IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002457

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Amended pursuant to Section 76 of the Coroners Act 2008 on 2 September 2024[1]

Inquest into the death of Heather Richelieu Pierard

Findings of:	Coroner Ingrid Giles
Delivered on:	29 August 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing dates:	27-29 November 2023 21 February 2024
Appearances:	Ms Gemma Cafarella, Counsel Assisting the Coroner, instructed by Ms George Carrington, Coroner's Solicitor Mr Sebastian Reid on behalf of Austin Health, instructed by Lander & Rogers Ms Fiona Ellis on behalf of Monash Health, instructed by K&L Gates Ms Erin Gardner on behalf of the Department of Health, instructed by the Department's in-house lawyers

[1] This version is an amended version of the Finding into the Death of Heather Pierard dated 29 August 2024, amended to insert an enhanced Table of Contents to improve navigability and to correct minor typographical errors.

	Ms Amanda Dickens on behalf of the Chief Commissioner of Police, instructed by the Victorian Government Solicitor's Office
	Ms Jasmine Still on behalf of Detective Senior Constable Garside, instructed by Hall & Wilcox
	Mr Christopher McDermott (27-29 November 2023) and Mr Chris Kais (21 February 2024) on behalf of Transgender Victoria, instructed by Allens
Catchwords	Suicide; transgender; gender diverse; LGBTIQA+; access to mental health services; access to gender-affirming care; cultural safety and wellbeing; postvention supports; missing persons; Victoria Police.

Readers are advised that this finding contains discussion of suicide. Readers are warned that there may be words and descriptions that may be distressing.

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SUMMARY

1. Heather Richelieu Pierard (**Heathe**r) was 20 years of age when she was found at home by her partner Greyson Mole (**Greyson**) 11 May 2021, having ingested a substance known as 'sodium nitrite'. Greyson called emergency services and paramedics attended. However, Heather could not be revived.

2. Heather had a long history of mental ill health and suicidal ideation, having attempted suicide numerous times during her life. Her diagnoses included gender dysphoria, major depressive disorder, borderline personality disorder, autism, and anxiety.

3. Heather is described by her partner Greyson as being passionate about music, film, and animals.[2] Her mother Kedra Pierard (**Kedra**) describes her as a person who '*brought joy to so many people. She would comfort and care for people even when she found it hard to do the same for herself. She made people laugh, made them feel important and loved… her transgender journey made her happier*'.[3]

THE CORONIAL INVESTIGATION

Jurisdiction

4. Heather's death was a *'reportable death'* under section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

Purpose of the Coronial Jurisdiction

5. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[4] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

[2] Coronial impact statement of G. Moyle, Court File.
[3] Coronial impact statement of Kedra Pierard, Court File.
[4] *Coroners Act 2008* (Vic), s 89(4).

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

9. Coroners are empowered to:

   (a) report to the Attorney-General on a death;

   (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

   These powers are the vehicles by which the prevention role may be advanced.

10. The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[5]

11. Consequently, the power to comment is not free ranging but rather is limited to the power to comment '*on any matter connected with the death*'.[6]

[5] *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[6] *Coroners Act 2008* (Vic) s 67(3).

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is important to stress that coroners are unable to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment or any statement that a person is, or may be, guilty of an offence.[8]

13. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case, many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

14. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately.

Standard of Proof

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

16. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[7] *Keown v Khan* (1999) 1 VR 69.

[8] *Coroners Act 2008* (Vic), s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. *See* sections 69(2) and 49(1) of the Act.

[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[11] (1938) 60 CLR 336.

17. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[12] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Rather, such proof should be the result of clear, cogent, or strict proof in the context of a presumption of innocence.[13]

The coronial investigation and clustering of the proceedings

18. Deputy State Coroner English (as she then was) initially held carriage of the investigation into Heather's death, followed by then-Deputy State Coroner Jacqui Hawkins. In July 2023, I assumed carriage of the investigation for the purposes of conducting further investigations, holding an Inquest, and making Findings. Detective Senior Constable Marc Gilbert (**DSC Gilbert**) was assigned as the Coroner's Investigator and compiled the coronial brief in relation to Heather's death.[14]

19. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. The circumstances of Heather's death did not involve any such considerations; therefore, whether or not to hold an Inquest was a matter of discretion under section 52(1) of the Act.

20. Pursuant to this provision, coroners have absolute discretion as to whether to hold an Inquest. However, a coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act.

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[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J: '*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'*.

[14] A second coronial brief called, referred to as the 'Collated Brief' was compiled by the Court in relation to the common issues in the cluster investigation. To accompany this brief, a statement of facts in relation to each deceased's circumstances of passing was prepared following input being invited from Interested Parties.

21. In deciding whether to conduct an Inquest, a coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

22. The convening of an Inquest into a suicide or suicides is rare. However, shortly prior to Heather's death in May 2021, the Coroners Court received reports of a number of suicides of transgender or gender diverse women, including:

- Natalie Wilson (COR 2020 4857, who died on 2 September 2020) (hereinafter '**Natalie**');
- Bridget Flack (COR 2020 6727), who died between 30 November and 11 December 2020 (**Bridget**);
- Matt Byrne (COR 2021 1636) who died on 30 March 2021 (**Matt**); and
- The person known by the pseudonym 'AS'[15] (COR 2021 2415, who died on 9 May 2021) (**AS**).

23. These were not the only suicides of transgender and/or gender diverse people (hereinafter '**TGD people**')[16] reported to the Coroners Court throughout this period, or subsequently thereto. However, there were a number of common features identified in relation to the circumstances of the deaths of these five people; namely the deceased were all young people who had affirmed or were on a journey to affirming their gender identity as female. Some were known to each other. The deceased had also experienced mental ill health. Some had been linked with service providers from a young age, and also faced a degree of social isolation during the COVID-19 lockdown periods.

[15] This person is required to be referred to as 'AS' pursuant to a pseudonym order issued on 28 August 2023 in these proceedings – *see* explanation further below. Further persons referred to in this Finding (including H. Leigh) are not formally covered by the pseudonym order but are referred to by chosen names (*see* T-113, lines 6-16).
[16] This definition will be further explored later in my Finding.

24. On the basis of these common factors, the cases were referred to the Coroners Prevention Unit (**CPU**) for joint consideration and advice.[17] The CPU identified and engaged a number of entities to provide statements and submissions to assist the Court's consideration of the issues common to the circumstances of each deceased, with the following organisations ultimately providing submissions:

- Victorian Department of Health;
- The Office of the Chief Psychiatrist of Victoria;
- Monash Health Gender Clinic;
- Austin Health Gender Clinic;
- Thorne Harbour Health, which includes the Equinox Gender Diverse Health Centre;
- The Royal Children's Hospital Melbourne;
- Royal Australian College of General Practitioners;
- Australian Psychological Society;
- Royal Australian and New Zealand College of Psychiatrists;
- Drummond Street Services;
- Victorian Commissioner for LGBTIQA+ Communities;
- Switchboard Victoria; and
- Transgender Victoria.

25. Given the complexity of the issues outlined in these submissions and which would require findings to be made thereupon, a decision was made to convene an Inquest into the five deaths.

[17] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

26. The inquest proceeded on 27-29 November 2023 and 21 February 2024, over four days in total, with Ms Gemma Cafarella appointed as Counsel Assisting the Coroner, and the Chief Commissioner of Police (**CCP**), the Secretary to the Department of Health, Monash Health, Austin Health, DSC Garside and Transgender Victoria all represented at Inquest.

27. Many members of the five deceased's family, chosen family and friends were present during these proceedings, with some choosing to attend the courtroom, and others following the proceedings online.

Scope of Inquest

28. Although the coronial jurisdiction is inquisitorial rather than adversarial,[18] it should operate in a fair and efficient manner.[19] When exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[20]

29. In *Harmsworth v The State Coroner*,[21] Nathan J considered the extent of coroners' powers, noting they are not '*free-ranging*' and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an inquest could become wide, prolix, and indeterminate. His Honour stated the Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions, or individuals. Significantly, he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[22]

[18] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*.
[19] *Coroners Act 2008* (Vic), s 9.
[20] *Coroners Act 2008* (Vic), s 8(b).
[21] (1989) VR 989.
[22] *Ibid.*

30. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[23] the limits to the scope of a coroner's inquiry and the issues that may be considered at an inquest were also considered. As there is no rule that can be applied to clearly delineate those limits, 'common sense' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry ...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

31. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.[24]

32. Given the issues under consideration, the scope of the present Inquest was crafted to be systems-focused. Rather than examining the circumstances of death of each individual, which were sufficiently documented in the written evidence, the aim was to examine the broader systemic issues impacting TGD people and their experience in accessing health and other services.

33. There were also two discrete scope items relating to Bridget and the missing persons search undertaken for her by Victoria Police.

34. A Directions Hearing was held on 13 October 2023 and Interested Parties were invited to provide submissions on the proposed scope. The settled scope of the inquest was as follows:

> *Relating to the passing of Bridget Flack:*
>
> 1. *Approach of Victoria Police to the missing persons search for Bridget Flack, including by reference to relevant policies and procedures;*
> 2. *Victoria Police policies, procedures, training, and initiatives relating to the transgender and gender diverse (**TGD**) community;*

[23] [2009] ACTSC 40. *See also* the comments regarding the limits of a coroner's inquiry, including that factual questions related to cause will generally be within the scope of the inquest.
[24] *See* Ruling No.2 in the 'Bourke Street' *Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel* (COR 2017 0325 and Ors), Coroner Hawkins, 23 August 2019, para. 55.

<u>Relating to all deaths within the cluster</u>:

3. *The evidence base concerning the incidence of mental ill health and suicidality in the TGD community, including the reasons for this;*
4. *Availability of and issues concerning provision of culturally-appropriate gender-affirming care to TGD people in Victoria, including where there are intersecting mental health issues and diagnoses;*
5. *Availability of and issues concerning provision of culturally-appropriate suicide prevention and postvention supports to TGD people in Victoria;*
6. *Availability of and issues concerning provision of culturally-appropriate social and emotional wellbeing supports to TGD people in Victoria; and*
7. *Prevention opportunities flowing from the above.*

Pseudonym order

35. Prior to a Directions Hearing in this matter being convened on 13 October 2023, on 28 August 2023, I issued a pseudonym order in this matter pursuant to section 55(2)(e) of the Act. The order required that, in order to assist the Court in referring to the deceased persons in a respectful and culturally appropriate manner in these proceedings, they should be referred to by the names that were in use prior to passing (even where not 'legally changed'), and which had been chosen by the deceased to correspond with their gender identity (**chosen names**).

36. Further, I ordered that one of the deceased be referred to by the pseudonym 'AS', which I considered to be necessary to secure the proper administration of justice in this proceeding, including to ensure AS's family's capacity to participate in the Inquest and to limit trauma and the impacts of the proceeding on her family's wellbeing.

37. On this basis, all deceased were referred to by what the evidence established to be their chosen name, or in the case of 'AS', a pseudonym. All deceased were referred to by 'she/her' pronouns, noting that, while their preferred pronouns may have changed over time, the evidence pointed to all five deceased using 'she/her' pronouns in the lead-up to passing.

Witnesses

38. The following witnesses were called to give *viva voce* evidence on the first day of Inquest:

    (a) **Elisabeth Lane**, the Court's lived experience expert;[25]

    (b) **Angela Pucci-Love**, Bridget's sister;

    (c) **Detective Senior Constable Garside**, Coronial Investigator in Bridget's case; and

    (d) **Deputy Commissioner Neil Paterson**, Victoria Police.

39. Thereafter, the Court convened two expert panels, each comprised of a number of experts who were considered appropriate to give evidence concurrently. On the second day of inquest, the first expert panel (**Medical Panel**) was made up of:

    (a) **Professor Jeffrey Zajac**, Austin Health Gender Clinic, medical practitioner and Head of Endocrinology Unit at Austin Health;

    (b) **Dr James Morandini**, Australian Psychological Society, Clinical Psychologist;

    (c) **Mrs Bailey Nation-Ingle**, Victorian Department of Health, State Suicide Prevention Response Adviser;

    (d) **Dr Gurvinder Kalra**, Monash Health Gender Clinic, Consultant Psychiatrist;

    (e) **Dr Neil Coventry**, Office of the Chief Psychiatrist, Chief Psychiatrist of Victoria (as he then was);

    (f) **Dr Peter Jenkins**, Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), Consultant Child and Adolescent Psychiatrist;

    (g) **Dr Mark Dalgleish**, Royal Australian College of General Practitioners (**RACGP**), General Practitioner;

[25] It is worth noting that a number of the other witnesses in this Inquest had their own lived experience as members of the TGD community.

(h) **Dr Tram Nguyen**, Royal Melbourne Children's Hospital Gender Service, Psychiatrist; and

(i) **Ms Carolyn Gillespie**, Director of Services, Thorne Harbour.

40. On the third day of inquest, the second expert panel (**Community Supports Panel**) was made up of:

(a) Mr Elliot McMahon, Drummond Street Services, Program Manager;

(b) Mr Joe Ball, Switchboard, Chief Executive Officer**;**

(c) Ms Anna Bernasochi, Switchboard, Suicide Prevention Manager**;**

(d) Dr Son Vivienne, Transgender Victoria, Chief Executive Officer**;**

(e) Ms Michelle McNamara, Transgender Victoria, Committee Board Member;

(f) Mx Vic Harden, Thorne Harbour, TGD Health Lead; and

(g) **Dr Todd Fernando**, Victorian Commissioner for LGBTIQ+ Communities **(**as he then was)

41. On the third day of inquest, I also heard coronial impact statements from Angela Pucci-Love (Bridget's sister), Kedra Pierard (Heather's mother) and Rachel Byrne (Matt's mother).

Closing submissions

42. On 21 February 2024, following the close of oral evidence, Counsel Assisting and legal representatives of Interested Parties were invited to provide closing submissions, having provided a written outline of those submissions in the lead-up to this hearing. In the course of those closing submissions, legal representatives addressed the Court on the findings that they submit are open to be made on the evidence, as well as on the comments and recommendations open to be made, including on matters relating to public health and safety and/or the administration of justice.

Sources of Evidence

43. This Finding draws on the totality of the product of the coronial investigation into Heather's death and the cluster investigation. That is, the court records maintained during the coronial investigation, the Coronial Briefs, further material sought and obtained by the Court, the evidence adduced during the Inquest and oral submissions provided by Counsel Assisting and Counsel representing the Interested Parties.[26] In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

BACKGROUND[27]

44. Heather was born on 31 July 2000. She was assigned male at birth. Her parents separated in 2007. Heather was described as having always been very feminine.

45. Heather had a close relationship with her mother. Her father was reportedly not supportive of some of her life choices.[28]

46. When still a child, Heather was diagnosed with depression, autism, and attention deficit hyperactivity disorder (**ADHD**). She was a patient of both the Royal Children's Hospital and Child and Adolescent Mental Health Services (**CAMHS**), until being referred to Headspace in 2017.[29]

47. Heather was bullied throughout primary school and high school. She had a suicide attempt in 2017 and was placed under the care of Orygen Youth Health between February 2017 and October 2018.[30]

[26] In the interests of certainty, this includes: (i) the Court file, inclusive of correspondence from Genspect; (ii) Coronial Brief compiled by DSC Gilbert; (iii) Collated Brief version 4, dated 3 November 2023; (iv) Summary of Material Facts dated 16 November 2023; (v) Additional Materials 1-11; and (vi) Transcripts of evidence from 27-29 November 2023 and submissions hearing on 21 February 2024.
[27] This section, and the section that follows, is derived from the 'Summary of Material Facts' in relation to Heather Pierard, dated 16 November 2023.
[28] Statement of K. Pierard, CB, p. 6.
[29] Letter to Dr L. Doyle from Inner West Area Mental Health Service, CB, p. 24.
[30] Statement of Dr. S. Kongasseri, Court file.

48. In 2017, Heather came out as transgender.

49. In early 2019, Heather started seeing a psychiatrist for assessment of gender dysphoria. She was diagnosed with gender dysphoria and, following assessment, she was prescribed gender-affirming hormone therapy.

50. During this period, she was under the care of a General Practitioner (**GP**) from Prahran Market Clinic and an endocrinologist at the Austin Health Gender Clinic, as well as a psychologist.[31] Her diagnoses included gender dysphoria, major depressive disorder, borderline personality disorder, autism, and anxiety.[32] She also reported regular recreational drug use.

51. In 2019, Heather moved out of home and moved into a Docklands apartment with her boyfriend Luke Redgen (**Luke**). Heather was polyamorous and in relationships with both Luke and Greyson Moyle (**Greyson**). After moving out of home, Heather worked at Subway. She resigned after a few months as she continued to struggle with her mental health.[33]

52. In December 2019, Luke died unexpectedly from acute meningitis. Three months later, in February 2020, Heather moved back in with her parents. Heather found it very difficult to deal with Luke's death. She resumed self-harming behaviours on several occasions, including cutting and taking excessive amounts of diazepam.

53. In February 2020, Heather was assessed by a consultant psychiatrist at the personality disorder service, Spectrum. It was considered that Heather would benefit from focused therapy to address her increased suicidal ideation, though without private health insurance, her options were noted to be limited. Her psychiatrist said that she would advocate for Heather to receive treatment through Spectrum, but that the waiting list was upwards of a year.[34]

54. On 21 June 2020, Heather attempted suicide by drug overdose. She was admitted to the Northern Hospital and discharged into the care of local area mental health services. Heather was

[31] Statement of Dr L. Doyle, CB, p. 22.
[32] Letter to Dr L. Doyle from Inner West Area Mental Health Service, CB, p. 24.
[33] Letter to Dr L. Doyle from Inner West Area Mental Health Service, CB, p. 26.
[34] Statement of Dr P. Speed, CB. pp. 27-29.

commenced on the anti-depressant, desvenlafaxine.[35]

55. From June 2020 to 17 December 2020, Heather received treatment at Spectrum, where she completed the 'Wise Choices' program, a group therapy program for people with borderline personality disorder.[36]

56. In August 2020, Heather moved into a house in Pascoe Vale South with Greyson and another housemate, Amanda. In the time Heather lived with Amanda, Amanda described needing to call an ambulance at least four or five times in response to Heather attempting suicide.[37]

57. Following her move to Pascoe Vale, she was case managed by NorthWest Area Mental Health Services (**NWAMHS**) in the community, during which time her desvenlafaxine dosage was increased and she was prescribed olanzapine and diazepam on a PRN (as-needed) basis.[38]

58. Heather enrolled in university for a 2021 start.

59. On 20 January 2021, Heather was discharged from Spectrum to her GP. She was referred to a private psychiatrist for an assessment for funding under the National Disability Insurance Scheme (**NDIS**) and an occupational therapist.

60. On 23 February 2021, Heather saw her GP regarding her prescriptions. She stated she had not yet made an appointment with the psychiatrist.

61. On 6-7 March 2021 Heather was admitted to the Short Stay Unit at the Northern Hospital after presenting with intoxication and self-harming behaviour. She did not meet the criteria under the *Mental Health Act 2014* (as then applied) and declined a voluntary admission to the psychiatric unit. As such, she was discharged with community-based mental health services.[39]

62. Heather's last appointment with the Austin Health Gender Clinic before her death was on 26 March 2021, when she reported her mental health was more stable, and that she was happy with the gender-affirming hormone treatment. The same day she saw a psychiatrist and her key

[35] Statement of Dr. S. Kongasseri, Court file.
[36] Statement of Dr P. Speed, CB. pp. 27-29.
[37] Statement of A. Simone, CB, p. 16.
[38] Statement of Dr. S. Kongasseri, Court file.
[39] Statement of Dr. S. Kongasseri, Court file.

clinician at the mental health team, and her medications were reviewed. Her safety plan was reviewed in the context of an ongoing risk of suicide.

63. Heather's mental health was significantly impacted by the deaths of her friends Matt Byrne (who died on 30 March 2021) and AS (who died on 9 May 2021).[40]

64. In April 2021, following Matt's death, Heather was assessed as suitable for admission into the Prevention and Recovery Centre (**PARC**), but ultimately declined the admission.[41]

IMMEDIATE CIRCUMSTANCES OF DEATH

65. At approximately 7:00am on 11 May 2021, two days after AS's death, Greyson and Heather woke up and lay in bed talking.

66. At some point during the morning, Heather's mother, Kedra spoke to her on the phone. Heather was providing only minimal replies to Kedra's questions and sounded very depressed. Kedra asked if Greyson was there, and asked Heather if she wanted her to call Heather's psychologist, to which Heather said yes. Kedra subsequently spoke to Heather's psychologist, who noted that she had an appointment at 1:00pm.[42]

67. At approximately 9:15am, Greyson left the house for 10 minutes to purchase milk.

68. When Greyson returned, Heather was sitting at her desk and told Greyson that she had ingested a substance. She then became unwell and lost consciousness.[43]

69. Greyson called emergency services. Ambulance Victoria paramedics arrived shortly thereafter but were unable to revive Heather.

IDENTITY OF THE DECEASED

70. On 11 May 2021, Heather Richelieu Pierard's identity was verified by her partner, Greyson

[40] Statement of K. Pierard, CB, pp. 7-8.
[41] Statement of Dr. S. Kongasseri, Court file. During her last contact with NWAMHS on 5 May 2021, she disclosed that she was not presently taking her gender-affirming hormones, though was not considered to present an imminent risk.
[42] Statement of K. Pierard, CB, p. 8.
[43] Statement of G. Mole, CB, p. 11.

