move to end irreversible medical treatment, especially surgery, of intersex infants and children, who are not yet able to provide fully informed and free consent, unless such procedures constitute an absolute medical necessity (2017, para. 26)

In 2018, CEDAW issued concluding observations to Australia on harmful practices included forced marriage, female genital mutilation, involuntary sterilisation and “medically unnecessary procedures on intersex children. It recommended that the government:

Adopt clear legislative provisions that explicitly prohibit the performance of unnecessary surgical or other medical procedures on intersex children before they reach the legal age of consent, implement the recommendations made by the Senate in 2013 on the basis of its inquiry into the involuntary or coerced sterilization of intersex persons, provide adequate counselling and support for the families of intersex children and provide redress to intersex persons having undergone such medical procedures (2018, para. 26)

4.1 Darlington Statement

The *Darlington Statement* is a 2017 community consensus statement by Australian and New Zealand intersex organisations and advocates (AIS Support Group Australia et al. 2017). Demands include:

- “**prohibition as a criminal act** of deferrable medical interventions, including surgical and hormonal interventions, that alter the sex characteristics of infants and children without personal consent”
- “mandatory independent access to funded counselling and peer support” including integration within multidisciplinary teams in hospitals
- “appropriate **human rights- based, lifetime, intersex standards of care** with full and meaningful participation by intersex community representatives and human rights institutions”
- “independent, effective **human rights-based oversight mechanism(s)** to determine individual cases involving persons born with intersex variations who are unable to consent to treatment, bringing together human rights experts, clinicians and intersex-led community organisations”

None of these demands are currently met. The *Darlington Statement* also calls for access to reasonable accommodations in education and employment, including “special needs requirements, workplace adjustments, job access assistance, and provisions for medical leave” (2017, para. 57).

IHRA and AISSGA recognise the relevance and applicability of the social model of disability to the situation of people born with intersex variations. We recognise the importance of resourcing for independent peer support and systemic advocacy, to provide affirmative ways of understanding human biological diversity for parents, prospective parents, and the general public.

5 Australian policy context

5.1 Senate inquiry

The Senate Community Affairs References Committee manage the Senate's health portfolio. In 2013, it held an inquiry into the involuntary or coerced sterilisation of people with disabilities, and intersex people (2013). The inquiry process documented medical practices, including a public submission by the Australasian Paediatric Endocrine Group (APEG). That submission suggested there are clear indications for surgeries:

Indications for surgery in DSD involve management of high cancer risk in the testes or ovaries, management of dysfunctional urine flow, creation of a vagina, or surgery for the purpose of appearance including reduction of an enlarged clitoris or repair or construction of a urinary outlet to the end of the penis (2013, 3).

Management of high cancer risks and urinary issues should not be controversial. However, these issues are intertwined with non-therapeutic rationales for treatment. The Senate Committee was itself 'disturbed' by entwinement of different rationales in clinical reports (2013, 92).

Regarding "Reconstructive reduction of an enlarged clitoris or repair or construction of a urinary outlet to the end of the penis", APEG states that:

The purpose of these procedures is for functional reasons such as to allow a male individual to urinate while standing, and for psychosocial reasons such as to allow the child to develop without the psychosocial stigma or distress which is associated with having genitalia incongruous with the sex of rearing (2013, 4)

These are cultural, not functional, requirements for cosmetic interventions. Subsequent to such interventions APEG notes "particular concern regarding sexual function and sensation" (2013, 4). Beliefs underpinning medical interventions lack evidence and clear indications. For example, reflecting an earlier 2006 statement, a 2016 clinical review states:

There is still no consensual attitude regarding indications, timing, procedure and evaluation of outcome of DSD surgery. The levels of evidence of responses given by the experts are low ... There is no evidence regarding the impact of surgically treated or non-treated DSDs during childhood for the individual, the parents, society or the risk of stigmatization (Lee et al. 2016, 176).

In 2017, the Committee on Bioethics of the Council of Europe reported that no clinically-accepted standard of care:

has emerged to explain, as a matter of science, how infant surgery will be certain to coincide with the child's actual identity, sexual interests, and desires for bodily appearance (Zillén, Garland, and Slokenberga 2017, 42)

In its 2013 report, the Senate committee found that, *inter alia*:

Normalising appearance goes hand in hand with the stigmatisation of difference... There is frequent reference to 'psychosocial' reasons to conduct normalising surgery. To the extent that this refers to facilitating parental acceptance and bonding, the child's avoidance of harassment or teasing, and the child's body self-image, there is great danger of this being a circular argument that avoids the central issues. Those issues include reducing parental anxiety, and ensuring social awareness and acceptance of diversity such as intersex. Surgery is unlikely to be an appropriate response to these kinds of issues. (2013, 74)

The Senate report called for protocols and guidelines consistent with recommendations by IHRA (then named Organisation Intersex International Australia):

3.129 The proposals put forward by Organisation Intersex International have merit, and are consistent with the committee's conclusions. The committee believes that a protocol covering 'normalising' surgery should be developed, and then adhered to in all cases of intersex children. Such a guideline should be consistent with Organisational Intersex International's recommendations (2013, 74–75)

Responding to the Senate inquiry, the federal government stated “the substantive regulation of medical treatment is a matter for state and territory governments” (Attorney General’s Department 2015). No Australian government has implemented the Senate committee recommendations.