Moyle, who signed a Statement of Identification to this effect.[44]

71. Identity is not in dispute and requires no further analysis.

MEDICAL CAUSE OF DEATH

72. On 12 May 2021, Forensic Pathologist Dr Heinrich Bouwer (**Dr Bouwer**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted a partial autopsy. Dr Bouwer reviewed the Victoria Police Report of Death Form 83, VIFM preliminary examination form, contact log, post-mortem computed tomography (**CT**) scan, and scene photographs and provided a written report of his findings dated 30 July 2021.

73. An internal examination was not performed, apart from obtaining stomach contents for toxicological analysis.

74. The post-mortem CT scan showed minor bilateral lung changes, with no other finding of note.

75. Extending from the right wrist to the upper arm were enumerable circumferential roughly parallel superficial pale to purple scars (so called 'self-harm' scars). Some of these appeared older and some appeared more recent with scab formation.

76. However, there was no post-mortem evidence of violence or injury contributing to death.

77. Toxicological analysis of blood, urine, and stomach contents revealed elevated levels of nitrate and nitrite in addition to desmethylvenlafaxine, olanzapine, metoclopramide, paracetamol, and delta-9-tetrahydrocannabinol.

78. On 23 August 2021, Dr Bouwer provided an updated report canvassing the above, after additional consideration of toxicological results in consultation with Associate Professor Dimitri Gerostamoulos (Head, Forensic Sciences & Chief Toxicologist, Forensic Services at the VIFM) (**A/Prof Gerostamoulos**).

79. In his report, Dr Bouwer noted that:

[44] Heather reportedly changed her name at the age of 18 to 'Heather Richelieu Pierard' to correspond with her gender identity.

'*3. Following ingestion nitrites and nitrates can be found in blood, stomach contents and other tissues. Nitrites are oxidized to nitrates in whole blood.*

4. Due to the rapid conversion of nitrites (NO2-) into nitrates (NO3¬-), the detection of excessive amounts of one or both compounds are indicative of nitrite/nitrate poisoning. The nitrate is the more stable oxidation state.

5. Including nitrites and nitrates in the cause of death formulation would more accurately reflect the toxicological analytical findings'.[45]

80. Accordingly, and in the absence of any certainty as to the substance that was ingested by the deceased, Dr Bouwer provided an opinion that the medical cause of death is *1(a) nitrate/nitrite toxicity*.

81. I accept that Dr Bouwer's opinion is (very appropriately) based on the scientific evidence yielded by the toxicological testing, interpreted with advice from A/Prof Gerostamoulos. Based on the toxicological testing alone, the cause of death may be attributable to ingesting either sodium nitrite or sodium nitrate (which are different substances, and which will be explored further below).

82. Notwithstanding, in addition to the expert advice provided by Dr Bouwer and A/Prof Gerostamoulos of the VIFM, I have the additional benefit of the comprehensive brief of evidence provided by the Coroner's Investigator. As I will detail later in this Finding, that evidence indicates that, while the investigator could not detect where it had been purchased, a container clearly labelled 'Sodium nitrite – $NaNO_2$ (anhydrous) 99.6% food grade' was found at the scene of Heather's death.[46]

83. While this evidence is circumstantial, it is compelling; it indicates clearly on the balance of probabilities that Heather ingested sodium nitrite (rather than sodium nitrate) as a means by which to take her life. The cause of death may therefore be more accurately formulated as '*1(a) sodium nitrite toxicity*'.

[45] Supplementary Report of Dr Heinrich Bouwer, 23 August 2024.
[46] Coronial brief, pp. 74-76. No evidence of a sodium nitrate purchase or packaging was found.

FOCUS OF CORONIAL INVESTIGATION AND INQUEST

Concerns raised in the course of my investigation into Heather's death

84. The Court received email correspondence in the lead-up to Inquest from persons known to Heather Pierard, AS, and Matt Byrne noting a concern that these deaths were suspected by community members to be the result of a 'suicide pact', possibly in association with online forums, and that there existed fears in relation to the existence of suspicious circumstances and/or coercion. This information was provided to Victoria Police for further investigation as appropriate, and no suspicious circumstances have been identified by investigating officers to date.

Coroners Prevention Unit (CPU) - Further investigation

85. In the interests of a comprehensive coronial investigation, and noting that certain issues had been raised in relation to the cluster investigation, I sought further assistance from the CPU regarding: (i) the significance of the fact that certain of the deceased were known to each other, and the implications this might have for my investigation; and (ii) the issue of sodium nitrite and the regulatory framework that underpins its use, sale, and access to members of the public, and whether there was thought to be any utility in making a recommendation to restrict its sale to or access by members of the public.

'Cluster within a cluster'

86. The available evidence indicates that at least three of the deceased persons (including Matt, Heather and AS) knew directly at least one other person in the cluster. Further to this point, the media coverage surrounding certain of the deaths combined with discussion about and deep concern regarding the deaths within local LGBTIQA+ communities, meant it was possible that some of the deceased persons knew about others' deaths even if they were not personally acquainted.

87. These connections - confirmed and possible - between the deceased persons, suggested that 'suicide contagion' may have played a role in the emergence of the cluster, which has implications for preventing further such suicides occurring in the future.

88. The term 'suicide contagion' carries a range of related meanings that I will examine later in this Finding.[47] In this instance, I use it to refer to how knowledge of a peer's suicidal behaviour may increase the risk that a person will subsequently engage in suicidal behaviour.[48] Peers can include friends and acquaintances of a person, and also members of the person's broader peer or social group that the person does not directly know: in these cases, members of Victoria's TGD communities.

89. Pursuant to a Memorandum of Understanding between the Coroners Court and the Department of Health dated 21 December 2021, the Court developed a practice of alerting the Department of Health whenever the suspected suicide of a TGD person is reported, in a de-identified manner, so that the Department could in turn consult with organisations such as Switchboard to develop appropriate targeted postvention responses. This arrangement continues to the present, and is consistent with advice in literature regarding suicide that timely postvention to reach and support those who are exposed to suicidal behaviour in their peer or social group is needed to minimise and contain potential suicide contagion.[49]

90. However, it is accepted that these alerts as they currently operate may not be maximising opportunities for effective postvention. One issue the Court encounters is that we do not always know about a deceased person's LGBTIQA+ identity when a suspected suicide is reported.[50] Another issue is that sharing information about deaths under investigation involves a balancing of complex, sometimes competing considerations: for example, the deceased person and their loved ones' right to privacy, versus the prevention imperative of identifying peers so they can be supported.

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[47] Cheng Q et al, "Suicide Contagion: A Systematic Review of Definitions and Research Utility", *PLOS One*, vol 9(9), 2014, DOI: 10.1371/journal.pone.0108724.

[48] See for example Walling MA, "Suicide Contagion", *Current Trauma Reports*, vol 7, 2021, pp.103-114; Hill NTM et al, "Association of suicidal behavior with exposure to suicide and suicide attempt: A systematic review and multilevel meta-analysis", *PLOS Medicine*, vol 17(3), 2020, DOI: https://doi.org/10.1371/journal.pmed.1003074; Gould MS and Lake AM, "The contagion of suicidal behaviours", in Patel DM et al (eds), *Contagion of Violence: WorkShop Summary*, Washington: the National Academies Press, 2013.

[49] Hill NTM et al, "Association of suicidal behavior with exposure to suicide and suicide attempt: A systematic review and multilevel meta-analysis", *PLOS Medicine*, vol 17(3), 2020, DOI: https://doi.org/10.1371/journal.pmed.1003074; Madelyn Gould and Alison Lake, 'The contagion of suicidal behaviours' (2013) 2(4) *National Academies Press*, accessible at https://www.ncbi.nlm.nih.gov/books/NBK207262/.

[50] The reasons for this are explained in detail in Coroners Court of Victoria, *Suicide among LGBTIQ+ people*, published 14 October 2022, and will be detailed later in my Finding.

91. There are often further issues at a very early stage of an investigation in which an understanding of the deceased's intent upon initial report of a death is based on only limited information and is subject to revision as the coroner's investigation develops. All of these factors make information-sharing a complex (and at times, fraught) exercise. This is an issue upon which extensive evidence was heard at Inquest and that I will return to later in the Finding.

92. Suffice to say that there is evidence that certain of the deceased persons engaged in discussions on online forums regarding suicide. However, on the balance of probabilities, I have insufficient evidence before me that a 'suicide pact' had in fact been made between any of the deceased within the cluster investigation. I consider it is more likely that AS, Matt, and/or Heather were impacted by so-called 'suicide contagion'.

93. Notably, the three deceased persons who directly knew at least one other person in the cluster, all used the same suicide method: ingestion of sodium nitrite. Further, a person in New South Wales (**NSW**), who I will refer to as 'E', was known to at least one of these three, also suicided via ingestion of sodium nitrate, two months after watching AS suicide via sodium nitrite on an online video call. The cluster was therefore not limited to this jurisdiction.

94. The CPU advises that sodium nitrite ingestion was practically unknown in Victorian suicides a decade ago. It is still a very uncommon method, accounting for less than 2% of suicides annually in recent years. The fact that four people (including one in NSW) who were socially linked to one another all used this method, within a matter of months, suggests very strongly that there was information-sharing between them, or between other members of the community, about the method.

95. There are risks inherent in drawing attention to a suicide method, including that this may spread knowledge of the method and also may increase the risk that vulnerable people will be drawn to that method. The Coroners Court recognises best practice safe communication regarding LGBTIQA+ suicides[51] includes avoiding discussion of method and means where possible. However, in this case I believe that any risks are counter-balanced by the prevention imperative

[51] Additional Materials 1, 'How to talk about LGBTIQA Suicide Safely', authored by Charlee (Switchboard).

that could be served by addressing sodium nitrite availability in the community.[52] In addition, I note that a coronial finding in which these issues were discussed was published by the State Coroner last month, and which I will turn to further below.

Regulation of sodium nitrite

96. The Court has previously investigated a number of deaths by suicide involving sodium nitrite. The most recent such case was that the investigation into the death of Mr Nathan Greenwood (**Mr Greenwood**), whose death was investigated by State Coroner Judge John Cain, with a finding published on 25 July 2024.[53] Judge Cain also had the benefit of the CPU's advice in relation to his investigation.

97. The CPU advised the Court that sodium nitrite is an inorganic compound similar in appearance to table salt. The *Australia New Zealand Food Standards Code* (**Food Standards Code**) permits the use of sodium nitrite in food products including particularly meat, poultry and game products. Sodium nitrite is also used as a treatment for cyanide poisoning, as an anti-corrosive, and as a precursor in the manufacture of pharmaceuticals, dyes and pesticides.[54]

98. Sodium nitrite is classified as a poison in the Commonwealth's *Standard for the Uniform Scheduling of Medicines and Poisons* (**Poisons Standard**). Depending on the concentration of sodium nitrite and its intended use, a product containing sodium nitrite could fall under one of four schedules in the Poisons Standard, each of which is subject to different access and labelling requirements, as follows:

- if the product contains 15% or less sodium nitrite, it is generally listed under Schedule 2, 5 or 6 of the Poisons Standard and can be accessed without restriction.

- if the product contains greater than 15% sodium nitrite, it is generally listed under Schedule

[52] In addition, I note that a coronial finding in which these issues were discussed was published by the State Coroner last month, and which I will turn to further below
[53] Finding into death of Nathan Greenwood, issued by his Honour Judge John Cain on 25 July 2024. Available: https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202021%20004938%20-%20GREENWOOD%2C%20Nathan%20-%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest.pdf.
[54] Abdollahi M and Khaksar MR, "Sodium nitrite," in *Encyclopedia of Toxicology*, third edition, 2014, accessed via https://doi.org/10.1016/B978-0-12-386454-3.01206-9.

7 of the Poisons Standard and its availability, use and possession may be restricted.

99. While medicine and poison scheduling occurs at a Commonwealth level, the restrictions applied to the scheduled substances are determined at the state level. In Victoria, the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) (**DPCS Act**) is the relevant legislation for this purpose. Under the Act, certain restrictions apply to all Schedule 7 poisons. For example:

- Under Section 38 of the DPCS Act, a person who sells or supplies any Schedule 7 poison in Victoria is required to keep an accurate record of the purchaser, date of supply, and name and quantity of the poison supplied.

- Under Section 40 of the DPCS Act a Schedule 7 poison must not be supplied to a child in Victoria.

100. Additional restrictions are also applicable to Schedule 7 poisons listed in Victoria's Poisons Code (a legislative instrument prepared under Section 12 of the DPCS Act). If a poison is listed in the Poisons Code, then it cannot be offered for general sale by retail, and authorisation or licensing under the DPCS Act is required to sell or supply the poison by wholesale or retail.[55] However, sodium nitrite is not listed in the Poisons Code, so there are no effective barriers in Victoria to a person obtaining a product containing sodium nitrite regardless of schedule, provided the person is aged 18 years or over.

Sodium nitrate versus sodium nitrite

101. While the evidence indicates on the balance of probabilities that Heather consumed sodium nitrite, the substance sodium nitrate is often mentioned in discussions about sodium nitrite. Therefore, for completeness I include the following information about sodium nitrate while noting that availability of and regulation of access to sodium nitrate are not issues in this case.

102. Sodium nitrate differs to sodium nitrite in its chemical composition, although they share similar attributes, both being white crystalline solids with a similar taste that are highly soluble in water. As outlined in the Food Code Standards, sodium nitrate is used as a food additive in

[55] Section 26 and Section 27 of the DPCS Act.

cheese products, and a curative in slow dried cured meats. Nitrates in the salt convert into nitrites over time when exposed to bacteria present on meats during the curing process. Sodium nitrate is also used in fertilisers, pyrotechnics and rocket propellant.

103. Sodium nitrate is not currently listed in the Poisons Standard, so there are no restrictions on sale or access to it. Substances containing lower concentrations of sodium nitrate are available for purchase at food ingredient suppliers in the form of curing-salt mixes. Substances containing higher concentrations for industrial purposes can be sourced online.

104. Although sodium nitrate is relatively non-toxic when ingested, 5% of the nitrate is rapidly reduced to the more toxic nitrite by bacteria in the saliva and gastrointestinal tract.[56] Ingesting a larger amount of sodium nitrate can therefore produce a toxic level of nitrite and lead to potentially fatal poisoning.

Sodium nitrite ingestion as a suicide method

105. The CPU has advised that in recent times, the worldwide number of reported suicide cases involving sodium nitrite as a suicide method has dramatically increased.

106. The dissemination of sodium nitrite ingestion as a suicide method in Australia appears to have been largely driven by a pro-euthanasia advocacy organisation with a publication detailing end-of-life strategies and step-by-step instructions for death. While the initial book was banned, subsequent e-publications are now regularly updated and are readily available, and include a plethora of material on sodium nitrite ingestion as an option for those seeking to end their lives.

Sodium nitrite suicide in Victoria

107. The CPU identified 52 sodium nitrite suicides in Victoria from 2017 to 2023. The CPU noted that despite the recent publicity and attention given to sodium nitrite ingestion as a suicide method, the annual number of deaths has been relatively steady since 2019 with an average

[56] Joosen D, Stolk L and Henry R, "Case report: A non-fatal intoxication with a high-dose of sodium nitrate," *British Medical Journal Case Reports*, 2014, doi:10.1136/bcr-2014-204825

of 10 deaths per year.

108. The CPU noted that where the sodium nitrite sources could be identified (in 23 of the 52 deaths), the sources were primarily online vendors (both Australia and based overseas) but were otherwise diverse, including food stores, chemical and laboratory supply companies and private sellers. The data also indicates that in 23 of the 52 suicides the deceased had researched the suicide method.

Restricting access to sodium nitrite

109. Sodium nitrite is widely used for legitimate purposes in many different areas including as a multifunctional food additive and sold as an online product, which causes difficulties in restricting the purchase and sale of the product.

110. During the course of the investigation into Heather's death, I sought to determine where she had sourced the sodium nitrite that she used to end her life. However, I was advised by Victoria Police that it had been unable to determine where she had purchased it from, noting that it appeared in different packaging to that of her friend, AS, who died close in time to her and who had purchased the substance via the online retailer 'eBay'. Heather had also reportedly purchased the substance online.[57] Suffice to say here that there was a container found with Heather at the time she died that was clearly labelled 'sodium nitrite'.

111. In addition, the CPU advised that the Therapeutic Goods Association recently considered the issue of how access to sodium nitrite should be regulated in Australia. This occurred in the context of an April 2021 proposal to create a new Schedule 10 entry in the Poisons Standard for products containing concentrations above 15% of sodium nitrite. At the time when this proposal was considered, products with a concentration above 40% Sodium Nitrite were listed in Schedule 7 of the Poisons Standards.

112. The ultimate outcome of the consultation process was that the Schedule 10 proposal was rejected, but the concentration threshold for a product to fall under Schedule 7 of the Poisons

[57] *See in this regard* the Statement of Dr S. Kongasseri, Court File, noting that, after her death, Heather's partner reported she had '*taken the contents of a suicide kit she purchased online*'.

Standard was lowered from 40% to 15%. The reasons given for the decision included:

- the legitimate uses for sodium nitrite across multiple industries (such as food, pharmaceuticals, explosives, dyes, and pesticides) meant that restricting the availability of sodium nitrite might have a substantial unintended impact on business;
- placing sodium nitrite products in Schedule 10 would mean that those products cannot be sold or used anywhere in Australia, without exception; and
- amending the existing Schedule entries was viewed as a means to place stronger controls on sodium nitrite access while not unduly restricting industrial uses.[58]

113. Having considered the available evidence, it is clear to me that individuals who may choose to suicide with the use of sodium nitrite can easily purchase the product online notwithstanding the purported restrictions in place on websites. In this regard, I am of the view that a recommendation to further restrict access to the online purchase of sodium nitrite is worth considering.

Taking down online information about sodium nitrite

114. The CPU also advised that another frequently mentioned intervention is to target online sources of information about sodium nitrite as a suicide method. The basis of this proposal is that the majority of people who self-harmed by taking sodium nitrite had learned about the method online.

115. While to date, no Victorian coroner has made a recommendation restricting the information about sodium nitrite suicide, the issue of controlling information about other suicide methods has been considered. Deputy State Coroner Spanos (as she now is) commented in her finding following the Coronial Investigation into the Death of Joseph Waterman (COR 2014 000169) that: '*Suicide organisations' publications advocating specific suicide methods…are banned in Australia but there is no practical way to prevent Australians from viewing and accessing*

[58] Therapeutic Goods Administration, "Notice of interim decisions on proposed amendments to the Poisons Standard (sodium nitrite) - June 2021", 12 October 2021, <https://www.tga.gov.au/

them via the internet'.

116. The CPU also concurs that, given the ubiquity of information about sodium nitrite suicide on the internet, there is no practical way to implement such an intervention.

117. Having considered the available evidence and advice from CPU, I agree that given the sheer volume of material online that is available to an individual who is seeking information about sodium nitrite as a suicide method, there does not appear to be a practical way to prevent Victorians (or Australians more broadly) from accessing that information or the product from other sources on the internet.

The way forward

118. I support the view of the State Coroner (articulated in the Finding into the Death of Mr Greenwood) that the Federal Government should investigate ways to further restrict the online sale and distribution of sodium nitrite in Australia. While it is unclear where Heather purchased the sodium nitrite from, it appears that, similar to others in the cluster, she sourced it online. Therefore, while it is clear that continued efforts are required to strengthen broader prevention opportunities aimed at the reasons people may choose to end their lives, I am of the view that looking at the means by which they may choose to do so – in this case, by looking at restricting online sale of sodium nitrite at a national level – is an appropriate and justifiable course of action.

119. In the State Coroner's Finding into death of Mr Greenwood, a recommendation was made '*that the Assistant Minister for Mental Health and Suicide Prevention; The Hon Emma McBride investigate in conjunction with other appropriate Ministers, Departments and Agencies of the Commonwealth ways to further restrict the online sale and distribution of sodium nitrite in Australia*'. I endorse this recommendation and, given the specific issues involved in my cluster investigation in relation to the use of this substance amongst members of the trans and gender diverse community as a suicide method (with the substance being implicated in the cause of death in three of the five cases), I will make the recommendation afresh with this context made explicit.

3 - Mental ill health and suicidality in the trans and gender diverse (TGD) community

120. The third item in the scope of inquest is '*[t]he evidence base concerning the incidence of mental ill health and suicidality in the TGD community, including the reasons for this'*.

121. I heard evidence in these proceedings that TGD people face disproportionate rates of mental ill health and suicidality compared to the population as a whole, as well as a higher rate of completed suicide.[59] While there is some variation in specific findings and datasets (particularly where studies are drawn from clinical populations, as opposed to the TGD population more broadly), there is clear evidence that the TGD community reports and experiences higher rates of depression, anxiety, suicidality and self-harm than the population as a whole,[60] with Dr Kalra of the Monash Health Gender Clinic stating that 50-75% of TGD people report having a mental health issue.[61]

122. At Inquest, Professor Zajac of Austin Health noted that, in his experience of treating TGD patients (through a clinic treating approximately 600 TGD individuals), '*virtually all […] report some kind of mental health problem. So it's almost universal*.'[62] Bailey Nation-Ingle of the Victorian Department of Health (**Department of Health**) stated that TGD people are one of the most at-risk populations globally for suicidal ideation, suicide attempts and also death by suicide, with Carolyn Gillespie of Thorne Harbour Health noting that TGD people are also reported to experience the highest rates of distress out of the LGBTIQA+ population

[59] Evidence of Dr P. Jenkins, RANZCP, T-211 line 28 to T-212 line 9.
[60] *See* evidence of Dr P. Jenkins, RANZCP, T-212 lines 4-9.
[61] *See* evidence of Dr G. Kalra, Monash Health Gender Clinic (**MHGC**), T-212 line 21 to T-213 line 6, referring to Ingrid Bretherton et al ''The Health and Well-Being of Transgender Australians: A National Community Survey' (2021) 8(1) *LGBT Health* 42 (**Bretherton Survey**). DOI: https://doi.org/10.1089/lgbt.2020.017 (**Bretherton Survey**) (I note that the transcript at T-212 line 27 refers to this as being authored by 'Weatherton' but the reference to 'Bretherton' is confirmed at T-214, line 10). The precise rate of mental ill health and suicidality in the TGD population varies according to the study cited and the specific mental illness being referred to – *see for example* T-213 lines 9-29. The Bretherton Survey involved 928 participants who reported high rates of co-occurring mental health issues, such as lifetime diagnoses of anxiety (67%) and depression (73%), as well as high rates of self-reported self-harm (63%) and attempted suicide (43%). In contrast, self-reported rates of depression, anxiety and suicide attempts for the general population are indicated at 11.6%, 26.3%, and 3.2% respectively – *see* LGBTIQ+ Health Australia, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People. Sydney, Australia: LGBTIQ+ Health Australia* (2021). Available at: https://www.lgbtiqhealth.org.au/statistics.
[62] *See* evidence of Professor J. Zajac, Austin Health Gender Clinic (Endocrinology) (**AHGC**), T-214, lines 16-21.

as a whole, with double or higher the rate of suicide attempts than cis-gendered participants.[63]

123. Despite this, both expert panels at Inquest emphasised that there is nothing inherent in being TGD that comprises or causes mental ill health or suicidality.[64] The Chief Psychiatrist (as he then was), Dr Neil Coventry, noted in particular that contemporary approaches in the provision of healthcare to TGD people have moved away from pathologisation of gender identity, a phenomenon Ms Gillespie described as where '*identity is seen as unwell or needing fixing or that there's something wrong in you*'.[65]

124. Dr Coventry emphasised that '*pathologising gender identity really neglects the impact of complex psychosocial structural factors, the discrimination, trauma, marginalisation, family issues and also this can impede people getting access to care, certainly access to appropriate mental health specialist care'*.[66] In a similar vein, the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) noted in its submission to the Court that '*the discrimination and marginalisation experienced by LGBTIQ+ people increases the risk of developing mental health conditions and creates barriers to accessing supportive services'*.[67]

Factors contributing to levels of distress, mental ill health, and suicidality in the TGD population

125. At Inquest, witnesses on both expert panels, as well as the Court's lived experience expert, Ms Lane, gave evidence regarding the factors contributing to levels of distress, mental ill health and suicidality in the TGD population. These factors include TGD peoples' experiences of family violence and rejection, social exclusion, discrimination and experience of violence, as well as the negative impacts of societal 'debate' on TGD issues and on the

[63] *See* evidence of Mrs B. Nation-Ingle, Department of Health, T-216 line 28 to T-217 line 1 and Ms C. Gillespie, Thorne Harbour Health, T-214, line 24 to T-215, line 7. *See further in this regard* Adam Hill et al, 'Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia' (Research Paper, Monograph Series No. 122, ARCSHS, La Trobe University, 2020) 50-53 (**Private Lives 3**). 'Cisgendered' is used for someone whose gender identity aligns with their sex assigned at birth.
[64] *See for example* the evidence of C. Gillespie, Thorne Harbour Health, T-222, lines 1-3.
[65] Evidence of C. Gillespie, T-325, lines 1-3.
[66] Evidence of Dr N. Coventry, Chief Psychiatrist, T-228 lines 14-23.
[67] *See* Collated Brief, p. 100.

very right of TGD people to exist.[68] The expert evidence demonstrates that the individual and cumulative impacts of these factors, which I will outline in further detail below, raise the risk of suicidality amongst the TGD population.

Discrimination

126. At Inquest, Dr Kalra of the Monash Health Gender Clinic (**MHGC**) cited an Amnesty International article which noted that TGD people face up to 50-60 instances of 'microaggressions' or incidents of casual discrimination per day.[69] Examples of discrimination faced by TGD people were given by Dr Nguyen of the Royal Children's Hospital Gender Service (**RCH Gender Service**) to include overt bullying, name-calling, physical assault, sexual assault, and not being accepted in schools or jobs, which can result in a sense of rejection that ultimately impacts mental health. Referring to a minority stress framework, Dr Nguyen stated that '*when you have [discrimination of these kinds] and it is ongoing there is a sense of anxiety, there's a sense of hypervigilance, there's poor self-esteem, a sense of self-shame. These all impact on a person's mental health… those who experience discrimination have increased rates of depression, anxiety, suicidality, and self-harm*'.[70]

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[68] *See in this regard* the evidence of Dr J. Morandini, RACGP, T-230 line 17 to T-231 line 17 and T-307 line 20 to T-308 line 9; C. Gillespie, Thorne Harbour Health, T-254 line 15 to T-255 line 17 and T-309 line 28 to T-312 line 2; Dr T. Nguyen, RCH Gender Clinic, T-308 line 25 to T-309 line 18; Professor J. Zajac, AHGC, T-309 lines 20-26; Mr Ball of Switchboard, T-424 line 15 to T-426 line 6; Ms M. McNamara of TGV, T-426 line 30 to T-427 line 30; Commissioner Fernando, T-428 line 2 to T-429 line 9; Ms A. Bernasochi of Switchboard, T-430 lines 2-14; Mr E. McMahon, Drummond Street Services, T-445 line 11 to T-447 line 9.

[69] Evidence of Dr G. Kalra, T-308 lines 11-14. *See in this regard* Mill O' Sull 'Transgender People Face Casual Discrimination Up To 60 Times A Day' *Amnesty International* (Web Page, 29 March 2017) <https://www.amnesty.org.au/transgender-people-face-casual-discrimination-up-to-60-times-a-day/#:~:text='Transgender%20people%20face%20casual%20discrimination%20up%20to%2060%20times%20a%20day',Mill%20'O'Sull&text=Transgender%20rights%20have%20come%20under,Jennings%20and%20actress%20Laverne%20Cox>.

[70] Evidence of Dr T. Nguyen, T-308 line 25 to T-309 line 12. Dr Nguyen's evidence at Inquest echoes the written submissions of the RCH Gender Service, in which it was stated that the external factors faced by TGD people that lead to poorer mental health outcomes can be understood using a 'minority stress framework'. A 2012 study described the 'minority stress model' in transgender people as '*the stressors related to being a marginalised minority group, which in turn can lead to negative physical and psychosocial outcomes. External stressors or distal factors occur across a spectrum of severity, such as misgendering, social exclusion, bullying, discrimination, verbal harassment, physical and sexual assault. These can lead to proximal stressors or internal factors, such as concealment of transgender identity, hypervigilance, internalised transphobia and fear of rejection. Minority stressors may be chronic or acute and over time can lead to negative health outcomes and health disparities such as increased substance use (including smoking and alcohol), depressed mood, anxiety, self-harm and suicidality.*' – *see* Submission of RCH

127. Transgender Victoria highlighted in its submissions that, at times, the fear of experiencing discrimination can also cause TGD people to delay taking steps towards affirming their gender '*until living in their birth gender becomes intolerable*'.[71] The point of gender affirmation can therefore be a period of particular vulnerability for TGD people, which MHGC noted in its submissions as a period that has been associated with an increase in suicide risk.[72]

128. Commissioner Fernando and Mr Elliot McMahon of Drummond Street Services also gave evidence about the compounding impacts of intersectionality on the experience of discrimination (for example, a person who is both transgender and Aboriginal may face heightened discrimination and a lower sense of wellbeing due to intersecting experiences of both transphobia and racism).[73]

Family violence and rejection

129. Mr McMahon gave evidence that, in a survey and subsequent report commissioned by Equality Australia in conjunction with Drummond Street Services, TGD respondents were found to be 2.7 times more likely to experience family violence over their lifetime than the population as a whole.[74] Mr McMahon stated that Australian research into LGBTIQA+

Gender Service, Collated Brief p. 286, referring to Michael Hendricks and Rylan Testa 'A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model' (2012) *Professional Psychology: Research and Practice* 43(5) 460. DOI: https://doi.org/10.1037/a0029597.

[71] Submissions of Transgender Victoria, Collated Brief, p. 258. In this vein, Dr Kalra drew a comparison with Dr Abraham Twerski's description of the way in which a lobster grows, and its period of vulnerability in discarding an outer shell that has grown restrictively around it (which requires it to shelter from prey), to a TGD person's experience of affirming their gender and the vulnerability and stress that this can entail in the face of anti-trans sentiment - Evidence of Dr G. Kalra, T-315, line 18 to T-316 line 6. *See also in this regard*: JINSIDER, 'Rabbi Dr. Abraham Twerski on Responding to Stress' (YouTube, 26 February 2009) <https://www.youtube.com/watch?v=3aDXM5H-Fuw>.

[72] Submission of Dr J. Erasmus, Collated brief, p. 90. *See further in this regard* Greta Bauer et al, 'Suicidality among trans people in Ontario: Implications for social work and social justice' (translated from original Québécoise French), *Revue Service Sociale* (2013) 59(1) 35. DOI: https://doi.org/10.7202/1017478ar. Cf evidence of Mr Elliot McMahon, T-437, lines 14-21: '*For many transgender women it's not the point of affirmation that is the most dangerous. I think that that danger often follows transgender women throughout their lives and of course that's true for some non-binary people and trans men as well, but I really do want to acknowledge that trans women and transfeminine people tend to bear the brunt of that*'.

[73] Evidence of Commissioner Fernando and Mr E. McMahon of Drummond Street Services, T-417, line 5 to T-418, line 6.

[74] Evidence of Mr E. McMahon, T-446 lines 2-7. *See in this regard* Madeline Gibson et al 'There's No Safe Place at Home: Domestic and family violence affecting LGBTIQ+ people' (Research Paper, Equality Australia: Sydney and Melbourne, Centre for Family Research and Evaluation and Drummond Street Services, 2020) 24.

experiences of family violence has found that recent experiences of suicidal ideation, suicide attempts, and high or very high psychological distress were associated with experiences of both family of origin violence and intimate partner violence.[75]

130. Mr McMahon also gave evidence in relation to the incidence of family rejection experienced by TGD people by virtue of their TGD status, which can include '*increased arguments and conflicts, abuse and neglect, silence and avoidance, control and isolation and revoking housing. Familial exclusion in any of those categories to any degree is potentially psychologically damaging*'.[76]

131. Ms Gillespie of Thorne Harbour Health noted that experience of violence or rejection from the family can '*escalate at points of outwardly affirming gender*'.[77] Indeed, Ms Lane, the Court's lived experience expert, noted that, in deciding to undergo her own gender affirmation process later in life, and in the lead-up to telling family, colleagues and friends, she '*made the expectation to lose everyone*'.[78]

Experience of violence in the community

132. Mr Joe Ball of Switchboard gave evidence that, through provision of its helpline services, Switchboard has become apprised of the unique experience by members of the TGD community (particularly transwomen) of violence who '*fear going outside, fear going on public transport, fear basic things that people can do'*. This can be heightened when one may be perceived as transgender in public, and be impacted by the degree to which one is seen to '*pass*' in one's affirmed gender.[79]

133. The submissions of Equinox outlined that experiencing physical assault correlated most highly with attempted suicide in the TGD community, referring to a study in which violence

[75] Evidence of Mr E. McMahon, T-446 lines 8-19.
[76] Evidence of Mr E. McMahon, T-445, lines 11-23.
[77] Evidence of C. Gillespie, Thorne Harbour Health, T-282 lines 3-7.
[78] Evidence of Ms E. Lane, T-25 lines 27-28.
[79] Evidence of Mr J. Ball, Switchboard, T-425, lines 13-25. *See also* evidence of Ms M. McNamara, T-426 line 23 to T-427 line 30. The notion of 'passing' was acknowledged by Mr Ball to be problematic, and the discussion of 'passing' was noted by Dr Vivienne to hinge on a '*binary construct that we're folded back into… the experiences of being not fitting are manifest from moment to moment on an ongoing basis when there's not a bathroom door that you can walk through safely or there's not a form that you can identify yourself i*n'.

experienced due to being TGD was reported by 21% of participants, and which doubled the probability of a lifetime suicide attempt.[80]

Social exclusion

134. Mr McMahon of Drummond Street Services gave evidence of the impacts of social exclusion faced by TGD people, noting that '*social exclusion for trans and gender diverse people impinges on our fundamental rights, among the types of social exclusion our community experiences are exclusion from income and protection. Exclusion from education. Poor work conditions including workplace discrimination. Lack of access to affordable healthcare of decent quality and lack of access to housing and basic amenities. [These are] some of the key social determinants of health and exclusion from access to them has long lasting material impacts on physical and mental health and well-being'.*[81]

135. The effects of discrimination and social exclusion on TGD people were noted to be potentially long-lasting, with Dr Coventry, then-Chief Psychiatrist, giving evidence that '*I think it runs the significant risk that people lose the protective factors that are very helpful for mental health and wellbeing, particularly if we're talking about children and young people that, with withdrawal from many other domains of their life, so thinking about young people that are already somewhat dislocated from education who drop out of education, they lose the opportunities for vocational training, tertiary education, all the other social impacts through this*'.[82]

'Debate' on TGD issues in the media

136. The Commissioner for LGBTIQA+ Communities, Commissioner Fernando (as he then was), noted in his submissions to the Court the deleterious impact on TGD people of '*criticisms, hate speech and attacks upon trans people in the media and on social media*',[83] an issue spoken to at Inquest by many witnesses, including those on the Medical Panel, such as Dr

[80] Submissions of Equinox, Collated Brief, p. 78. *See in this regard* Sav Zwickl et al, 'Factors associated with suicide attempts among Australian transgender adults' (2021) 21 *BMC Psychiatry* 81. DOI: https://doi.org/10.1186/s12888-021-03084-7.
[81] Evidence of Mr E. McMahon, T-446 line 20 to T-447 line 2.
[82] Evidence of Dr N. Coventry, Chief Psychiatrist, T-318 line 20 to T-319 line 2.
[83] Submissions of the Commissioner for LGBTIQA+ Communities, Collated Brief, p. 122.

Nguyen of the RCH Gender Service[84] and Professor Zajac of Austin Health.[85] Significantly, Bailey Nation-Ingle of the Department of Health gave evidence that, following an 'anti-trans rally' held in March 2023 in Melbourne, the Department received many calls from service providers indicating a significant increase in the numbers of referrals to their services, including those supporting LGBTIQA+ people following a suicide attempt, suicidal ideation or self-harm. Mind Australia also reported a significant increase of referrals from TGD people at that time.[86]

The right to exist

137. At Inquest, Ms Gillespie described the '*philosophical, ideological, religious objections to the existence of trans and gender diverse people*' that underpin the experience of discrimination and social exclusion of TGD people.[87] Dr Mark Dalgleish gave evidence of the deleterious impact of such attitudes, insofar as the very existence, welfare and wellbeing of TGD people, which ought to be non-negotiable, are shifted '*into spheres that are seen as being debatable or optional*'.[88] Dr Dalgleish opined that the questioning of gender identity necessarily entails questioning an intrinsic quality that underpins one's very existence, noting that '*gender, and to a large degree sexuality is embodied, it is deeply personal in their fullest sense because it is not just how we are operating in the world, it's how we are in our very existence*'.[89]

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[84] T-317 lines 13-26, referring to the stated impact on a young TGD patient of a former Prime Minister's comments on 'gender whispering'. This point was also raised by Ms M. McNamara of Transgender Victoria at T-434 lines 4-27.
[85] T-317 line 28 to T-318 line 16, referring the impact of media commentary on sporting events in which TGD athletes are competing or seeking to compete.
[86] Evidence of Mrs B. Nation-Ingle, T-313 lines 12-23.
[87] Evidence of C. Gillespie, Thorne Harbour Health, T-315 lines 9-12.
[88] Evidence of Dr M. Dalgleish, T-319, lines 21-22. These words were echoed at Inquest by Dr Vivienne of Transgender Victoria, who noted that the provision of care and services to the TGD community should not require one to have to first establish that '*we exist and we have the right to be well*'; this should be a given. *See* evidence of Dr S. Vivienne, T-519 lines 2-5.
[89] Evidence of Dr M. Dalgleish, T-250, lines 6-10. *See also* Submissions of Transgender Victoria, Collated Brief, p. 253. Ms M. McNamara of Transgender Victoria also spoke to this issue at Inquest at T-435, lines 4-15: '*When the leadership of this country and the media apparently unite in opposition to our very identity and we had Mark Dalgleish speak about the centrality of our identity to our whole being and our whole existence in this planet, in this world, in these unceded lands, it really shakes you to the core and it shakes me to the core when I'm challenged by media articles and leadership that denies my identity and um for a population of the characteristics that we've heard who have such fragile mental health and who are exposed to such shocking rates of suicidality and suicide attempts, it can only have a deleterious effect on their mental health*'.

138. While the weight of the evidence suggests that the burden of stigma, discrimination and exclusion is heavy for the adult TGD community, evidence at Inquest was heard that the inverse may exist for children and young people who are supported to identify as TGD or to explore a TGD identity and who exhibit no mental health issues, distress and experience of suicidal ideation. Dr Tram Nguyen of the Royal Children's Hospital Gender Service stated:

> *'Can I make the obvious statement that being trans and gender diverse is a wonderful part of human diversity, to be celebrated, and it's not a mental health condition and not all trans and gender diverse people will experience gender dysphoria or have mental health diagnoses. I have the luxury and the absolute joy of working with young people, particularly those who are under eight and who are supported and affirmed by their parents and their community, and they do not have a mental health condition and they live and thrive'*.[90]

Classifications

139. The Coroners Prevention Unit (**CPU**), in providing advice to the Court on the cluster investigation, also emphasised that, while there are increased risks of suicidality, distress and mental ill health amongst TGD people, not conforming with a birth-assigned gender expectation is not itself a mental health 'condition'.[91]

International Classification of Diseases and Related Health Problems

140. The CPU referred to the World Health Organization (**WHO**) International Classification of Diseases and Related Health Problems (**ICD**), which is used in Australia for classification of health-related conditions. According to the WHO, the 11th Edition of the ICD (**ICD-11**) which came into effect from 1 January 2022, redefined and replaced outdated diagnostic categories, including 'transsexualism' and 'gender identity disorder in children', with

[90] Evidence of Dr T. Nguyen, T-229 lines 16-26. Dr Kalra of the MHGC also provided a unique perspective of his work with the Indian Hijira community, a cultural group in India whose members do not align with a gender binary. Dr Kalra noted that the sense of dysphoria and mental ill health in this community is not as prevalent as seen in the Western context, which he posits is due to the increased cultural acceptance for the Hijira community in India - Evidence of Dr G. Kalra, T-234 line 25 to T-235 line 10.

[91] *See in this regard* Coroners Prevention Unit Cluster Report (**CPU Cluster Report**), Collated Brief, pp. 10-11. *See also in this regard* the Submissions of Transgender Victoria, Collated brief, pp. 256-258.

'gender incongruence of adolescence and adulthood' and 'gender incongruence of childhood' respectively. Gender incongruence is defined in the ICD-11 as '*characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group*'.[92]

141. In the ICD-11, gender incongruence has been moved from the 'Mental and behavioural disorders' chapter and into the new 'Conditions related to sexual health' chapter, to reflect current knowledge that TGD identities are not conditions of mental ill health, and that classifying them as such can cause enormous stigma. Transgender Victoria noted that this revision was of great importance to TGD people '*as it depathologises being transgender and more closely accords with TGD peoples' understanding of themselve*s'.[93]

Diagnostic Statistical Manual

142. The CPU also noted that in 2013, the Diagnostic Statistical Manual (**DSM-5**), which is published by the American Psychiatric Association and is used by some clinicians as a classification of mental disorders in Australia, the diagnostic category of '*gender identity disorder*' was changed to '*gender dysphoria in adolescents and adults*' and '*gender dysphoria in children*'. The change is reflected in the revision published in March 2022 (**DSM-5-TR**) which focuses on the gender-related distress experienced by an individual, rather than the individual's gender itself. Gender dysphoria in this context is defined as a '*clinically significant distress or impairment related to gender incongruence, which may*

[92] *See* CPU Cluster Report, Collated Brief, pp. 10-11, referring to WHO, Gender incongruence and transgender health in the ICD, Available: https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd#:~:text=ICD%2D11%20has%20redefined%20gender,gender%20incongruence%20of%20childhood%E2%80%9D%20. Extended definitions are included for gender incongruence in childhood and in adolescence/adulthood, with the latter described thusly: '*Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis''*.

[93] Submissions of Transgender Victoria, Collated brief, pp. 255-258. In this connection, Transgender Victoria emphasised the need to avoid pathologisation of TGD identities through use of words such as 'comorbidities' to describe co-occurring mental health conditions in TGD people.

include desire to change primary and/or secondary sex characteristics'.[94] I note that the DSM-5-TR and definitions therein are not used by all clinicians in providing gender-affirming treatment.[95]

143. As will be discussed in the next section, not all individuals who identify as TGD will experience psychological distress or meet the criteria for gender dysphoria, and some people can experience gender-related distress without identifying as TGD. In Australia, it is important to note that the presence of gender dysphoria is not required to access gender-affirming treatments. In its submissions to the Court, the RANZCP stated '*gender dysphoria emerges in many different ways and is associated with significant distress for those who experience it. However, gender incongruence is not inherently pathological*'.[96] Dr Peter Jenkins on behalf of the RANZCP emphasised at Inquest that the RANZCP does not believe that being TGD is a mental health condition.[97]

144. Notwithstanding these changes to the DSM and ICD, their effect may still be somewhat '*pathologising'*.[98] Dr Coventry noted the ongoing challenge that gender-related issues are still viewed through the prism of disease. He stated that *'[t]he incongruence is actually from how our culture might be responding, so I find these labels very unhelpful because they are very unsophisticated, they focus on the individual… so I think while the World Health Organization as my colleague Peter Jenkins was mentioning is an improvement, I think it's still talking about disease entities which creates barriers, I think, for people to be able to*

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[94] 'What is Gender Dysphoria', *American Psychiatric Association* (Web Page, August 2022) <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>. An extended definition is included to guide diagnoses of gender dysphoria.