5.2 Flawed principles

A 2010 framework for the treatment of intersex children was developed in Melbourne, Australia. It claimed that psychosocial risks that can be minimised through medical intervention include:

- *Risk that child will not be accepted by parents in the chosen sex of rearing, leading to impaired bonding with associated negative consequences*
- *Risk of social or cultural disadvantage to child, for example, reduced opportunities for marriage or intimate relationships*
- *Risk of social isolation, restrictions or difficulties, for example caused by embarrassment or social stigma associated with having genitalia which do not match the gender in which the person lives (Gillam, Hewitt, and Warne 2010, 415)*

The mention of marriage prospects is highly unusual, demonstrating similarity between rationales for intersex genital surgeries and rationales favouring FGM in countries where that practice remains a norm. The paper was criticised by some clinicians at the time, for example as:

The authors have opted to ignore the existing DSD ethics literature in an effort to arrive at principles putatively unburdened by previous ethical engagement... responding to the major DSD debate of a decade ago, namely over genital surgeries in infancy...(Dreger, Sandberg, and Feder 2010)

The paper makes no mention of access to peer support, nor a need to promote acceptance of human diversity. In 2013, a derivative framework was published by the State of Victoria, with limited community input (Department of Health 2013). The 2013 Victorian guidelines have not been binding on the State or its hospitals, have been disregarded in subsequent policy, and do not protect children’s rights. For example, in July 2019 a Victorian government website continues to state:

*Potential for cosmetic surgical correction of **ambiguous genitalia** for virilised[sic] females should be discussed with the endocrinologist. Most surgical correction is now delayed until 6 months of age or later (Victorian Agency for Health Information and Safer Care Victoria 2018)*

That Department’s current page on congenital adrenal hyperplasia (CAH) was developed with a medicalised parent-led group. It problematises genital appearance and proposes that surgery “may” be required. These surgeries share commonalities with those in *Re: Carla*. The web page states:

Children with non-salt-losing CAH are usually healthy, but may be born with genital abnormalities [sic] resulting from an excess of androgen. In girls, non-salt losing CAH is usually diagnosed at birth because the clitoris is large and the labia are partially fused. Sometimes, however, the changes [sic] may not be very obvious. In cases where the diagnosis is not made at birth, the growth of the clitoris continues and becomes much more obvious as time goes by...

Girls with CAH may need surgery to reduce the size of the clitoris to normal, separate the fused labia and enlarge the vaginal entrance. The technical name for this operation is 'clitoral recession or reduction and vaginoplasty'. It is done either in one or two stages. The clitoral reduction or recession is done in the first few months of life. The vaginoplasty is sometimes done at the same time as the clitoral reduction, but may be left until adolescence (Department of Health & Human Services 2014)

Nevertheless, the 2013 Victorian guidelines were commended in the federal government response to the Senate report. Despite these claims about the necessity of cosmetic interventions, the Senate report noted:

3.98 One of the difficulties that is seldom discussed is how to establish what constitutes 'normal', particularly in relation to what genitals 'should' look like. OII expressed concern about 'the absence of standard objective measures for cosmetic perceptions of "normal" female genitals'... (2013, 64)

3.100 What little research exists regarding 'adequate' or 'normal' genitals, particularly for women, raises some disturbing questions ... The committee received no information indicating whether or not this natural variation in genital size and shape is taken account of ...or how medical specialists learn about the diversity of appearance of genitals or how they define 'normal' in their clinical practice (2013, 65)

5.3 Framework on female genital mutilation (FGM)

The Australian framework on FGM shows profound confusion about intersex, appearing to describe intersex infants as “neither female or male” regardless of actual sex assignment, until they undergo surgery (Attorney General’s Department 2013). The FGM framework does not discuss necessity or evidence. Medical rationales, including parental distress, appearance “enhancement” and marriageability, mirror rationales evident for FGM in societies where FGM is the norm. The WHO recognises that medicalisation cannot justify FGM, but evidence from the federal Department of Health shows that clitorectomies, labioplasties and other vulvoplasties (including for aesthetic purposes) have increased in numbers in recent years (Department of Health 2014).