[95] The classification of gender dysphoria under the DSM-5 is strongly resisted by some health care practitioners who are of the view that this continues to pathologise gender identity – *see for example* the approach of the MHGC outlined at 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>; and Dr T. Nguyen, RCH Gender Clinic, T-230, lines 2-12 – '*I would also like to add to the comment around the DSM-5 classification that it is pathologising, it doesn't speak to the trans experience, and it perpetuates binary gender stereotypes in terms of preferences and behaviours but in addition to this the real problem with it, it's the perpetuation of its use. It's used in spaces where it is required for medical affirmation, or it is required for surgical affirmation so there needs to be systemic changes not just within the DSM-5 and moving on to DSM-6 but within systems that continue to uphold it as a requirement*'.

[96] Royal Australian and New Zealand College of Psychiatrists submission, Collated Brief, p. 99. It is noted that this part of the RANZCP's submissions referenced Position Statement 103 which relates to the RANZCP's position in working with TGD people in Australia and New Zealand and the role of psychiatrists in responding to their mental health needs. However, this aspect of the position statement remains unchanged.

[97] Evidence of Dr P. Jenkins, RANZCP, T-231, lines 19-21.

[98] Evidence of Dr T. Nguyen, RCH Gender Clinic, T-230, lines 2-12.

access care and it also creates barriers in terms of cultural sensitivity in terms of looking at the impact of stigma and discrimination on someone's health and well-being rather than internally what's going on'.[99]

Analysis

Levels of distress, mental ill health and suicidality in the TGD population

145. I consider that the evidence at Inquest established unequivocally that those in the TGD community face disproportionate rates of distress, mental ill health, and suicidality compared to the population as a whole. The reasons for this are multifactorial, intersecting, and linked to extrinsic factors associated with the broader community's responses to TGD people, which can include experience of discrimination, violence and exclusion that erode the TGD community's wellbeing and contributes to mental ill health.

146. I have considered this evidence in light of the reported experience of the five deceased persons whose deaths I am investigating as part of the cluster. In respect of the issue of discrimination, I note that Natalie's fear of being discriminated against as a transgender person was described by her psychologist as something that deeply affected her mental health and led her to equivocate in relation to engaging with a gender clinic to affirm her identity as female, believing she would be '*severely discriminated against by others due to being transgender*'. This was described as a major barrier in her being able to overcome her fear of being in public and contributed to her increasing isolation.[100]

147. The experience of social isolation was also demonstrated in the evidence related to all five deaths in this cluster, and was amplified by COVID-19 lockdown conditions. For example, in the years after she finished high school, Matt was described as rarely leaving her bedroom due to anxiety and depression. Matt was also never able to secure a job, despite continuing to look and apply for work.[101] I also heard evidence that AS and Matt lived isolated lives, often confining themselves to their bedrooms, and while Bridget was supported by Mx Leigh

[99] Evidence of Dr N. Coventry, Chief Psychiatrist, T-232 line 26 to T-233 line T-234 line 19.
[100] Statement of R. Berthelsen, CB in the matter of Natalie Wilson, p. 55.
[101] Statement of J. Byrne, CB in the matter of Matt Byrne, p. 23; Statement of R. Byrne, CB in the matter of Matt Byrne, p. 18.

and her sister Angela following the COVID-19 lockdowns, she too reported becoming increasingly isolated in her small Flemington apartment, where she lived alone.[102]

148. The experience of family rejection was also evident amongst certain of the deceased whose deaths I am investigating as part of the cluster. For example, while she enjoyed support from other members of her family, including her father, AS's mother told her on her sixteenth birthday that if she wished to pursue gender affirmation, she would not be welcome in the family home.[103] This led AS to leave the family home which she described as an '*involuntary*' act. Indeed, AS noted that she needed this understanding and support, and her experience of family rejection made her feel '*more alone and vulnerable*'.[104]

149. Finally, heightened fears of violence against TGD people were also reflected in evidence that, following Bridget going missing on 30 November 2020, many LGBTIQA+ community members feared she had been attacked, kidnapped, or murdered.[105]

Impact of gender-affirming care on distress, mental ill health and suicidality

150. The evidence of Professor Zajac of Austin Health was that in general, mental health issues and distress experienced by TGD individuals is significantly reduced after commencing gender affirming treatment.[106] This was echoed by Dr Kalra of MHGC,[107] Dr James Morandini of the Australian Psychological Society,[108] and Dr Tram Nguyen of the RCH Gender Service.[109] Dr Mark Dalgleish also opined that the overall health of TGD people can improve when receiving gender-affirming care.[110]

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[102] Statement of H. Leigh, CB in the matter of Bridget Flack, p. 45.
[103] Statement of S.T, CB in the matter of AS, p. 7 and also CB in the matter of AS, p. 54.
[104] *See* CB in the matter of AS, p. 54.
[105] Submissions of the Commissioner of LGBTIQA+ Communities, Collated Brief, pp. 122, 124, 130 and 136.
[106] Statement of Dr J. Zajac, Collated Brief, p. 51, referring to Lucas Foster et al 'Short-Term Effects of Gender-Affirming Hormone Therapy on Dysphoria and Quality of Life in Transgender Individuals: A Prospective Controlled Study' (2021) 29(12) *Front Endocrinal (Lausanne).* DOI: 10.3389/fendo.2021.717766.
[107] Evidence of Dr G. Kalra, T-252 line 24 to T-253 line 5.
[108] Evidence of Dr J. Morandini, T-256 line 12 to T0257 line 4.
[109] Evidence of Dr T. Nguyen, T-259 line 27 to T-260, line 20.
[110] Evidence of Dr M. Dalgleish, T-255, line 19 to T-256, line 6. I will return to this further below in analysing the evidence in relation to provision of culturally-appropriate gender-affirming care; its relevance to the present scope item is that for TGD people, affirming one's gender may in fact reduce suicidal ideation and distress and lead to significantly improved mental health outcomes.

The need for improved data regarding the TGD community

151. While noting that there is clear evidence of disproportionate mental ill health, distress and suicidality amongst the TGD population, the data on this issue is widely considered to be incomplete, including in relation to the incidence of completed suicides in the TGD community.

152. In Victoria, this has been attributed to '*systemic issues around data collection*',[111] insofar as entities such as Victoria Police, and until recently, the Coroners Court of Victoria and the Department of Health, have not had a comprehensive system for capturing and recording all gender identities (including transgender and non-binary identities), instead relying on the so-called traditional binary male/female designations.[112]

153. This is compounded by the fact that there is no population level data on the number of TGD people nationally or in Victoria.[113] In a 2019 study, it was estimated that 0.1% - 2% of the population identify as TGD[114] and that this cohort represents a sizeable and increasing proportion of the general population,[115] with significant and growing numbers of people who are willing to publicly identify as TGD.[116] However, the current data is likely to be a significant under-count of the numbers of TGD people in Australia.[117]

154. A report issued by the Coroners Court in 2022 entitled 'Suicide among LGBTIQ+ people' acknowledged the limitations in the available dataset on suicides amongst the LGBTIQA+ population in Victoria.[118] Indeed, the report did not include data on deaths of TGD people as a discrete part of the LGBTIQA+ community due to concerns it may represent a

[111] Evidence of Mrs Nation-Ingle, Department of Health, T-219, line 15.
[112] This gives rise to the risk not only of failing to accurately record transgender identities but, as specifically noted by Dr Mark Dalgleish, it also gives rise to a risk that non-binary identities will not be recognised and recorded – *see evidence* of Dr M. Dalgleish, T-223 lines 13-16.
[113] Evidence of Commissioner Fernando, T-397, lines 13-15. *See also* evidence of Mr Ball, Switchboard, T-397 line 24 to T-398 line 5.
[114] *See* Ada Cheung et al 'Position statement on the hormonal management of adult transgender and gender diverse individuals' (2019) 211(3) *Medical Journal of Australia* 127. DOI: 10.5694/mja2.50259.
[115] *See* Qi Zhang et al 'Epidemiological considerations in transgender health: A systematic review with focus on higher quality' (2020) 21(2) *International Journal on Transgender Health* (**Zhang et al**). DOI: 10.1080/26895269.2020.1753136.
[116] Submissions of Transgender Victoria, Collated Brief, p. 254.
[117] *See* evidence of Mr J. Ball, Switchboard, T-398 lines 27-29.
[118] Evidence of Mrs Nation-Ingle, Department of Health, T-218 line 25 to T-219 line 2.

significant undercount of the suicides in this cohort, and following concerns from community organisations on the impact of this. The report further recognised that *'[i]ncomplete or inaccurate data may only offer limited insight into suicide among LGBTIQ+ communities and could potentially be unhelpful (and even damaging) to prevention efforts*'.[119]

155. As noted in the above report, the lack of systems agility to accurately capture data has significant practical and policy implications. It is evident that accurate estimates of the proportion, distribution, and composition of the TGD population, as well as projections of resources required to adequately support health needs of TGD people, will ultimately depend on the availability of systematically collected high-quality data,[120] such as via the Australian census.[121]

156. In the context of accurately recording the rate of suicides in the TGD community in Victoria, I note that the Coroners Court has recently updated its own database to be capable of capturing all gender identities, which I will return to later in this Finding,

157. However, coroners investigating suicides may not be aware the subject of their investigation was a member of the TGD community unless this is documented in the coronial material: for example, by members of Victoria Police who submit the initial report of death (**Form 83**) or by the coroner's investigator, also a member of Victoria Police, who gathers witness statements and evidence.

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[119] *See* 'Suicide among LGBTIQ+ people' (Report, *Coroners Court of Victoria*, 14 October 2022) <https://www.coronerscourt.vic.gov.au/sites/default/files/2022-10/Coroners%20Court%20of%20Victoria%20-%20Suicide%20among%20LGBTIQ%2B%20people.pdf>.

[120] *See* Zhang et al . This ought to include a disaggregation, as noted by Commissioner Fernando, of those identifying as gender diverse or gender non-conforming as well as those identifying as transgender (*see in this regard* evidence of Commissioner Fernando, T-395 line 29 to T-396 line 6 and Mr J. Ball, Switchboard, T-400 lines 9-26) Mr Ball also gave evidence that TGD people might identify in different ways at different times of their lives – *see in this regard* T-397 lines 24-26.

[121] *See in this regard* '2026 Census topic review: Phase two directions' *Australian Bureau of Statistics* (Web Page, 12 December 2023) <https://www.abs.gov.au/statistics/research/2026-census-topic-review-phase-two-directions> and evidence of Ms M. McNamara, T-399 lines 12-22. However, as of 26 August 2024, the ABS has indicated that this will not occur in the 2026 census – 'Changes to 2024 Census Testing Plans' *Australian Bureau of Statistics* (Web Page, 26 August 2024) <https://www.abs.gov.au/media-centre/media-statements/changes-2024-census-testing-plans>.

158. While there is a myriad of reasons why a person's LGBTIQA+ status, or more specifically, TGD status, might not be immediately apparent to Victoria Police members tasked with reporting a suicide,[122] I consider that improved data collection systems at every step of the investigation process is required to capture this information as and when it may become known. Accordingly, Victoria Police should turn its attention, as a priority, to updating its LEAP systems and associated forms (such as the Form 83) to allow for all gender identities to be captured in line with the Australian Bureau of Statistics Standard[123] and consistent with the commitment under Priority Area 3 of 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32'.[124] A pertinent recommendation will follow.

4 – Provision of culturally-appropriate gender-affirming care

159. The fourth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate gender-affirming care to TGD people in Victoria, including where there are intersecting mental health issues and diagnoses'.*

Terminology

160. Prior to analysing the evidence received on the provision of culturally-appropriate gender-affirming care to TGD people in Victoria, I consider that it is worth briefly outlining the applicable terminology. Dr Mark Dalgleish gave evidence at Inquest of the importance of language to capture the breadth of experiences within the TGD community, stating that '*when it comes to providing gender affirming healthcare we also want to be affirming in every aspect of what we are doing, and that means that we have to recognise a diverse – a diverse expression of identities, sexuality identities, gender identities, other identities that form the wholeness of who we are as humanity*'.[125] I have approached this task with Dr

[122] For a list of these, *see* Suicide among LGBTIQ+ people' (Report, *Coroners Court of Victoria*, 14 October 2022) p 4 <https://www.coronerscourt.vic.gov.au/sites/default/files/2022-10/Coroners%20Court%20of%20Victoria%20-%20Suicide%20among%20LGBTIQ%2B%20people.pdf>.
See also in this regard the evidence of Commissioner Fernando, T-412 lines 16-23 – '*I do note that there may be some sensitivities around police officers being able to ask the question of gender identity and/or sexuality on Form 83 to any parent or senior next of kin who may be at the scene, but nonetheless I think it is an important exercise for Victoria Police to do in regard to a cultural safety framework that the organisation should adopt*'.
[123] *See in this regard* the evidence of C. Gillespie, Thorne Harbour Health, T-225 line 18 to T-226 line 9.
[124] *See in this regard* evidence of Commissioner Fernando, T-411, lines 24-28.
[125] Evidence of Dr M. Dalgleish, T-244 line 26 to T-245 line 8.

Dalgleish's words in mind, noting that in relation to certain terminology, there are several available definitions.

161. As a broad starting point, I note that '**gender**' is used to refer to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. The World Health Organization (**WHO**), which is the agency of the United Nations responsible for, *inter alia*, providing leadership on global health matters, notes that gender interacts with but is different from '**sex**', which refers to the different biological and physiological characteristics of females, males and intersex people, such as chromosomes, hormones, and reproductive organs.

162. Gender and sex are related to but different from '**gender identity**', which is described by the WHO as a person's internal and individual experience of gender, which may or may not correspond to their sex at birth.[126] Gender identity has also been described as 'a *person's innermost concept of self as male, female, a blend of both or neither'*.[127]

163. The term '**TGD people**' is commonly used, including in the World Professional Association for Transgender Health (**WPATH**) 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (**WPATH Standards**) to be '*as broad and comprehensive as possible in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth*'.[128]

- Within the acronym 'TGD', a '**transgender person**' is a person whose gender identity or expression is different from that assigned at birth or who sits outside the gender binary.

[126] 'Gender', *Worth Health Organisation* (Web Page) <https://www.who.int/europe/health-topics/gender#tab=tab_1>.
[127] CPU Cluster Report, Collated Brief, p. 4. *See further in this regard* Charles Roselli 'Neurobiology of gender identity and sexual orientation' (2018) 30(7) *Journal of Neuroendocrinology*. DOI: 10.1111/jne.12562.
[128] Eli Coleman et al 'Standards of Care for the Health and Transgender and Gender Diverse People, Version 8' (2022) 6(23) *Journal of Transgender Health*. (**WPATH Standards 8**). DOI: 10.1080/26895269.2022.2100644. Conversely, the term '**cisgender**' is used for someone whose gender identity aligns with their sex assigned at birth. I have also used the acronym '**LGBTIQA+'** in this Finding to refer to Lesbian, Gay, Bisexual, Trans and Gender diverse, Intersex, Queer, Questioning, and Asexual communities, being an inclusive umbrella abbreviation of diverse sexualities, genders, and sex characteristics (including TGD people). These definitions are used in the Victorian Government LGBTIQA+ Inclusive Language Guide, October 2023 (Web Page) <https://www.vic.gov.au/sites/default/files/2023-10/LGBTIQA%2B-inclusive-language-guide.pdf>.

The terms male-to-female and female-to-male may be used to refer to individuals who are undergoing or have undergone a process of gender affirmation.

- '**Gender diverse**' is a broad term that encompasses a diversity of gender identities and gender expressions including: bigender, trans, transgender, genderqueer, gender fluid, gender questioning, gender diverse, agender, and non-binary. Gender diverse refers to identities and expressions that reject the belief that gender is determined by the sex someone is assigned at birth.

- The term '**non-binary**' is used to describe one whose gender is not exclusively male or female. Non-binary is both an identity and an umbrella term describing a range of people who exist outside societal expectations that gender is only a binary of male and female.[129]

164. The process of '**gender affirmation'** (also known as 'transitioning', though this is often not preferred terminology)[130] will be outlined further below, and is described simply as '*the personal process or processes a trans person determines is right for them in order to live as their defined gender and so society recognises this. This may involve social, medical, and/or legal steps that affirm a person's gender'.*[131]

165. Finally, as noted by Transgender Victoria, the WHO describes '**gender-affirmative healthcare**' as including '*any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity*'.[132]

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[129] *See in this regard* the Submissions of Equinox, Collated Brief, p. 72.
[130] *See in this regard* Submissions of Equinox, Collated Brief, pp. 72-73: '***Transitioning*** *describes a TGD individual's progress towards living their gender identity, either privately and/or publicly, when that identity is other than the gender identity presumed at birth. Transitioning in many cases (but by no means all) will involve some gender affirming medical or health care, however in nearly all cases the gender affirmation process will have begun well before this occurs. Throughout this response we refer to 'affirmation' rather than 'transitioning' as a truer representation of what TGD people experience*'.
[131] *See* CPU Cluster Report, Collated brief, p. 5, referring to 'LGBTQIA+ glossary of common terms, *Australian Institute of Family Studies* (Web Page, February 2022) < https://aifs.gov.au/resources/resource-sheets/lgbtiqa-glossary-common-terms>.
[132] *See* Submission of Transgender Victoria, Collated Brief, p. 256, referring to 'Gender Incongruence and transgender health in the ICD'. *World Health Organization* (Web Page) <Gender incongruence and transgender health in the ICD (who.int)>.

166. I will explore further below what the term '**culturally-appropriate**' means in the context of care and services provided to the TGD community. However, as a basic proposition and as noted by the CPU, referring to the submissions of Thorne Harbour Health, culturally-appropriate care of TGD people is that which is safe, accessible and welcoming insofar as it avoids the medicalisation or pathologisation of gender identity, avoids discrimination, is trauma-informed and holistic, and often involves peer workers and/or is peer-led; *'if you can see yourself in a service, you can attend a service'.*[133]

167. In the preceding section of this Finding, I have already noted basic definitions of '**gender incongruence**' (a marked and persistent incongruence between an individual's experienced gender and the assigned sex) and '**gender dysphoria**' (clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics). In relation to these definitions, I acknowledge that some organisations do not use or support use of the definition and classification of 'gender dysphoria' under the DSM-5, and adopt the advice of the WHO's ICD-11 which instead recommends using the term '**gender incongruence**', including in a diagnostic context.[134]

The process of gender affirmation

168. I heard evidence at Inquest that gender affirmation can involve social, legal, and medical affirmation.[135] Dr Nguyen of the RCH Gender Service noted that gender affirmation is '*not a linear process*'.[136] A gender affirmation journey is unique to the individual – '*there is no requirement for transgender people to undertake any form of affirmation; there is no*

[133] CPU Cluster Report, Collated brief, p. 16, referring to Equinox Submissions. Collated Brief. Ms M. McNamara of Transgender Victoria provided a helpful definition at Inquest of the related concept of '*cultural safety',* noting *'my simple definition would be that a cultural safety exists when a marginalised person for whom the cultural safety is being established, walks into a service and feels instantly at home and comfortable that they can - all their needs can be met … as a full person within that* service' – *see* T-525 lines 11-16.

[134] *See in this regard* 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>. In this connection, Professor Zajac appeared to comment that the distinction may not be meaningful to some: '*the surgeons usually insist on one or two psychiatrists or psychologists or somebody like me writing – writing, saying that the person has general incongruence or gender dysphoria, or whatever it is we're calling it that day'* – T-243 lines 7-11.

[135] I note that I received evidence of further forms of affirmation within these categories, to include familial affirmation as well as affirmation of gender in the workplace, professional associations, unions, and educational institutions – *see in this regard* the submissions of Transgender Victoria, Collated Brief, p. 258.

[136] Evidence of Dr T. Nguyen, T-236, lines 11-12; reflected in submissions of Equinox, Collated Brief, p. 75.

prescribed order and there are as many trans-narratives as there are trans people'.[137] Further, a gender affirmation process is not restricted to any particular timeframe and may be a lifelong process even where certain elements of affirmation are ceased, such as hormone treatment.[138]

169. **Social affirmation** may include use of chosen names, pronouns, online profiles, clothes, hair-style, grooming (hair removal, make-up), and clothing. **Legal affirmation** involves a formal change of name and gender markers on legal documents such as a birth certificate, passport, or Medicare card. **Medical affirmation** may include processes by which a person changes their physical sex characteristics via hormonal intervention and/or surgery (including chest reconstructive surgery, breast augmentation, or genital surgery),[139] and while this is the focus on many policy discussions in this space, medical affirmation is not the goal of all TGD people.

170. Dr Coventry, Chief Psychiatrist, noted the importance of gender-affirming care being individual-led and that it should not be assumed, for example, that '*everyone wants medical affirmation in terms of your physical appearance matching your gender identity*'. Culturally-appropriate gender-affirming care means '*not challenging one's sense of identity, showing shared respect, dignity, shared understanding and really intense listening and working together for people to be making appropriate decisions about their own health and their future. That's the respect everyone is entitled to*'.[140]

Standards, guidelines, assessment and access to care

171. The Australian Professional Association for Transgender Health (**AusPATH**) is Australia's peak body for professionals involved in the health, rights and well-being of TGD people.[141]

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[137] Submissions of RCH Gender Service, Collated Brief, p. 279.
[138] Evidence of Dr T. Nguyen, T-236, lines 20-23. *See also* T-244 lines 9-16 per Dr Nguyen – '*just because someone stops hormones doesn't mean that they have stopped their gender affirmation. An example of this is someone who might be happy with the permanent effects of testosterone and don't feel they need to have it ongoing. That doesn't mean their gender has changed, it just means that they feel affirmed in who they are in their body and don't feel the ongoing requirement for hormone treatment*'.
[139] Submissions of RCH Gender Service, Collated Brief, p. 279. Gender affirming surgeries are currently not available in Victoria to people under 18 years of age.
[140] Evidence of Dr N. Coventry, T-238 lines 15-20.
[141] See in this regard the Submissions of Transgender Victoria, Collated Brief, p. 264.

AusPATH has endorsed the **WPATH Standards**[142] to guide healthcare professionals on the process of medical gender affirmation in Australia, in conjunction with position statements and standards released separately by AusPATH.[143] These standards include those addressing initiation of gender-affirming hormone therapy via the 'informed consent' model (**AusPATH Informed Consent Standards**), which build upon those previously developed and issued by Equinox Gender Diverse Health Centre (**Equinox**),[144] which are also endorsed by AusPATH.

Two potential models for medical affirmation

172. Different gender clinics and health practitioners offering gender-affirming care operate using different models. The first is the WPATH model. The Monash Health Gender Clinic (**MHGC**), which is publicly funded, operates using the WPATH model and requires a comprehensive mental health assessment to be conducted prior to any gender-affirming medical treatment commencing. While there have been significant changes made to the standards contained in WPATH-7 (issued in 2012) and WPATH-8 (issued in 2022), under these standards of care, a mental health assessment is still required to be conducted prior to gender-affirming medical treatment commencing,[145] with any mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment to be addressed before treatment is initiated.[146] MHGC also assesses suicide risk as part of the mental health assessment and factors this into any treatment plan.[147]

173. The WPATH model is used at MHGC for the delivery of all gender-affirming care, including commencement of hormone treatment and surgeries, some of which are offered through

[142] WPATH Standards 8.
[143] AusPATH notes on its website that it '*recommends judicious use of the [WPATH] SOC 8 together with the Position Statements that AusPATH has released*' - 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' *AusPATH* (Web Page, 1 September 2011 and updated in 2022) <https://auspath.org.au/2011/09/01/world-professional-association-for-transgender-health-standards-of-care-version-7/>.
[144] *See* AusPATH (2024). Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy. Australia: Australian Professional Association for Trans Health. Version 1.1. (Web Page) ,https://auspath.org.au/wp-content/uploads/2024/06/AusPATH_Informed-Consent-Guidelines_DIGI_2024_RLv01.pdf>.
[145] *See* summary of requirements at S256 - WPATH Standards 8.
[146] Statement of Dr G. Kalra, Collated Brief, p. 327, referring to WPATH Standards 8 S172.
[147] Statement of Dr J. Erasmus, Collated Brief, p. 92 (noting this statement was provided when WPATH-7 was still in place) 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>.

MHGC or in partnership with private surgeons. The WPATH Standards require letter(s) of support from a mental health professional as a pre-condition for gender-affirming surgery,[148] including to ensure the patient fulfils the WPATH criteria such as capacity to consent to the surgery, gender incongruence being marked and sustained, and assessment of any health conditions.[149]

174. The WPATH Standards are viewed by some as perpetuating a form of gatekeeping that limits access to gender-affirming care. However, proponents such as MHGC note that the WPATH Standards are applied flexibly, in a person-centred manner, and underscore the importance of a cautious approach to gender-affirming care.[150]

175. The second model for providing gender-affirming medical care is the '<u>informed consent' model</u> or '<u>shared decision-making pathway</u>', adopted by Austin Health Gender Clinic, Equinox,[151] and other gender clinics, as well as individual GPs providing gender-affirming care outside of a gender clinic setting (usually at a patient's own expense). Rather than being predicated on a mental health assessment, consent models of hormone-prescribing resist the notion that a doctor can determine the validity of a person's gender, and instead centre the TGD person in the decision-making process, whilst ensuring that the patient understands and can consent to the potential impacts that gender-affirming hormone therapy may have on their body and life.[152]

176. Professor Zajac of Austin Health noted that, for his patients, first contact is made by a peer navigator, followed by a GP or endocrinologist to assess a patient for gender-affirming

[148] *See* WPATH Standards 8 S256.
[149] *See in this regard*: https://www.healthdirect.gov.au/gender-affirming-surgery#what-is
[150] *See in this regard* Homewood et al 'Urological focus on gender affirmation surgery' (2024) 53(5) *Australian Journal of General Practice* DOI: 10.31128/AJGP-11-23-7044; 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#starting-at-clinic>.
[151] Carolyn Gillespie of Thorne Harbour Health (which Equinox forms a part of), gave evidence at Inquest that '*the premise of the work of Equinox is an informed consent model which assumes that clients of the service know themselves and without any evidence otherwise we assume that they are in a position to make decisions in relation to their own body and their lives. So that's directly to address some of the gatekeeping issues that people have in terms of historically having to get psychiatric assessments and psychological reports and whatnot in order to access gender affirming care*' - Evidence of Carolyn Gillespie, T-264, lines 8-16.
[152] AusPATH Informed Consent Standards.

hormone therapy, with a psychiatrist also available if needed.[153] Professor Zajac noted that, while a mental health assessment is not a precondition for delivery of gender-affirming treatment, he recommends all patients have ongoing mental health support when affirming their gender identity.[154]

177. Professor Zajac gave evidence at Inquest that '*in terms of the models used, the WPATH - what you might call the mental health model – is gradually being replaced by the informed consent model*', opining however that those with significant mental health problems are '*better off'* with the WPATH model.[155] Dr Kalra of MHGC concurred that the WPATH model is more appropriate for those '*with complex mental health issues or perhaps more than two or three mental health issues',* noting that those within this cohort '*end up coming to the Monash Health Gender Clinic*'.[156] For MHGC, existence of serious mental illnesses is not a barrier to gender-affirming care *per se*, but the presence of illnesses such as schizophrenia and other major mental illnesses may warrant a longer period of assessment prior to any gender-related treatments commencing.[157]

The importance of gender-affirming care being culturally-appropriate for TGD people

178. Ms Gillespie gave evidence that Equinox, established in 2016, was the first service of its kind, designed to allow TGD people to '*access a really culturally affirming general practice service, so what we offer is all aspects of GP care including hormone initiation, sexual health, mental health, vaccination, endocrinology, nursing support, secondary consultation to prison services…*'.[158]

179. Equinox employs TGD-identifying nursing staff and peer workers as well as GPs who identify as members of the LGBTIQA+ community. Ms Gillespie described: '*our community*

[153] Submissions of Professor J. Zajac, Collated Brief, p. 53. Professor Zajac also noted that the gender-affirming services that Austin Health provides are delivered through the state-funded Trans and Gender Diverse in Community Health Initiative (**TGDiCH**), a consortium of Austin Health, Your Community Health (at PANCH in Preston), Ballarat Community Health and Thorne Harbour Health and includes endocrinologists, psychiatrists, GPs, peer workers and other support personnel – *see* Collated Brief p. 52.
[154] Submissions of Professor J. Zajac, Austin Health Gender Clinic, pp. 51-53.
[155] Evidence of Professor J. Zajac, Austin Health Gender Clinic, T-269, lines 17-26.
[156] Evidence of Dr G. Kalra, T-271, lines 11-17.
[157] 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#starting-at-clinic>.
[158] Evidence of Ms C. Gillespie, Thorne Harbour Health, T-210 line 26 to T-211 line 15.

holds our community',[159] noting that TGD people are best-placed to determine what culturally-appropriate care looks like for them.

180. Ms Gillespie stated that, in terms of the relationship between Equinox and the TGD community, there is '*genuine and meaningful inclusion around processes and decisions that get made. So when services and systems are built like Equinox was truly in partnership and led not just in partnership but led by trans and gender diverse people, it meant that we have a service that now sees thousands of people and supports them because it's actually structured to meet those needs*'.[160]

181. The benefit is that TGD people feel genuinely able to access the service and have their health needs met. This may also avoid the significant health risks which can arise where TGD people report delaying or avoiding needed medical treatment to avoid the risk of discrimination.[161]

The importance of multidisciplinary care

182. During my investigation, I received evidence that the importance of a multidisciplinary approach to gender-affirming care for TGD communities is underscored in both the WPATH and 'informed consent' models of care. WPATH promotes care from a multidisciplinary team as vital to the wellbeing of TGD people and considers this to be a key part of any assessment or treatment plan, with regular reviews between service providers, including importantly when there are indicators of risk.[162] This approach is exemplified by gender clinics such as MHGC, which is staffed by a multidisciplinary team comprising consultant

[159] Evidence of Ms C. Gillespie, Thorne Harbour Health, T-284, lines 14-15.
[160] Ms Gillespie also noted in this regard the Inquest process demonstrated cultural safety for TGD people through visible signs of inclusion, as well as consultation with people with lived experience prior to the convening of the hearing '*to talk about how we could best make these structures and processes culturally safe for our trans and gender diverse community*' – *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-320, line 15 to T-321 line 7. To this end, Ms Lane noted, in assessing whether a space was safe for her to access as a transgender woman, and in referring to the courtroom, '*Now, what I do is, I look for any signs of inclusion. Things like the flag you have here, or the flags here, show support and this is a really important thing for the community*' – T-32, lines 18-21.
[161] Submissions of Equinox, Collated Brief, p. 84, referring to Lucille Kerr, Christopher Fisher and Tiffany Jones 'TRANScending discrimination in health & cancer care: a study of trans & gender diverse Australians' 2019 117 *Australian Research Centre in Sex Health* (**Kerr et. al., 2019**). DOI: 10.26181/5d3e1cc21a99c. This study found in relation to TGD people high levels of unmet healthcare needs, discomfort discussing their needs, feeling misunderstood, emergency department avoidance, barriers to care, numerous instances of poor treatment in the healthcare system and hesitancy to disclose their gender – see p. 6.
[162] WPATH Standards 8.

psychiatrists, clinical psychologists, a social worker, endocrinologists, peer support workers, a project worker, research assistant and administrative workers along with external private consultants in speech pathology and plastic surgery.[163]

183. Ms Gillespie of Equinox highlighted the importance of a multidisciplinary approach for those receiving gender-affirming medical care through an informed consent model, stating '*I think from our perspective, having holistic integrated care is just good healthcare and it doesn't matter who it is that's sitting in front of you but particularly for trans and gender diverse folk, when you provide a holistic integrated model, you can attend to all of the things that impact on someone's mental health and their wellbeing. So for us we work within an organisation that can really be often a one stop shop*'.[164] This may include additional services such as culturally-safe alcohol and other drug support, support for family violence and other issues that may be faced by TGD persons seeking access to care, as well as providing a pathway to receipt of acute mental healthcare where needed.[165]

184. Professor Zajac of Austin Health lamented the deficiency in private practice in providing multidisciplinary gender-affirming care, where it is usually '*just me and the GP, it's hard to find at - for me to get access to the wide range of supports that are available at a place like Thorne Harbour and some of the other general practices who have an interest in this area*'.[166] Professor Zajac considered this was less than ideal where the potential mental health effects of gender-affirming hormones are required to be monitored, and in light of his recommended approach that all TGD persons undergoing gender-affirming hormone therapy have access to mental health support.[167]

185. This fragmentation of care can also be exacerbated where, as noted by Dr Nguyen in relation to care in the private sector, Medicare does not provide a billing item for case-conferencing in many circumstances, and different practitioners who liaise with each other in relation to a patient will often do so based on duty of care alone.[168]

[163] *See* Statement of Dr G. Kalra, Collated Brief, p. 324.
[164] Evidence of C. Gillespie, T-281, lines 19-26.
[165] Evidence of C. Gillespie, T-286, lines 2-7.
[166] Evidence of Professor J. Zajac, T-286 lines 11-17.
[167] Submissions of Austin Health Gender Clinic, pp. 51-53.
[168] Evidence of Dr T. Nguyen, T-287 line18 – T-288 line 2.

Access to gender-affirming medical care and impact on wellbeing of TGD adults, including those with co-existing mental health conditions

186. As noted earlier in this Finding, the evidence of Professor Zajac of Austin Health was that, generally, mental health issues and distress experienced by TGD individuals is reduced after commencing gender-affirming hormone treatment.[169]

187. Professor Zajac referred to a recent controlled study in which one group of TGD participants was taken off the waiting list at a gender clinic and provided gender-affirming hormone treatment (testosterone) immediately, while a second group of TGD participants at the gender clinic remained on the waitlist without hormone treatment (the waitlist being three months). A range of responses was sought from both groups during this period in relation to measures of wellbeing, mental health, and suicidality, with the study concluding that '*immediate testosterone compared with no treatment significantly reduced gender dysphoria, depression, and suicidality in transgender and gender-diverse individuals desiring testosterone therapy*'. Professor Zajac remarked that there is '*clear evidence from this controlled study that even as short a period as three months can improve the wellbeing of individuals*'.[170]

188. The improved mental wellbeing and reduced suicidality of TGD persons upon commencing gender-affirming treatment was echoed by Dr Kalra of MHGC, who gave evidence at Inquest that '*we do see people who have embarked on the medical affirmation pathway and we follow up people who have started on hormones or have undergone surgery for one year, starting perhaps three months after their first appointment after they've started on hormones or undergone surgery and we do see that positive effect in the reduction of their distress, in almost disappearance of the suicidal thoughts that they were experiencing. So we do see that happening over a period of time once they have embarked on the pathway'*.[171]

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[169] Statement of Dr J. Zajac, Collated Brief, p. 51, referring to Lucas Foster et al 'Short-Term Effects of Gender-Affirming Hormone Therapy on Dysphoria and Quality of Life in Transgender Individuals: A Prospective Controlled Study' (2021) 29(12) *Front Endocrinal (Lausanne)*, DOI: 10.3389/fendo.2021.717766.
[170] Evidence of Professor J. Zajac, T-262 line 10 to T-263, line 16. *See further in this regard* Brendan Nolan 'Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinisation: A Randomised Clinical Trial' (2023) 6(9) *JAMA Network Open*, DOI: 10.1001/jamanetworkopen.2023.31919.
[171] Evidence of Dr G. Kalra, T-252 line 24 to T-253 line 5.

189. Indeed, the benefit of improved mental wellbeing upon commencing of gender-affirming hormone therapy was noted in a number of the submissions provided to the Court, including those of the Royal Australian College of General Practitioners (**RACGP**),[172] Equinox,[173] and the Australian Psychological Society.[174] While observing some limitations to the 2021 study he referred to, Dr Erasmus, formerly of MHGC, also noted that hormone therapy may improve quality of life and decrease depression and anxiety.[175]

190. Dr James Morandini of the Australian Psychological Society referred to a number of studies noting '*modest improvements*' in psychological functioning following commencement of gender-affirming hormone treatments, with certain studies noting an improvement to wellbeing that is slightly stronger than most anti-depressant treatments would yield. Dr Morandini noted that '*the standard of evidence is still needing to build, but certainly there is no evidence that suggests that these treatments on average have harmful effects for people'*.[176]

191. In this connection, it is noted that each of the submitting organisations, prior to Inquest, was asked by CPU to address the existence of any risks or harmful effects associated with feminising and masculinising gender-affirming medical treatments. The known risks and side effects reported by these organisations were predominantly related to physical health (e.g. lower bone mineral density in transwomen following commencement of gender-affirming hormone therapy),[177] but also included those that may also impact on TGD peoples' mental health and wellbeing, such as the risk of mood swings or behavioural disturbance from hormone treatment (e.g. estrogen,[178] progesterone,[179] or cyproterone)[180]

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[172] *See* submissions of RACGP, Collated Brief, p. 109.
[173] *See* submissions of Equinox, Collated Brief, pp. 77-78.
[174] *See* submissions of Australian Psychological Society, Collated Brief, p. 58.
[175] *See* submissions of Dr J. Erasmus, Collated Brief, p. 90, referring to Kellan Baker et al 'Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review' (2021) 5(4) *Journal of the Endocrine Society*. DOI: 10.1210/jendso/bvab011. Therein, it was noted that no studies had been found where quality of life scores decrease or depression and anxiety increase following commencement of gender-affirming hormone therapy. The authors found there was insufficient evidence to draw a conclusion about the effect of hormone therapy on death by suicide (*see* Collated Brief, p. 78).
[176] Evidence of Dr J. Morandini, T-256 line 12 to T-257 line 4.
[177] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 91.
[178] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 92.
[179] Evidence of Professor J. Zajac, T-372 line 27 to T-373 line 2.
[180] Submissions of RCH, Collated Brief, p. 282.

with RACGP noting in this context a risk of emotional lability and risk of depression/anxiety for those affirming male-to-female, and increased aggression and emotional lability for those affirming female-to-male.[181]

192. The implications are that those with a mental illness who are affirming their gender should have a comprehensive mental state examination where indicated, and be monitored for changes in mood, appropriateness of medication regimes, consideration of potential drug-to-drug interactions, and assessment of any increased risk of suicidality,[182] as is already provided for in both the WPATH Standards and informed consent model.[183] The MHGC submission notes, for example, that given that estrogen can trigger mood swings, it is important that a person who has borderline personality disorder or a mood disorder has adequate control of their condition before commencing gender-affirming hormone treatment.[184]

193. Evidence was heard at Inquest that further long-term studies are needed to assess certain of the health impacts of gender-affirming care on the TGD population (an example given was an increased risk of heart disease or stroke in transwomen).[185] However, Professor Zajac opined that, in the short-term '*we know quite a lot*' and that these risks are explained in detail as a precondition to those seeking to commence gender-affirming hormone treatment.[186]

194. He also noted in response to questioning from Counsel for Transgender Victoria that his experience was that the proportion of people de-transitioning (namely, the act of stopping or reversing the social, medical, and/or legal changes achieved during a gender affirmation process) is very small, opining that '*the material in some of the press about how common this is not based on any factual data'*.[187]

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[181] Submissions of RAGCP, Collated Brief, p. 105.
[182] Submissions of RAGCP, Collated Brief, p. 105.
[183] *See in this regard* Australian Informed Consent Standards, p. 11 – '*Complex mental health issues should be addressed, and the patient supported, prior to commencing hormone therapy*'.
[184] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 92.
[185] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 91. See further the evidence of Professor J. Zajac, T-372 line 15 to T-373 line 12.
[186] Evidence of Professor Zajac, T-372 lines 27-28.
[187] Evidence of Professor Zajac, T-372 lines 8-15. This is consistent with studies noting the need for improved data on so-called 'detransitioning' to better-inform health responses - *see for example* Pablo Espósito-Campos et al 'Gender detransition: A critical review of the literature' (2023) 51(3) *Actas Esp Psiquitar.* PMID: 37489555.

195. Notwithstanding the gap in data on long-term physical health outcomes for TGD people undergoing gender-affirming treatment, I heard extensive evidence at Inquest, detailed in this section, supporting general outcomes of improved mental wellbeing and reduced suicidality amongst TGD people when they access gender-affirming medical treatment.

196. Further, Mrs Nation-Ingle, State Suicide Prevention and Response Adviser within the Department of Health, noted that '*delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive*'.[188] This is supported by the previously-noted submission of MHGC, in which it was stated that the time between making a decision and then being able to access gender affirming care can be a particularly vulnerable period and has been associated with an increase in suicide risk, hence reinforcing the need to minimise barriers to accessing gender affirming care once a decision to affirm one's gender has been made.[189]

197. The importance of timely access to gender-affirming care as a means to improved wellbeing for TGD people was also emphasised by those beyond the Medical Panel. Transgender Victoria stated that, while the decision to affirm one's gender requires courage and may be delayed by the individual, access to gender-affirming care once the decision to affirm has been made is critical to reducing lack of congruence between gender identity and gender assumed at birth, and often '*will ameliorate the ridicule, vilification, psychological and physical abuse and serious violence that TGD people suffer from*'.[190]

[188] Evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Private Lives 3. It is noted that this was not expressly stated in Private Lives 3 but in a journal article subsequently produced by the Private Lives 3 Research team, namely Adam Hill et al, 'Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among trans and gender diverse people in Australia' (2023) 53(2) *Suicide and Life-Threatening Behaviour* (**Hill *et al.* 2023**), DOI: https://doi.org/10.1111/sltb.12946

[189] Submission of Dr J. Erasmus, Collated brief, p. 90. See further in this regard Greta Bauer et al, 'Suicidality among trans people in Ontario: Implications for social work and social justice' (translated from original Québécoise French), *Revue Service Sociale* (2013) 59(1) 35. DOI: https://doi.org/10.7202/1017478ar.

[190] Submissions of Transgender Victoria, Collated brief, p. 248 and p. 260, referring to Hill *et al*. 2023 and 'AusPATH: Public Statement of Gender Affirming Healthcare, including for Trans Youth' *AusPATH* (Web Page, 26 June 2021) <https://auspath.org.au/2021/06/26/auspath-public-statement-on-gender-affirming-healthcare-including-for-trans-youth/>.