5.4 Numbers of rights violations

Lack of transparency underpins practices that violate children’s human rights. Little statistical information is available.

In reporting to the media in 2013, a representative of the Royal Children’s Hospital Melbourne (Victoria) has stated that it performs 10-15 “genital reconstruction operations a year often on girls under the age of two” and “outcomes are good” (Bock 2013). In the same year, the hospital reported to the Senate an “opinion” favouring early surgeries while acknowledging contention, and “we acknowledge that outcomes related to current approaches remain to be established” (Royal Children’s Hospital Melbourne 2013, 7).

Some data from the Australian Institute of Health and Welfare (AIHW) is available (Carpenter 2018b, 470–73), including for “vulvoplasties”, defined in a 2014 Department of Health review as “any surgery performed on the outside female genital structures” (Department of Health 2014). According to analysis of AIHW data and the Departmental review:

- The Department found a “marked increase” of 105% in numbers of publicly-funded vulvoplasties in adolescents and adults between 2003/4 and 2012/13. Numbers in 0-19 year age groups increased from 101 in 2002/3 to 258 in 2014/5
- According to AIHW data, an average of 71.5 vulvoplasties were performed per year in children aged under 15 between 2002/3 and 2014/5; between 57-95 per year.
- There were 371 publicly-funded vulvoplasties for so-called “congenital malformations” between 2007/8 and 2011/2; averaging 74.2 per year (Department of Health 2014).
- Additional surgeries take place under different categories such as “procedures for anomalies of genitalia” (Carpenter 2018b, 470–73).
- There is no evidence of any overall reduction in numbers of surgeries relevant to minors with intersex variations between 2002/3 and 2014/5 (Carpenter 2018b, 470–73).

A 2015 national sociological study of the situation of people born with atypical sex characteristics found that experiences of medicalisation were often negative, with poor information, many poor outcomes, and “strong evidence suggesting a pattern of institutionalised shaming and coercive treatment” (Carpenter 2016a). Based on a convenience sample of 272 respondents, education experiences were impacted by bullying, stigmatisation of physical characteristics and imputed identities, and also with medical interventions during puberty (T. Jones 2016). Respondents had high rates of early school leaving, with 19% completing only primary school (T. Jones 2016). The report also found high rates of poverty. Rates of suicidality far exceeded the Australian average.

5.5 NHRI and State inquiries

In 2017, the Australian Human Rights Commission (Australia’s National Human Rights Institution or NHRI) commenced an inquiry on protecting the human rights of people born with variations in sex characteristics in the context of medical interventions (Australian Human Rights Commission 2018b; Topsfield 2018). It established an expert advisory group, including representatives from IHRA, AISSGA and PWDA/DPOA. We believe the inquiry was established in part in response to recent Family Court cases which incontrovertibly demonstrate continued perpetration of human rights violations. These have helped overcome a lack of transparency, and epistemic injustices and claims of changed clinical practices that promote disbelief that such practices take place. The inquiry’s consultation period closed in September 2018 (Australian Human Rights Commission 2018a); it sought to be trauma-informed. A report is expected by the end of 2019. We hope that it will generate more helpful recommendations. We warmly congratulate our NHRI for conducting this work, and for seeking to include community representatives, as well as representatives of clinical institutions that may themselves conduct harmful practices. We note that implementation of the inquiry recommendations, as in 2013, is far from certain.

In 2019, the Tasmanian Law Reform Institute commenced an inquiry on transgender and intersex rights, within a framework considering State reform on legal gender recognition. An issue paper addresses those issues, but also the harmful practices that are the subject of the longer, deeper NHRI inquiry (Tasmania Law Reform Institute 2019). While we are concerned at the framing of this inquiry, we hope that it may produce helpful recommendations. However, we are particularly concerned at the lack of an expert reference group and community participation, and we note that a lack of resourcing for intersex-led organising hampers our ability to contribute to multiple inquiries.

This is a particular concern where individuals are expected to recount traumatic and harmful experiences to multiple inquiries, where inquiry processes may reproduce harms, including discussion and exposure to medical justifications for harmful practices, and reforms are lacking.

6 Case example: *Re: Carla (Medical procedure)*

Few cases relating to medical procedures are considered by the Family Court. As noted in the government's submission to the Committee, cases typically involve sterilisation. In recent years, cases include *Re: Kaitlyn* [2017] FamCA 83 (Family Court of Australia 2017), which coincidentally saw an adolescent girl prescribed testosterone without her informed consent, and *Re: Carla (Medical procedure)* [2016] FamCA 7.