Barriers to accessing gender-affirming care

Waitlists and moral distress

198. Long waiting lists to access gender clinics were described at Inquest by Dr Nguyen as a great source of '*moral distress*' for clinicians, who have substantially *'more demand than we have capacity to see*'.[191] As of July 2024, MHGC's wait-list was over **two years**, with MHGC currently booking appointments for clients whose referrals were received in June 2022.[192] Austin Heath's Gender Clinic waiting list was closed as of March 2024.[193] Equinox's waitlist, at the time of Inquest in November 2023, had been closed since April 2022, with some 1,500 clients already being treated at the clinic.[194]

199. Dr Morandini noted that the waitlists for gender-affirming surgeries can be '*terrible*' and are '*causing significant distress to folks in the community*'. Dr Morandini noted that there are delays of up to two years to access surgeries such as vaginoplasty for transwomen.[195]

200. Dr Nguyen of RCH Gender Services gave evidence of an upward trend in demands for gender-affirming medical care, opining that in the future, she '*would expect that we will then have more demand and increased waitlists. This is not something that will be ending soon*'.[196]

201. In the context of extremely long waiting lists, choosing the right pathway may have critical impacts on the timing in which gender-affirming treatment is able to be received. The pathways for accessing gender-affirming care are quite different; one starts with a psychiatrist or psychologist (in the case of clinicians following the WPATH Standards of

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[191] *See* evidence of Dr T. Nguyen, T-297, lines 23-24. Dr Nguyen noted that, as of November 2023 at RCH Gender Clinic, '*our current waiting list for the initial appointment is somewhere between four to six months and then after that into the full multidisciplinary team can be another six months to 18 months and at times people age out of the service. […]. We would like to provide more care and we would like to improve access' – see* T-297 line 26 to T-298 line 3.

[192] 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>.

[193] https://www.austin.org.au/gender-clinic/ 'Gender Clinic (Endocrinology)' *Austin Health, Clinics & Services* (Web Page) <https://www.austin.org.au/gender-clinic/>.

[194] Evidence of C. Gillespie, T-294 lines 22-24. It is noted that at the time of issuing this Finding, this may have changed.

[195] Evidence of Dr J. Morandini, T-290, lines 21-29.

[196] Evidence of Dr T. Nguyen, T-300 lines 15-21 and T-303 lines 231-23.

Care, as at MHGC); the other starts with an endocrinologist or GP (in the case of clinicians following the informed consent model, as at Austin Health, Equinox or private GPs). Those seeking to affirm their gender must therefore have some idea as to which pathway they might be more suitable for and identify the appropriate waiting list to 'join'. This may not always be clear for would-be clients.

202. Dr Kalra gave an example of where someone may be waitlisted for an informed consent pathway of medical affirmation, and the service provider eventually assesses them as being more appropriate for a WPATH pathway (due to the complexity of mental health issues, for example) and they are referred to MHGC for another 18-month wait. Evidence also indicates that Matt, for example, had appointments at multiple clinics for the purposes of being prescribed gender-affirming hormone therapy,[197] and was later referred to Monash Health for assessment in relation to gender-affirming surgery.

203. This raises the critical issue as to how the wellbeing of TGD people on waiting lists for gender-affirming care is managed. Dr Kalra of MHGC noted that a social worker from MHGC will telephone those on the MHGC waitlist within a two-month period to do an intake assessment, assess their needs, and inform them of the alternative informed consent model as '*many folks are not aware of the pathway*'.[198] During this '*vulnerable period*', MHGC depends upon grassroots organisations such as Thorne Harbour Health to assist in providing social and emotional wellbeing supports to those on the MHGC waitlists.[199] Ms Gillespie noted that, at Equinox (which is part of Thorne Harbour Health), for those on the waiting list, there is '*a really robust peer network of support available for people which people may or may not choose to tap into […] the role of peers can't be underestimated in supporting people's wellbeing or even affirming how rubbish it is actually to have to wait*'.[200]

[197] *See* statement of A. Brownhill, CB in the matter of Matt Byrne, p. 49.
[198] Evidence of Dr G. Kalra, T-292 lines 10-16.
[199] Evidence of Dr G. Kalra, T-299 line 22 to T-300 line 11. However, MHGC will shortly trial a peer-run engagement group, namely a 5-week online program for people on its waitlist, as well as one-on-one peer support – *see* T-292 line 24 to T-293 line 13.
[200] Evidence of C. Gillespie, T-301 lines 10-15 and 27-29.

204. Dr Dalgleish noted that for individual GPs providing gender-affirming treatment, there can be difficulties accessing psychologists for patients through the federally-funded Mental Health Care Plan system.[201]

Evidence of strategies to reduce waitlists

205. Professor Zajac made a suggestion in his submissions to the Court, endorsed by Dr Kalra, that to address the issue of long waitlists and the existence of two separate medical affirmation pathways, there should be a '*central intake point, managed by peer navigators or gender clinic nurses responsible for triaging clients and referring them to either pathway. [This] could be a means by which significant wait lists are reduced as well as limiting client distress. […] If this proposal was implemented, persons with gender incongruence seeking gender affirmation could be waitlisted to the most appropriate pathway dependent on their complexity of need. In this circumstance MHGC would be allocated clients who would likely, in accordance with the WPATH model, require psychiatric assessment*'.[202] This was described at Inquest by Dr Kalra as '*a* ***funnel model*** *I would call it, wherein everybody joins one waitlist in the neck of the funnel*'.[203]

206. Dr Kalra also emphasised the importance of availability for delivery of gender-affirming care to regional and rural patients, which was endorsed by Dr Coventry[204] and Professor Zajac,[205] and of the need to ensure a better process to manage waitlists.

207. While there was significant support for addressing waitlist issues and consolidating available options for TGD patients, other witnesses took a different view of the proposed 'funnel model'. Ms Gillespie of Thorne Harbour Health expressed a concern that a central intake point would inadvertently replicate 'gatekeeping' of gender-affirming care and emphasised the importance of TGD people being involved in scoping any proposals to reduce waitlists. Ms Gillespie opined that '*the ultimate goal here is that it doesn't matter what the touchpoint*

[201] Evidence of Dr M. Dalgleish, T-302, lines 9-21.
[202] Submissions of Dr G. Kalra, Collated brief, p. 327, referring to submissions of Professor Zajac, Collated Brief, p. 53.
[203] Evidence of Dr G. Kalra, T-338 line 26 to T-339 line 1 (my emphasis).
[204] Evidence of Dr N. Coventry, T-342 line15 to T-343 line 6.
[205] Evidence of Professor Zajac, T-344 lines 11-14.

is, a trans and gender diverse person should get good universal healthcare wherever they are, just like any other member of the Victorian community'.[206]

208. Dr Dalgleish recognised the value of a central intake point while avoiding so-called 'gatekeeping', and proposed a central referral system telephone line which could '*act almost as a centralised referral system without actually limiting direct community referrals, self-referrals to other services as well*'.[207] Dr Nguyen also recognised the attraction of a '*streamlined one stop shop*' though noted this may run counter to a vision in which gender-affirming care is '*everybody's business*' and could be delivered by GPs where a TGD person lives, and who is known to them longitudinally.[208]

209. Professor Zajac opined that whatever approach is adopted, it needs to be more streamlined, '*but I think we need to give the system a shake because, well, I think more of the same is not going to get us anywhere*'.[209]

Cost

210. Transgender Victoria, in its submissions to the Court, noted the cost, complexity and administrative burden on TGD people of affirming their gender, including **legal affirmation** (such as changing a name or record of sex on a birth certificate with Births, Deaths and Marriages Victoria, or doing so on a passport via the Australian Passport Office), for which Transgender Victoria provides funding (sourced from donations) to TGD Victorians seeking to legally affirm their gender so that cost is not a barrier to them doing so.[210] Ms Lane, the Court's lived experience expert, also noted at Inquest the costs to TGD people associated with **social affirmation** in changing wardrobe to clothing that affirms one's identity.[211]

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[206] Evidence of C. Gillespie, T-340 line 16 to T-341 line 3.
[207] Evidence of Dr M. Dalgleish, T-341, lines 23-26. They made the comparison with termination of pregnancy services where '*the Royal Women's Hospital have a telephone number that anyone can phone up and access and that telephone number can refer to different services…so it can act… almost as a centralised referral system without actually limiting direct community referrals, self-referrals to other services as well*'.
[208] Evidence of Dr T. Nguyen, T-342, lines 5-13.
[209] Evidence of Professor J. Zajac, T-344 lines11-21.
[210] Submission of Transgender Victoria, Collated Brief, p. 262. See also in this regard the evidence of Dr T. Nguyen, T-237, lines 18-26.
[211] Evidence of Ms E. Lane, T-40 lines 28-30.

211. However, the biggest cost, for those TGD people going down that pathway, is usually that associated with **medical affirmation**. Unless one has access to a publicly-funded clinic such as MHGC (which currently has two-year wait times), Austin Health, or Equinox, which is funded through Medicare and other program funding (whose waitlist at the time of Inquest was closed), the costs of consultations for gender-affirming treatment are required to borne by the patient, or, as is the preferred terminology of Equinox, 'client'. As noted by Transgender Victoria, this can result in '*very large out of pocket costs for patients seeking treatment in private clinics which is often the only option available given the wait times and limited availability of public clinics*'.[212]

212. Professor Zajac gave evidence that he bulk-billed his TGD patients, but there are still costs associated with treatment. In particular, he noted there was a lack of consistency as to the way prescriptions are issued and costs meted out (for example, to access testosterone via the Pharmaceutical Benefits Scheme, there is a requirement for TGD people to have hormones prescribed by an endocrinologist rather than a GP).[213]

213. Dr Dalgleish noted that Medicare bulk-billing for GP consultations is increasingly unsustainable, and does not allow easily for remunerable multidisciplinary conferencing, which is critical to comprehensive holistic care for TGD people. Dr Nguyen agreed, noting that current issues with bulk-billing will likely place additional demands on the public system in the future.[214]

214. There are also costs associated with the requirement for psychological or psychiatric support. As Dr Dalgleish noted, even those with a mental healthcare plan are only entitled to a rebate from Medicare rather than the full cost of the session with a psychologist being covered.[215] This is significant in light of the fact that, while those affirming their gender via an informed consent model may not require a mental health assessment in order to commence treatment, most are recommended to maintain mental health support throughout the affirmation process. There is also the added burden on TGD people of researching whether the services

[212] Submission of Transgender Victoria, Collated Brief, p. 266.
[213] Evidence of Professor J. Zajac, T-240, lines10-13.
[214] Evidence of Dr M. Dalgleish, T-288, lines 5-12; Evidence of Dr T. Nguyen, T-303, lines 8-22.
[215] Evidence of Dr M. Dalgleish, T-302, lines 9-21.

they seek to access are likely to be culturally safe,[216] in a community that is already financially disadvantaged and often fearful of discrimination in healthcare settings.[217]

215. Finally, and significantly, the cost of gender-affirming surgery can be tens of thousands of dollars. Due to the lack of availability of certain surgeries in Australia, many TGD people are required to travel overseas to access such surgeries, which adds to the expense of the procedures themselves. Those without private health insurance will be further limited in available options.

216. Ms Lane, the Court's lived experience expert, spoke openly at Inquest of the costs of her own gender-affirming surgery, which included facial feminisation surgery in Spain at the cost of approximately $30,000, as well as a number of surgeries in Australia and Thailand, totalling approximately $100,000.[218] In her statement to the Court, Ms Lane noted that gender-affirming surgery '*has a lot of costs associated and for me I had to sell my investment property to pay for them. It means my dream to retire at 60 are just that, a dream and I will be working until I am 70. Not everyone has the financial support for this and there is very limited Medicare to assist with the cost*'.[219]

Workforce issues

217. A further barrier to accessing gender-affirming medical care is the fact that the pool of clinicians providing such care to the TGD population is relatively small, meaning that there is an insufficient number of gender-affirming clinicians to meet demand for their services.

[216] *See* Collated brief, p. 227; 'Understanding LGBTQA+SB suicidal behaviour and improving support: insight from intersectional lived experience' (Research Paper, RMIT University, 2023). DOI: https://doi.org/10.25439/rmt.23640978.v1

[217] Some examples of discrimination in a healthcare setting were provided at Inquest, including from Professor Zajac, who noted that he had '*a patient, a young transman getting acne from his testosterone who went to see a dermatologist. The dermatologist came out of his office and yelled at him and said, 'Get out of my waiting room', so if that's not discrimination what is? And that person was scarred for years*' – *see* T-309 lines 20-26.

[218] Evidence of Ms E. Lane, T-27, line 20 to T-28 line 26.

[219] Statement of Ms E. Lane, Collated Brief, p. 43.

218. Professor Zajac noted that there is inadequate access to endocrine services as *'it's only a small percentage of endocrinologists who will see trans individuals. … some people feel they haven't had enough training, which is true, and some people just refuse'*.[220]

219. Similarly, there are only a small number of GPs who deliver gender-affirming care outside of a gender clinic context,[221] with Professor Zajac highlighting his experience where '*one GP in a clinic is very enthusiastic and keen to treat trans individuals but the partners or the other GPs in that clinic are not, and that's often the problem for the patient'*.[222] This was affirmed by Dr Dalgleish who noted that in being a GP offering gender-affirming care outside a gender clinic context '*you're often on your own*', and others in the clinic may not be supportive.[223]

220. Dr Nguyen gave evidence that the workforce issues in delivering gender-affirming care are rooted in discrimination and '*hostility within the medical profession to the vision of gender affirming care amongst medical practitioners of all, of various sub-specialties, psychiatry in particular because that is my craft group, but also others….So what this means for trans people is that the access to care is limited because practitioners feel at risk*'.[224]

221. Drs Nguyen and Dalgleish noted a clear need for capacity-building in mainstream health providers, further gender diversity and cultural safety training for clinicians, and a non-discriminatory approach by medical indemnity insurers.[225] This was echoed by Mx Harden of Thorne Harbour Health, who delivers training to GPs on TGD health, and who stated that a significant barrier faced by GPs '*is that they don't feel supported by their colleges or by their medico-legal insurance, and places like that. So having leadership from those organisations I think would help clinicians feel that they have someone behind them, they*

[220] Evidence of Professor J. Zajac, T-241, lines 23-29.
[221] Evidence of Dr T. Nguyen, T-275 lines 15-16.
[222] Evidence of Professor J. Zajac, T-276 lines 5-11.
[223] Evidence of Dr M. Dalgleish, T-274, lines 4-5. Dr Dalgleish noted however that the RACGP has a special interest group for TGD health that offer GPs training through Thorne Harbour Health – *see* evidence of Dr M. Dalgleish, T-326, lines 6-13. Mx Harden of Thorne Harbour Health also noted that this new interest group '*sends a really clear signal that RACGP are invested in improving trans and gender diverse health…in the GP sphere*' – *see in this regard* T-459 lines 19-24.
[224] Evidence of Dr T. Nguyen, T-274 line 21 to T-275 line12.
[225] See generally T-274 line 21 to T-278 line 13.

have this organisation - you know, their college is supporting the work they're doing'.[226] They noted further that improved access to primary healthcare clinicians offering gender-affirming medical care would see a reduction in waitlist of gender clinics.[227]

222. There was extensive evidence at Inquest about additional mainstream GPs, sexual health physicians or private endocrinologists receiving training to be in a position to prescribe gender-affirming hormones to TGD persons,[228] including as a means to reduce waitlists. As noted earlier, Dr Nguyen's and others' vision is one in which delivering gender-affirming care is '*everybody's business*' and could be delivered by clinicians based where a TGD person lives.[229] This would also help address the issue highlighted by Dr Kalra of the lack of services for TGD people living in rural or regional areas, an issue also noted by Dr Coventry.[230] However, there may be fears of TGD people facing discrimination from accessing mainstream services[231] and fears on clinicians' part of backlash in providing health services to the TGD population,[232] which will be addressed further below.

Gender-affirming care for children and young people

223. In the course of my investigation, the Court received submissions from the Royal Children's Hospital Gender Service (**RCH Gender Service**), which provides gender-affirming care for children and young people who are referred prior to their 16th birthday and who reside in Victoria. Dr Tram Nguyen, consultant psychiatrist and a co-director of the RCH Gender Service also gave evidence at Inquest as part of the Medical Panel.

224. I have not addressed children and young persons' gender-affirming treatment pathway in detail in this Finding because, while there is evidence that AS received gender-affirming treatment as a young person in Queensland, the five deceased persons in this cluster inquest

[226] Evidence of Mx V. Harden, Thorne Harbour Health, T-521 lines 15-29.
[227] Evidence of Mx V. Harden, Thorne Harbour Health, T-524, lines 9-21 – '*My solution is to have primary healthcare clinicians be able to provide gender affirming or medical gender affirmation services. If a trans person can go to their regular GP and discuss their gender identity with them and know that they won't face discrimination, they won't be refused care, that will reduce the wait lists at all of the specialist services, trans and gender diverse healthcare, gender affirming healthcare. Medical affirmation is not specialist care, and it doesn't need to be held at specialist's services*'.
[228] See for example in relation to GPs the evidence of Dr M. Dalgleish, T-352 lines 13-26.
[229] Evidence of Dr T. Nguyen, T-342, lines 5-13.
[230] Evidence of Dr N. Coventry, T-342 line 15 to T-343 line 6.
[231] Evidence of Dr T. Nguyen, T-323 line 23 to T-324 line 8.
[232] *See in this regard* the evidence of Mx V. Harden, Thorne Harbour Health, T-457 lines 7-12.

were all adults when they died, and their pathways to gender-affirming medical care (with the exception of AS, who then resided outside this jurisdiction), commenced in adulthood. I am thus limited in part by the scope of Inquest and the principles in *Harmsworth*.[233]

225. However, in light of the prevention role of the Court and the evidence of Dr Nguyen, it would be remiss of me not to briefly address the issue of care being provided to children and young people. In this connection, referring to two recent studies, Dr Nguyen gave evidence at Inquest that young people who were commenced on gender-affirming medical care in early adolescence had associated reduced depression and suicidality compared to those who were commenced later and those who were commenced in adulthood.[234] She noted several hypotheses around this, including the greater congruence of physical appearance with experienced gender (based on not having developed secondary sex characteristics of the young person's sex at birth) leading to a greater internal sense embodiment and lower chance of being discriminated against, as well as the possibility that having a supportive family facilitating the young person's pathway was contributory to wellbeing outcomes.[235]

226. Dr Nguyen also gave evidence that for young people who are supported early in their gender identity pathway, such as through puberty suppression, their mental health outcomes are on par with their cisgendered peers, compared to those who have not had that early affirmation.[236]

227. The option of medical gender affirmation for children and young people therefore presents an opportunity for early intervention and prevention of distress, mental ill health, and suicidality that TGD people can face later in life.

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[233] *Harmsworth v The State Coroner* [1989] VR 989.
[234] Evidence of Dr T. Nguyen, T-259 line 27 to T-260, line 7. *See further in this regard* Diane Chen et al 'Psychosocial Functioning in Transgender Youth after 2 Years of Hormones' (2023) 388(3) *New England Journal of Medicine* 240-250. DOI: 10.1056/NEJMoa2206297 *This 2-year study involving transgender and nonbinary youth found that gender-affirming hormones (**GAH**) improved appearance congruence and psychosocial functioning*, and Jack Turban et al 'Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults' (2022) 17(1) *PLOS One.* DOI: https://doi.org/10.1371/journal.pone.0261039. *which found that access to GAH during adolescence and adulthood is associated with favourable mental health outcomes compared to desiring but not accessing GAH*.
[235] Evidence of Dr T. Nguyen, T-260, lines 8-20.
[236] Evidence of Dr T Nguyen, T-261 line 29 to T-262 line 6.

228. The submissions of the RCH Gender Service provide a detailed overview of the clinical care pathway for children and young people being treated by the service, and emphasise the multidisciplinary nature of this care, the comprehensive ways in which any mental health issues are addressed, and that care is provided with regard to the WPATH Standards 8 and the Australian Standards of Care and Treatment Guidelines for TGD children and Adolescents.[237] Dr Nguyen gave evidence that care is provided to children and young people presenting to the service through a family-focused, '*holistic person-centred model*', the end point of which is not necessarily medical prescribing.[238]

229. I acknowledge that a divergence of opinion exists in the community in relation to how to best address and treat distress related to gender identity, particularly in children and young people. In this connection, I received correspondence following the close of evidence from an organisation named 'Genspect' seeking further evidence to be called at Inquest from clinicians who support, *inter alia*, a different approach to providing care for children and young people facing gender-related distress,[239] and highlighting the outcomes of the final report authored by Dr Hilary Cass, which includes recommendations on ways in which to improve the United Kingdom's National Health Service (**NHS**) funded gender identity services, and which was published in April 2024 (**Cass Review**).[240]

230. While I gave careful consideration to Genspect's correspondence, I was conscious of the limits of the scope of the Inquest and considered that a detailed examination of the issues raised in Genspect's correspondence would stray beyond the confines of the settled scope. Further, at the time the correspondence from Genspect was received, the Inquest had already occurred, the coronial briefs had been tendered, and interested parties had already made

[237] *See* submissions of RCH Gender Service, Collated Brief, pages 276-289.
[238] Evidence of Dr T. Nguyen, T-268 lines 24-26.
[239] Correspondence received from Genspect dated 20 March 2024, Court File, referring, inter alia, to what Genspect described as '*mounting global concern amongst countless medical and allied health professionals about the efficacy and safety of GAC*' [gender-affirming care].
[240] Correspondence received from Genspect dated 11 May 2024, Court File, referring to, *inter alia*, 'Independent review of gender identity services for children and young people: Final report' (Research Paper, Cass Review, April 2024) Accessible at: <https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf>. The Genspect correspondence highlights, *inter alia*, that *'[i]n her report, Cass concludes that there is no clear evidentiary basis for medical gender affirmation interventions in children and confirms that the evidence for puberty suppression and cross-sex hormone treatment is of such poor quality that no foundation exists for clinical decisions and informed consent*'.

closing submissions. It is also pertinent to note that Genspect had not sought to participate actively in the inquest by seeking standing as an interested party.[241]

231. Importantly, the Inquest did not identify any issues with the approach of RCH Gender Service or the gender-affirming care given to young TGD people, which is provided in accordance with national and international standards, that would warrant further evidence being called. While those standards may evolve over time (and do evolve, when one looks at the long history of WPATH), there was nothing to suggest from Dr Nguyen or from any witness from any organisation – which included a wide range of entities across the health services spectrum, including those providing gender-affirming care, the Victorian Department of Health, Victoria's Chief Psychiatrist, and representatives from peak professional bodies - that the approach to gender-affirming care for children and young people in Victoria warranted further examination in the manner urged upon me by Genspect. Conversely, the positive impacts in providing gender-affirming care to this cohort were highlighted by a number of witnesses, including Mrs Bailey Nation-Ingle from the Department of Health.[242]

232. For completeness, I note that I considered Dr Nguyen to be an impressive witness. Her evidence was articulate, reasoned, and spoke of a doctor who cares deeply for her young patients and their families. While health services in other jurisdictions might be evaluating service models aimed at addressing gender-related distress in children and young people, including the United Kingdom's NHS, the evidence at the Inquest demonstrates that the care provided by Dr Nguyen and her colleagues at the RCH Gender Service is multidisciplinary, holistic, individualised, and appropriately cautious. I consider that the relevance of any issues raised by the Cass Review will be a matter for the RCH Gender Service to consider in light of this existing approach.

233. In such circumstances, and having considered in detail the studies and reports referred to in correspondence by Genspect, I was not of the view that it was necessary or in the interests

[241] *See in this regard* sections 56 and 66 of the Act. Further, Further, section 64 specifies that the witnesses to be called at Inquest, and the determination of the relevant issues for the purposes of the Inquest, are matters for the Coroner.
[242] *See for example* Evidence of Mrs B. Nation-Ingle, T-259 lines 9-18.

of justice to call further evidence on this topic, and as a courtesy, the Court informed Genspect of the same earlier this month.

Analysis

234. Historically, TGD people have faced numerous barriers to accessing gender-affirming care. Certain of these barriers have been attributed to 'gatekeeping' of gender-affirming medical care by medical practitioners, who in the past could decide when, where, and how TGD people were able to medically affirm their gender identity.[243] The most recent WPATH Standards, while still viewed as a form of 'gatekeeping' by some, have lowered requirements for hormone treatment before surgical interventions, and removed requirements for living in desired gender role prior to receipt of gender-affirming care.[244] In a further step towards supporting the self-determination of TGD people, the 'informed consent' model, the second pathway to gender affirmation in Victoria, is premised on the TGD person being in control of their own health, and explicitly rejects the notion of medical practitioners as 'gatekeepers' of gender-affirming care.[245]

235. Despite this, significant barriers still exist for TGD people affirming their identities, particularly via a medical pathway, including due to issues of cost, access and long waitlists in the face of increasing demand for access to gender-affirming care.[246] Given the evidence I heard at Inquest that '*delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive*',[247] coupled with the evidence that trans and gender diverse people are already one of the most at-risk populations globally for suicidal ideation

[243] Submissions of Transgender Victoria, Collated Brief, p. 264.
[244] See examples contained in 'World Professional Association for Transgender Health Standards of Care for Transgender and Gender Diverse People, Version 8 Frequently Asked Questions (FAQs)' (Web Page, WPATH) <https://www.wpath.org/media/cms/Documents/SOC%20v8/SOC-8%20FAQs%20-%20WEBSITE2.pdf>.
[245] Ms C. Gillespie of Thorne Harbour Health (which Equinox forms a part of), gave evidence at Inquest that '*the premise of the work of Equinox is an informed consent model which assumes that clients of the service know themselves and without any evidence otherwise we assume that they are in a position to make decisions in relation to their own body and their lives. So that's directly to address some of the gatekeeping issues that people have in terms of historically having to get psychiatric assessments and psychological reports and whatnot in order to access gender affirming care*' – *see* T-264, lines 8-16.
[246] *See in this regard* evidence of Dr T. Nguyen, T-303 lines 21-22.
[247] Evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Hill *et al*. 2023.

and attempts,[248] I consider these ongoing barriers to gender-affirming care to raise serious concerns in relation to the health and wellbeing of TGD Victorians.

236. Indeed, in terms of the five people whose deaths I have investigated as part of the cluster, I consider these access issues to be most clearly reflected in the experience of Matt, who, in October 2019, underwent a medical procedure for gender-affirming purposes (an attempted orchiectomy) that was attempted by an unlicensed non-medical person with resulting complications, including excessive bleeding. When Matt presented to the emergency department after the aborted procedure, she told doctors that she had opted to go to a non-medical person for the procedure as she had been '*unable to obtain orchiectomy via conventional means*'.[249] I refer to the link between this incident and Matt's suicide further in the Finding into her death; suffice to say here that I consider this to be a cogent – and deeply troubling – example of the need for improved accessibility of gender-affirming medical care for those assessed as suitable.

Strategies to improve access to gender-affirming care in Victoria

237. While there are three gender clinics that receive some form of public funding in Victoria for delivery of gender-affirming care to adults (MHGC, AHGC, and Equinox), these are the only publicly-funded options for those seeking access to gender-affirming care, and they simply cannot keep up with the demand for services.[250] The RCH Gender Service is similarly-stretched.[251]

238. Ms Gillespie gave evidence that, at Equinox (which, at the time of Inquest, had a closed waitlist since April 2022, and had approximately 1,500 existing clients), when the waitlist is opened, it is opened for 175 people. '*It takes us roughly two years to clear that waitlist and then we re-open it and it's full within about 10 days of re-opening*'.[252]

[248] *See* evidence of Mrs B. Nation-Ingle, Department of Health, T-216 line 28 to T-217 line 1.
[249] ED Discharge summary, Matt Byrne, p. 4/80, Court File. An orchiectomy or orchidectomy is the removal of testicles.
[250] *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-295 lines 19-23.
[251] *See* evidence of Dr T. Nguyen, T-297, line 23 to T-298 line 25.
[252] *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-294 line 22 to T-295 line 5.

239. The pattern of increasing demand for gender-affirming care that far outstrips supply is a feature across all of the publicly-funded gender clinics, and calls into question the wellbeing of the individuals on the waitlists, who may have limited options for mental health support in the interim, at a point where they are often most vulnerable. The long waitlists also create moral distress for clinicians providing gender-affirming care, exacerbated by existing workforce issues faced by those delivering such care in an environment that is often marked by hostility and burnout. This situation is clearly untenable for patients and healthcare providers alike.

240. I therefore intend to make a recommendation, as a matter connected with the deaths I am investigating, to the Department of Health to consider **immediately increasing resourcing** to meet the growing demand for publicly-funded gender clinics delivering critical culturally-appropriate gender-affirming care to TGD patients. While noting, *inter alia*, that allocation of funding to services is subject to Victorian Government budgetary decisions, the Department has indicated in closing submissions that it agrees in principle with this proposition.[253] Indeed, the Department's witness provided clear, useful and cogent evidence at Inquest, underpinning the need for greater access to gender-affirming care as a means to ameliorate levels of distress and suicidality amongst TGD Victorians.[254]

241. The evidence from this Inquest has demonstrated that best practice care at such gender clinics (exemplified by existing approaches at clinics such as Equinox) is multidisciplinary, individualised, and culturally-safe through, *inter alia*, use of peer navigators and co-design with those from the TGD community, based on the maxim '*nothing about us without us*'.[255]

242. The Department may consider, as advocated by Transgender Victoria, that any additional resourcing for gender-affirming medical care is paired with revision of the existing framework for delivery of gender-affirming care to TGD Victorians, noting that the existing framework is now over six years old, in order to ensure the framework can keep up with current levels of demand. Transgender Victoria submits that any new framework emphasises

[253] *See in this regard* Outline of Submissions of the Secretary to the Department of Health, 13 February 2024, Court File, pp. 1-2.
[254] *See in this regard*, the evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Hill *et al*. 2023.
[255] See in this regard the evidence of Mx V. Harden, T-458, lines 18-26 – '*As a trans person myself, I won't trust a service or a program that's developed if there are no trans and gender diverse people involved*'.

the provision of services not only through publicly-funded gender clinics but also through primary healthcare networks.[256]

243. In this connection, I heard substantial evidence inquest advocating for GPs and other primary health providers being trained to provide gender-affirming care to TGD people on the basis that such care is not required to be provided through a specialist service. I consider that the evidence at Inquest has indeed demonstrated the need for **further training of healthcare professionals** who may come into contact with or provide gender-affirming healthcare to TGD patients. I agree, as urged upon me by Counsel Assisting, that the RACGP and RANZCP, under the guidance of TGD experts, should develop and offer training and support to all healthcare professionals under their remits, including those who provide or wish to provide care to TGD people, with the aim of ensuring cultural safety for TGD people accessing services in these settings.

244. While not every GP or psychiatrist might feel equipped to deliver gender-affirming care to those in the TGD community, the expansion of existing training will ensure that appropriate referrals can be made and all TGD patients be cared for in a culturally-safe manner.

A note about the 'funnel model'

245. In providing for any new framework or funding increase for delivery of gender-affirming care in Victoria, the Department may wish to consider methods to streamline access points to waitlists, including Dr Dalgleish's proposal of a telephone intake point that can provide information and referrals without limiting direct community referrals or self-referrals to other services[257] (particularly to health providers outside a gender clinic contact). While the idea of a 'funnel' as a central intake point for all gender-affirming care providers in Victoria

[256] See in this regard Outline of Submissions if Transgender Victoria, p. 1, referring to First Submission pf Professor Euan Wallace, Secretary to the Department of Health, itself referring to 'Development of trans and gender diverse services in Victoria', noting that the existing framework for providing health and social services to TGD Victorians was developed in response to a report commissioned by the Department of Health in 2018 by Australian Healthcare Associates (**AHA**). Available: https://www.health.vic.gov.au/publications/development-of-trans-and-gender-diverse-services-in-victoria-final-report. Transgender Victoria also emphasises that while a new framework is being delivered, urgent increases in funding are provided for existing and new public health clinics – *see* Outline of Submissions on behalf of Transgender Victoria, pp. 1-2, Court File and oral submissions of Mr C. Kaias on behalf of Transgender Victoria at Submissions Hearing T-52 line 11 to T-53 to T-54 line 14.
[257] Evidence of Dr T. Nguyen, T-342, lines 5-13.

was not broadly supported at Inquest, it is clear that, at a minimum, more information is required on the gender-affirming pathways available both for the benefit of the clinical community and for those who may seeking to join such a waiting list, which could be centrally available.[258]

5 – Provision of suicide prevention and postvention supports in the TGD community

246. The fifth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate suicide prevention and postvention supports to TGD people in Victoria'.*

247. Ms Bernasochi of Switchboard Victoria (**Switchboard**), which runs LGBTIQA+-specific suicide prevention, bereavement[259] and postvention[260] programs, gave evidence at Inquest that, in the past, there has been a lack of LGBTIQA+-specific, and in particular, TGD-specific, funding nationally for suicide prevention initiatives. While acknowledging that there are no reliable data on the number of TGD people in Victoria, Ms Bernasochi noted that '*we do have consistent data about rates of suicidal distress among trans and gender diverse people. This data alone should be enough for us to see significant investment in trans and gender diverse suicide prevention*'.[261]

248. Ms Bernasochi opined that, to be most effective, suicide prevention and postvention responses in the LGBTIQA+ communities need to be culturally-appropriate, community-centred and peer-driven. Such supports need to be '*particularly targeted for LGBTIQA+ people who have been bereaved or exposed to […] suicide. Unlike general postvention practices, these actions emphasise the cultural identities of those affected and seek to affirm, celebrate and connect with the LGBTIQA+ identification and communities*'.[262] The approach

[258] Evidence of Dr G. Kalra, T-292 lines 10-16.
[259] Defined by Switchboard as *'[t]he period of grief, mourning, or sadness following deep loss, typically following the death of someone*' – *see* 'LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings', Collated brief, p. 172.
[260] Defined by Switchboard as '[a]*ctivities and intervention related to supporting and helping people bereaved by suicide. This may include counselling, support groups, support from medical professionals etc. This aims to reduce the heightened risk of those bereaved by suicide and promote healing.* – *see* 'LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings', Collated brief, p. 172.
[261] Evidence of Ms A. Bernasochi, T-420 lines 2-6.
[262] LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings, Switchboard, Collated brief, p. 178.

of Switchboard recognises that connectedness with the LGBTIQA+ community can moderate suicidality and that '*narratives of sexual and gender diversity are key sources of strength which can reduce feelings of burdensomeness*'.[263]

Addressing 'suicide contagion'

249. The need for a culturally-appropriate response to suicide prevention is particularly borne out in addressing the risk of so-called 'suicide contagion' in LGBTIQA+ communities, which Ms Bernasochi describes as '*an observable phenomenon that happens following a suicide death where people who are exposed to that suicide or bereaved by that suicide become a greater likelihood of experiencing suicidal distress themselves or going on to die by suicide*'.[264] Ms Bernasochi gave evidence at Inquest that suicide contagion is experienced differently in the LGBTIQA+ community to that of the population at large, due to the high rates of suicidal distress that exist '*pervasively*' in these communities, and in particular for TGD communities, a perception from the outside that '*a suicide is being blamed around identity for that person's death*', as well as a perception from within that '*being an at-risk population feeds into the perpetuation of contagion too*'.[265]

Available suicide prevention initiatives aimed at LGBTIQA+ communities in Victoria

250. Switchboard is a peer-led organisation working nationally to provide culturally-appropriate suicide prevention programs for the LGBTIQA+ community, funded in the most part by the Department of Health. Amongst multiple other initiatives, Switchboard operates two seven-day-a-week helplines, one as the Victorian partner of 'QLife', which is the national helpline for the LGBTIQA+ community, the second being the State-wide 'Rainbow Door' helpline, being a family violence, mental health, and suicide prevention helpline that was established

[263] Submission of Switchboard, Collated Brief, p. 159. Ms Bernasochi gave evidence at Inquest of what a culturally-appropriate postvention activity looks like, *'[s]o what we might consider a postvention activity that is a social intervention, might be providing education to a bereaved community, it might be providing debriefing support, it could be working with key people in the community who are writing messaging around a loss, it could be around getting support pathways known to people, it could be facilitating a memorial*' – *see* T-499 lines 7-13. *See further in this regard* the evidence of Mr J. Ball, T-509 lines 11-21.
[264] Evidence of Ms A. Bernasochi, Switchboard, T-496 lines 19-24. The term is, however, problematic when associated with LGBTIQA+ and more specifically, TGD identities, as it '*is actually associated with homophobia and transphobia, as if our lives are somehow infectious or problematic*' – *see* T-496 lines 12-19.
[265] Evidence of Ms A. Bernasochi, Switchboard, T-497 lines 13-19.

following the Royal Commission into Victoria's Mental Health System (**Royal Commission**).[266] Switchboard also designed and maintains the first-ever LGBTIQA+ suicide prevention hub, 'CHARLEE', an online resource containing information and support details for those impacted by suicide.[267]

251. In addition to funding certain of the peer-led suicide prevention initiatives offered by Switchboard to the TGD and LGBTIQA+ communities more broadly, the Department has a number of programs aimed at reducing suicidality in LGBTIQA+ communities, including in response to the Royal Commission, which made recommendations on a number of LGBTIQA+-specific mental health and suicide prevention initiatives, including (but not limited to):

- The new *Victorian suicide prevention and response strategy (2024-2034)* and initial two-year implementation plan (yet to be publicly released at the time of this Finding being delivered), which are being developed in close consultation with whole-of-government partners and the Suicide Prevention and Response Expert Advisory Committee, which includes organisational representatives from Switchboard Victoria and Drummond Street Services, as well as lived and living experience representatives who identify as LGBTIQA+;

- The co-production of an LGBTIQA+-specific aftercare service, which is due for completion in 2024;[268]

- The expansion and enhancement of the Hospital Outreach Post-Suicidal Engagement (**HOPE**) program, through which Switchboard Victoria has been funded to deliver a LGBTIQA+ affirmative practice and suicide prevention training package to HOPE services in 2023-2024 to ensure HOPE staff have the most expansive learning

[266] See evidence of Mr J. Ball, T-381 line 28 to T-382 line 13.
[267] *See in this regard* 'Charlee' (Web Page) <https://www.charlee.org.au/>.
[268] 'Aftercare' referring the care received by people following a suicide attempt, planning and/or intent, in light of the fact that an attempt is known to be the most significant risk factor for further suicidal behaviour and compassionate aftercare can reduce further suicide attempts and suicide deaths) – AM-4.

opportunity to improve their practice supporting LGBTIQA+ people experiencing suicidal distress; and

- As part of the existing Memorandum of Understanding between the Coroners Court and the Department, the Suicide Prevention and Response Office receives notification of suspected suicides among high priority communities, including LGBTIQA+ people, working with Switchboard, the Coroners Court and Standby Support After Suicide to monitor suspected suicides of TGD Victorians, including working to ensure that culturally-appropriate postvention takes place.[269]

Analysis

252. The Department has an increasing number of initiatives aimed at addressing the high rates of suicide in TGD communities, and in the LGBTIQA+ community more broadly. These initiatives are to be commended, and underpinned by the broader work of the Department in endorsing a new requirement for health services to report on 'sex at birth' and 'gender' as part of its annual changes process for key health services data collections, as part of the whole-of-government LGBTIQA+ strategy, 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32'.[270] Such changes are paving the way for a clearer picture of the health needs and outcomes of the TGD community.

253. I consider that the evidence at Inquest demonstrates the critical importance of ensuring culturally-appropriate suicide prevention and postvention supports are available to the LGBTIQA+ community and in particular, the TGD community, given the high rates of self-harm, suicidality, and completed suicides in these communities. As noted earlier in this Finding, this need was clearly demonstrated in the enormous efforts of Switchboard and other community-based organisations to mobilise following Bridget's death, to provide supports to community members, some of who knew Bridget personally, and some of whom

[269] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.
[270] Correspondence from the Department to the Court dated 5 March 2024, AM-11.

were impacted as members of the TGD and broader LGBTIQA+ community.[271] The postvention supports that were required, and the risk of 'suicide contagion', was experienced in a way that was unique to the LGBTIQA+ community and required a culturally-appropriate response that was swift, tailored, community-specific and peer-led.[272]

254. I also consider that the evidence of 'suicide contagion' received during the coronial investigation demonstrates the importance of culturally-appropriate suicide prevention and postvention supports to the TGD community, and well as the need for early intervention. As detailed elsewhere in the Findings into these deaths, the available evidence indicates that at least three of the deceased persons (Matt, who died on 30 March 2021, AS who died on 9 May 2021, Heather who died two days later on 11 May 2021) knew directly at least one other person in the cluster. Given their means of suicide by way of ingesting sodium nitrite, it is likely that there was some discussion of this method of suicide amongst them (including with a fourth person in NSW, 'E', who died on 23 July 2021 after ingesting sodium nitrate).

255. Further to this point, the media coverage surrounding certain of the deaths, combined with online discussion about and deep concern regarding the deaths within local LGBTIQA+ communities, meant it was possible that some of the deceased persons knew about others' deaths even if they were not personally acquainted, and that these concerns crossed borders into the LGBTIQA+ community in other states and territories. In relation to Bridget going missing and her subsequent death, Mr Ball noted '*I think we still feel it today, that news – her going missing was shared in our major news outlets, this court case… when she was missing it was shared in Star Health, it was shared on Joy FM, it impacted so many people, 6000 plus*'.[273]

256. As I have noted in the Findings into the deaths of Matt, AS, and Heather, these connections - confirmed and possible - between the deceased persons, suggested that 'suicide contagion' played a role in the emergence of the cluster, which has implications for preventing further

[271] The evidence of Ms Bernasochi in this regard was: '*Significantly from a contagion and postvention perspective, the key messaging we sent out was 'You didn't have to know Bridget, you don't have to be immediately, have immediate kinship to be impacted to reach out to support and please do*' – *see* T-498 lines 26-30.
[272] *See generally* the evidence of Mr J. Ball and Ms A. Bernasochi, T-488, line 19 to T-493 line 16.
[273] Evidence of Mr Ball, Switchboard, T-489, lines 14-20.

such suicides occurring in the future, and for the ongoing resourcing of culturally-appropriate postvention supports to TGD people.

257. A pertinent recommendation will follow.

6 – Social and emotional wellbeing supports

258. The sixth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate social and emotional wellbeing supports to TGD people in Victoria*'.