Re: Carla was cited in the government's submission as an example of court oversight for "therapeutic" medical intervention (Australian Government 2019, para. 229), and so we present more details here. The case was initiated by parents of a child pseudonymously named Carla and adjudicated in Queensland. Carla was "born in 2010, is now five years of age and is about to start school", and "was born with a sexual development disorder" [sic] (at [1]) known as 17-beta hydroxysteroid dehydrogenase 3 deficiency (17 β -HSD3), with XY chromosomes, testes, and predominantly female genitalia. Justice Forrest stated that her sterilisation could "be authorised by either of Carla's parents". This has taken such cases out of Court jurisdiction.

Justice Forrest argued that gonadectomy (sterilisation) was justifiable due to a potential "intermediate" cancer risk, with clinical consensus of "risk of germ cell malignancy at ...an intermediate level" (at [19]); it was "virtually impossible to regularly monitor them for the presence of tumours" (at [20]). However, according to clinical literature, retention and monitoring of gonads should have been uncontentious. The clinical statement cited in the judgment to support an "intermediate" risk advises that clinicians should "monitor" gonads in children with this intersex trait (Hughes et al. 2006, 558). A 2010 clinical review reduced estimated risk (Pleskacova et al. 2010). A German multidisciplinary team has advised that monitoring is effective even for "high risk" groups (Amnesty International 2017, 28). Other clinical reports recommend sterilisation based on assigned gender (Carpenter 2018a). Gender stereotyping substantively comprises the rationale for sterilisation, citing parental reporting and clinical affidavits:

- a. Her parents were able to describe a clear, consistent development of a female gender identity;*
- b. Her parents supplied photos and other evidence that demonstrated that Carla identifies as a female;*
- c. She spoke in an age appropriate manner, and described a range of interests/toys and colours, all of which were stereotypically female, for example, having pink curtains, a Barbie bedspread and campervan, necklaces, lip gloss and 'fairy stations';*
- d. She happily wore a floral skirt and shirt with glittery sandals and Minnie Mouse underwear and had her long blond hair tied in braids; and*
- e. Her parents told Dr S that Carla never tries to stand while urinating, never wants to be called by or referred to in the male pronoun, prefers female toys, clothes and activities over male toys, clothes and activities, all of which are typically seen in natal boys and natal girls who identify as boys. (at [15])*

Nevertheless, Justice Forrest suggested that sterilisation should deliberately proceed prior to the child's ability to consent, stating it would be:

less psychologically traumatic for Carla if it is performed before she is able to understand the nature of the procedure (at [30])

Despite justifications for early sterilisation, no such claim was made about trauma arising from a further possible surgery:

Carla may also require other surgery in the future to enable her vaginal cavity to have adequate capacity for sexual intercourse. (at [18])

Carla's medical history was also put before the Family Court:

Surgery already performed on Carla has enhanced the appearance of her female genitalia. (at [2])

In 2014, Carla underwent ... a 'clitoral' recession and labioplasty to feminise Carla's external appearance (at [16])

No court approval had been sought or considered necessary. Yet rates of gender change from puberty vary between intersex variations but are known to be high for children with 17 β -HSD3 raised female. We note that Australian clinical literature clearly states:

As is well known, spontaneous change of gender identity from female to male occurs after the onset of puberty in 46,XY children with ... 17 β -hydroxysteroid dehydrogenase deficiency (Hewitt and Warne 2009, 61).

Even if Carla maintains a female identity, irreversible and invasive medical interventions are not warranted until she can determine her needs herself. Consequences of sterilisation include lifelong requirements for hormone replacement, at a financial cost to the individual including fees for medication and doctor visits. All medical interventions require post-surgical follow-up. In childhood, regular pre- and post-surgical genital inspections and evaluation are routine (see for example Yang, Felsen, and Poppas 2007).

Numerous academics have expressed concern at these decisions (Carpenter 2018b, 2018c; M. Jones 2018; Kelly and Smith 2017; Richards and Pope 2017). Suggesting complacency on medical interventions on children with intersex variations, a Queensland government department had stated in 2012, prior to the surgeries detailed in *Re: Carla*:

Previously it was an accepted practice to assign the external genitalia of a child during their childhood, often through surgical intervention, to determine the sex of the child early in their life. Research and investigation now advises against any irreversible or long-term procedures being performed on intersex children, unless a condition poses a serious risk to their health (Department of Communities 2012, 14).

Aileen Kennedy (2016) states that medicine and law are complicit in the pathologisation of intersex traits. Suggesting complicity, an anonymous Queensland state government department participated as a friend of the court in *Re: Carla (Medical procedure)* (Family Court of Australia 2016). There was no independent children's lawyer. The case was not brought to the attention of human rights or community institutions.

The parents have not contacted AISSGA or IHRA for independent peer support, and no reference was made to peer support in the judgment.

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