259. I heard evidence at Inquest that, over and above the barriers in accessing gender-affirming medical care for those who seek it, TGD people may also experience discrimination and poor treatment in accessing mental health and other services that may mean they avoid accessing those services.[274] Mr McMahon noted in this connection that '*poor quality of care is extraordinarily damaging to future help-seeking behaviour, not to mention the existential threat to the lives of trans and gender diverse people*'.[275]

260. Mx Harden confirmed that the difficulties of TGD people in accessing health and other services do not just relate to gender-affirming care but that '*we have difficulty accessing any kind of healthcare or support that affirms our gender*'.[276] In the same vein, Ms Bernasochi gave evidence that '*not everyone who's trans and gender diverse seeks medical affirmation and that if we're actually thinking about preventing suicide it's not just that around the supports for people who are seeking to medically affirm their gender*'.[277]

Barriers for TGD people accessing mainstream mental health and other health services

261. At Inquest, Dr Coventry, Chief Psychiatrist, posited several reasons for TGD people facing such barriers in the context of accessing mental health services, which he noted to include: (i) anticipation of discrimination based on past negative contact; (ii) the desire not to be a

[274] *See in this regard* the evidence of Dr S. Vivienne, Transgender Victoria, T-468, line 27 to T-469, line 3; Mr E. McMahon of Drummond Street Services, T-469 line 9 to T-470 line 14; Dr N. Coventry, Chief Psychiatrist, T-322 line 27 to T-323 line 18; and Commissioner Fernando, T-464 line 1 to T-465 line 18.
[275] Evidence of Mr E. McMahon, Drummond Street Services, T-25-28.
[276] Evidence of Mx Harden, Thorne Harbor Health, T-455 line 24 to T-456 line 7.
[277] Evidence of Ms A. Bernasochi, T-432, lines 6-12.

burden, described by Dr Coventry thusly, '*there's also a sense I think for many people when they're in crisis in mental health that they don't want to be seen as a bulk burden, it becomes their self-narrative that can block them accessing services*'; (iii) a lack of awareness as to the crisis support services that are available before the requirement for an acute in-patient setting; and (iv) geographical barriers for those in rural and regional Victoria.[278]

262. Dr Nguyen noted that a perceived lack of cultural safety can also feed into TGD peoples' experience of accessing mainstream health services, which is likely to occur '*at the point where you're most vulnerable and then to have experience of discrimination, misgendering, having to disclose your gender in public spaces, having intrusive or inappropriate physical examinations, and - so there is likely to be secondary to that an avoidance of services and not feeling safe*'.[279]

263. Dr Nguyen referred to a study from Latrobe University which found that '*the physical and mental health of TGD Australians continues to be poorer than the general population. Accessing healthcare for our participants was highly problematic, with high levels of unmet healthcare needs, discomfort discussing their needs, feeling misunderstood, emergency department avoidance, barriers to care, numerous instances of poor treatment in the healthcare system and hesitancy to disclose their gender'*.[280]

264. Ms Gillespie of Thorne Harbour Health observed, in relation to Natalie's experience (who reportedly expressed that, after a period of time in a youth psychiatric ward in 2004, she had formed the impression that she felt that she had to deny her female gender identity to be able to leave the ward and she developed mistrust of hospitals and psychiatric intervention),[281] the '*the long tail of singular instances of discrimination and invisibility making*'.[282] Dr Kalra acknowledged that there have been historical issues with TGD people accessing mainstream

[278] Evidence of Dr N. Coventry, Chief Psychiatrist, T-322 line 27 to T-323 line 18.
[279] Evidence of Dr. T. Nguyen, RCH Gender Service, T-323 line 23 to T-324 line 8.
[280] *See* evidence of Dr T. Nguyen, T-324, lines 4-8. *See further in this regard* Kerr et. al., 2019, p. 6 . Mx Harden also gave evidence on this point, noting that TGD people often delay accessing healthcare and that '*health conditions that would benefit from early intervention are prolonged and then get to the point where emergency attention is needed*' – *see* T-456 lines 1-7.
[281] Statement of C. Wilson, CB in the matter of Natalie Wilson pp. 16-17; Statement of R. Berthelsen, CB in the matter of Natalie Wilson p. 52.
[282] Evidence of C. Gillespie, Thorne Harbour Health, T-324 line 19 to T-325 line 9.

health services but '*the confidence in [the] trans and gender diverse community in coming out perhaps and seeking help has improved over time.*'[283]

265. However, the Community Panel gave evidence that there remain distinct and current barriers for members of the LGBTIQA+ community accessing mainstream health services. Commissioner Fernando noted that it is little more than four years since the World Health Organization stopped categorising being TGD as a mental health disorder, and opined that:

> '*LGBTQIA+ people have been living in a world where we're taught by many, including those in the professions supposed to help us, to be diseased, to be carriers of those diseases or potential carriers of those diseases but the health practitioners in those services I think we need to recognise were taught by a generation of teachers who were operating at a different standard – or under a different standard of care. But the point I think I'm trying to make is that there is a history because of that curriculum or because of that teaching or way of practice, that many in our communities don't feel that they have trust in services*'.[284]

266. Ms Michelle McNamara of Transgender Victoria emphasised the fatigue experienced by some TGD people associated with '*trans broken arm syndrome*', where a TGD person might, for example, present at an emergency department in a mental health crisis, but have the presenting issue ignored, and instead the focus is on the person being TGD.[285] Mx Harden of Thorne Harbour Health noted a further dimension to this fear on the part of TGD people accessing mainstream health services can also relate to the fear that their hormone medication may be '*stopped or blamed for their mental health*'.[286]

267. Commissioner Fernando noted the importance of CAT teams and other frontline mental health services undergoing proper TGD sensitivity training to ensure that TGD people presenting to health services in mental health crisis can receive culturally sensitive care.[287] He also spoke of the need to ensure current models of mental health and suicide prevention

[283] Evidence of Dr G. Kalra, T-325, lines 13-22.
[284] Evidence of Commissioner Fernando, T-464 line 14 to T-465, line 3.
[285] Evidence of Ms M. McNamara, Transgender Victoria, T-465 line 27 to T-466 line 8.
[286] Evidence of Mx V. Harden, Thorne Harbour Health, T-468 lines 7-12.
[287] Evidence of Commissioner Fernando, T-465 lines 4-18.

care for LGBTIQA+ communities are responsive to community needs, by, for example, embedding peer workers (who are connected with LGBTIQA+-led organisations) within mainstream health services.[288]

268. To this end, as noted in the preceding section, Ms Anna Bernasochi of Switchboard advocated for further cultural safety training of mainstream health practitioners and embedding of peer workers in hospital settings to improve the cultural safety of mainstream health services for LGBTIQA+ persons, using a model of care that aligns with the way in which LGBTIQA+ communities intervene and provide suicide prevention and mental healthcare within LGBTIQA+-specific services.[289]

Examples of the social and emotional wellbeing supports required by the TGD community

Support for families to promote connection with family of origin

269. Evidence was heard at Inquest that providing support for families and parents of TGD people is critical to improving social and emotional wellbeing and reducing suicidality amongst the TGD population, on the basis that a supportive family of origin is considered a protective factor against suicide for TGD people, underscoring the importance of family cohesion.[290]

270. Mr McMahon gave evidence of the programs run by Drummond Street Services to promote the wellbeing of families, including provision of intensive supports to families in which there is Child Protection involvement and one of the family members is LGBTIQA+, as well as 'The Village', a seven-week program supporting parents of TGD children, structured around themes including anxiety, navigating educational settings, family dynamics and relationships.[291] Ms McNamara noted the work of Transcend in working with parents of

[288] Evidence of Commissioner Fernando, T-466 lines 19-24. This was endorsed by Ms A. Bernasochi – *see* T-511, lines 21-29.
[289] Evidence of Ms A. Bernasochi, Switchboard, T-466, line 10 to T-468 line 2 (part of this appears to be misattributed to Commissioner Fernando in the transcript).
[290] *See* evidence of Mr J. Ball, T-452, lines 17-29.
[291] Evidence of Mr E. McMahon, T-450, line 27-T-451, line 25. *See in this regard* 'The Village' *Queerspace* (Web Page) <https://www.queerspace.org.au/our-programs/the-village/>.

TGD young people, as well as the work of Transfamily, which provides peer support to parents, siblings and other loved ones of TGD people.[292]

271. Mx Harden and Mr Ball also noted the need for ongoing support for parents and family members of TGD people who might be otherwise unfamiliar with even the concept of being TGD and who might be struggling to understand this in relation to a child or family member (with Mr Ball noting that for some parents '*the first trans and gender diverse person they ever met was their child*'), opining that support services for families ought also to be accessible and visible, and provided through mainstream services, GP clinics and community health settings.[293]

Supports for older TGD people

272. I heard evidence at Inquest from Mx Harden that a significant stressor for older TGD people is what will happen if they face a condition such as dementia, and the way in which that might impact their gender identity, including whether that gender identity will be denied in an aged care setting.[294] The requirement for the social and emotional wellbeing needs of older TGD people to be catered to was also canvassed by Ms Bernasochi, who referred to Switchboard's 'Out and About' program, where volunteers visit LGBTIQA+ older people who are living in care or on care packages as a means to stay connected and enjoy hobbies,[295] and for which Ms McNamara is a volunteer. She gave evidence of her work with this program and emphasised the need for social and emotional wellbeing supports in the older cohort, noting, '*I see isolated people and I go and visit isolated people and see them at risk of suicide through their ill-health and isolation*'.[296]

[292] Evidence of Ms M. McNamara, Transgender Victoria, T-461 line 10 to T-462 line 1. *See in this regard* 'Transcend' (Web Page) <https://transcend.org.au/> and 'Transfamily' (Web Page) <https://www.transfamily.org.au/>.
[293] Evidence of Mx Harden, Thorne Harbour Health, T-451 line 27 to T-452 line 15 and of Mr J. Ball of Switchboard, T-452 line 17 to T-453 line 24.
[294] Evidence of Mx Harden, Thorne Harbour Health, T-471 line 19 to T-472 line 7.
[295] Evidence of Ms A. Bernasochi, T-432, lines 17-20. *See* 'Out and About' *Switchboard* (Web Page) <https://www.switchboard.org.au/out-and-about>.
[296] Evidence of Ms M. McNamara, T-484 lines 7-11.

Multidisciplinary approach to social and emotional wellbeing supports in TGD communities

273. Dr Vivienne of Transgender Victoria spoke of the role of peer navigation as a means of promoting social and emotional wellbeing in TGD people accessing health services and social and emotional wellbeing supports, by facilitating '*the connection between care domains that are otherwise quite siloed*', for example, providing a peer support service to '*join the dots*' between a gender clinic and an eating disorder clinic.[297] Mx Harden of Thorne Harbour Health also noted that the care provided at Equinox is multidisciplinary in nature and that existing patients can and are connected to external counselling services (though the reverse route, from those counselling services back to Equinox, will entail traversing the already-described issues with the Equinox waitlist).[298]

Other factors related to the social and emotional wellbeing of the TGD population

274. Evidence was heard at Inquest that certain of the social and emotional wellbeing supports for the LGBTIQA+ community are not necessarily offered through services alone but through connection and participation in the broader community.

275. Mr Ball of Switchboard gave evidence that, in LGBTIQA+ communities, there are three commonly-accepted factors that protect against suicide: (i) a supportive family of origin; (ii) having a concept and vision of one's future; and (iii) connection to community in the broader sense (that is, not just connection with the LGBTIQA+ community but being able to access opportunities in the community at large, such as sports, faith-based activities, and other spaces, without discrimination).[299] Indeed, Ms Lane gave evidence of the joy and connection she experiences in attending ballet,[300] and Ms McNamara gave evidence of the fulfilment she receives through singing in a TGD-specific choir and Buddhist women's study group.[301]

[297] Evidence of Dr S. Vivienne, T-472, lines 14-26.
[298] Evidence of Mx Harden, T-475 lines 5-17.
[299] Evidence of Mr J. Ball, T-440, line 23 to T-441-T-442, line 9.
[300] Evidence of Ms E. Lane, T-29 lines 10-15.
[301] Evidence of Ms M. McNamara, T-444, lines 2-14.

Commissioner Fernando noted the importance for Aboriginal people in the LGBTIQA+ community to be connected to Country as a key factor in reducing social exclusion.[302]

Analysis

Improved access to mental and other healthcare services for TGD Victorians

276. I consider that the risks to the wellbeing of TGD patients from long waitlists for gender-affirming care, high costs, and ongoing workforce issues are compounded by the fact that mainstream health and mental health services may not be genuinely accessible or culturally safe for many in the TGD community. The Inquest heard evidence that TGD people face barriers in attending emergency departments when suicidal, due to fear of ridicule, discrimination or rejection, or based on a past experience of discrimination (as exemplified by Bridget avoiding an admission through the public mental health system in favour of a private mental health admission). The wellbeing of TGD people is thus placed at further risk by a public health system that at times, struggles to be responsive to the basic needs of some of its most vulnerable community members.

277. I consider that the evidence at Inquest has established a clear need to devise and implement a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD persons. This will ensure that a cohort that has a higher risk of mental ill health, distress, and suicidality will have greater degree of safety in accessing mainstream services, including in crisis. This work will build upon the existing commendable efforts of the Department of Health to make mainstream health services more culturally-safe for TGD people including, since July 2024, collecting data that can accommodate where one's identified gender differs from birth sex, with concomitant guidance for health practitioners collecting this data.

278. A pertinent recommendation will follow.

[302] Evidence of Commissioner Fernando, T-444, line 16 to T-445, line 9. I note that Commissioner Fernando identifies as a queer cisgendered Wiradjuri man, descended from the Kalari Peoples.

Improved access to other culturally-appropriate social and emotional wellbeing supports

279. I consider that the evidence at Inquest demonstrated there is a need to ensure provision of culturally-appropriate supports for TGD people and their families as a means to reduce social isolation, improve connectedness and address wellbeing in the context of the community's high rates of suicide, distress and mental ill health.

280. As noted earlier in this Finding, I received evidence during this investigation that AS and Matt lived isolated lives, often confining themselves to their bedrooms, with both reluctant to reach out to services for counselling and other wellbeing supports in the lead-up to their deaths.

281. Evidence at Inquest demonstrated that social and emotional wellbeing supports are required not just for TGD people but also for their loved ones. The need for support services for family of origin was demonstrated by the eloquent evidence at Inquest of Angela, Bridget's sister, who noted that, in order to support Bridget in the process of affirming her gender (which she came to support, having found the process confronting at first), she tried to find a means to educate herself about the journey her sister was on, including via Google searches. At that stage she was unaware of the support services that existed and ultimately never received any support for her own role as a family member of a TGD person on an affirmation pathway.[303]

282. Finally, I note that, at present, the provision of social and emotional wellbeing supports to the TGD community occurs through a number of community-controlled and government-funded services and covers a wide range of potential initiatives (some of which overlap with the suicide prevention initiatives outlined in the previous section), and which have different focuses and aims. One example is the 'Trans and Gender Diverse Peer Support Program'

[303] Evidence of A. Pucci-Love, T-55, line 15 to T-57 line 4. While not evidence, I note for completeness in this connection the coronial impact statement (**CIS**) of Rachel Byrne, Matt's mother, included this observation in relation to Matt's gender affirmation process, of which she was supportive but throughout which Matt was reluctant to allow her parents to use 'she/her' pronouns: '*Classed as an adult, there was no support around having these conversations with parents which I believe is a missed opportunity for any family with a loved one undergoing the transition process*'. *See* CIS of Rachel Byrne, p. 8, Court File.

funded by the Department of the Health and delivered by Transgender Victoria, and through which various social and emotional wellbeing are delivered.[304]

283. Transgender Victoria made submissions at Inquest that, in consultation with TGD people, a framework should be developed at state and federal level promoting access to professional social support services for TGD people. At Inquest, Ms McNamara noted the importance of programs to address social inclusion of TGD people as a means to promote social and emotional wellbeing. She referred to promoting inclusion of TGD people in '*both their own communities, the LGBTIQA+ communities, but broadly their faith communities and other parts of their lives which intersect with their identities*', with the need for a comprehensive framework underpinning the same.[305]

284. As with all scope items, this raises the issue of improving data in relation to the number of TGD people in Victoria and recognising TGD status on data collection systems. As Dr Vivienne opined, '*at every step along the way, if there's no scope to be seen, then there's no scope to be cared for*'.[306] This was also noted by Commissioner Fernando, who stated that '*governments cannot resource what [they don't] know about communities*'.[307]

285. A pertinent recommendation will follow.

7 – Prevention opportunities

286. The seventh item in the scope of inquest is *'[p]revention opportunities flowing from the above'.*

287. The majority of prevention opportunities flowing from these proceedings have been canvassed and outlined throughout this Finding. However, there is a discrete set of issues related to the systems and practices of the Coroners Court that were raised prior to and during Inquest that I will detail in this section. As Counsel Assisting noted at the first Directions

[304] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.
[305] Evidence of Ms M. McNamara, T-448, lines 21-28.
[306] Evidence of Dr S. Vivienne, T-486, lines 3-4.
[307] Evidence of Commissioner Fernando, T-401 lines 3-4.

Hearing for this Inquest, '*the Court will not shy away from reflecting on areas for its own improvement as a critical part of these proceedings*'.[308]

Improved data collection to assist in identification of suicides in the TGD community

288. One of the resounding themes of the Inquest was the need for improved data collection in relation to: (i) the number of people who make up the TGD community itself; (ii) the systems that exist across government entities and their capacity to capture all gender identities; and (iii) the ways in which to capture better data on the incidence of TGD suicide. The Coroners Court has an important role in (ii) and (iii).

289. In May 2024, the Coroners Court implemented key changes to its internal database to give it the functionality to capture additional data, including 'preferred name', 'sex at birth' and 'gender' (the record of 'gender' being independent to that of 'sex at birth'). Following a co-design process, these reforms will align with the new database being designed for the Victorian Institute of Forensic Medicine, which will be used by staff at Coronial Admissions and Enquiries who take reports of deaths on behalf of the Coroner. Accordingly, the Court's systems are now well-placed to capture accurate data on the gender identities of those whose deaths reported to the Coroner.

290. Given that the initial report of a death is often actioned by police members, it is important that changes are made to Victoria Police systems and forms, including the Form 83 Report of Death for the Coroner, so that details such as preferred name and gender can be captured as early as possible in the coronial investigation .[309] However, the updates to the Court's internal database mean that it is capable of recording such details at *any point* of a coronial investigation. This means that, regardless of whether preferred names and gender are identified in a Form 83, Coroners and their staff will be able to record these details later in an investigation where applicable.

[308] Transcript of Directions Hearing on 13 October 2023, T-21, lines 27-29.
[309] The Coroners Court will receive a 'Form 83 – Report of death for the Coroner' for the vast majority of deaths even where these are reported by other persons, such as medical practitioners.

The role of the Court in postvention responses following the suicide of a TGD person

291. As noted in this Finding, as part of the existing Memorandum of Understanding between the Coroners Court and Department of Health, the Department's Suicide Prevention and Response Office receives notification of suspected suicides among high priority communities, including LGBTIQA+ people. The Department works with the Court to monitor suspected suicides of TGD Victorians, including working to ensure that culturally-appropriate postvention takes place.[310] This is done in conjunction with community-controlled organisations such as Switchboard.

292. It is recognised that these alerts, as they currently operate, may not be maximising opportunities for effective postvention. One issue the Court encounters, is that coroners do not always know about a deceased person's LGBTIQA+ identity (or if applicable, TGD identity) when a suspected suicide is reported.[311] Another issue is that sharing information about deaths under investigation involves a balancing of complex, sometimes competing considerations: for example, the deceased person and their loved ones' right to privacy, versus the prevention imperative of identifying peers so they can be supported.

293. There are often further issues at a very early stage of an investigation in which an understanding of the deceased's intent upon initial report of a death is based on only limited information and is subject to revision as the coroner's investigation develops. All of these

[310] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.

[311] The reasons for this are explained in detail in Coroners Court of Victoria, *Suicide among LGBTIQ+ people*, published 14 October 2022, and include that: (i) witnesses may not wish to disclose information to police members and the Court about the deceased's LGBTIQA+ identity, to protect the privacy of the deceased, especially for people who may be newly identifying as LGBTIQA+ or may not be 'out' to their families or work colleagues; (ii) family members and other witnesses with whom the coroner's investigator engages, may not be aware or accepting of the deceased's LGBTIQA+ identity, and therefore this information is not provided in their witness statements; (iii) police members writing reports for the coroner may omit information on the deceased's LGBTIQA+ identity because they deem it not to be relevant; or may use broad terms and vague language which does not explicitly communicate the deceased's LGBTIQA+ identity; (iv) consulting stakeholders have informed the Court that communicating with police and coroners following a suicide can be a deeply traumatic process due to negative historical interactions with police. This might be a reason why the deceased's LGBTIQA+ identity might not be disclosed to police; (v) when police attend the scene of a death to be reported to the Court, they are required to fill out a form titled Initial Report of Death to the Coroner. This initial report of death does not prompt the police member to ask any questions about the deceased's gender and sexual identity; and (vi) there can be inconsistencies and ambiguities in the coronial material regarding the deceased person's gender and sexual identity. Additionally, gender and sexual identity themselves are complex and deeply personal, such that the deceased's loved ones may struggle to express these in communications with police.

factors make information-sharing a complex (at times, fraught) exercise. The Court is very open to dialogue on these issues, including the ways in which it can best support suicide postvention efforts to reduce the likelihood that suicide contagion may occur.

Issues associated with the 'senior next of kin' hierarchy under section 3 of the Coroners Act 2008

294. I heard evidence at Inquest that the Court's 'senior next of kin' hierarchy can raise complexities for the loved ones of a deceased where the deceased is a member of the LGBTIQA+ community. The 'senior next of kin' is defined in section 3 of the Act, which sets out a 'cascading hierarchy', or an 'order of priority' of persons, the first of whom will have certain rights and responsibilities in the coronial process (such as being able to make an objection to an autopsy direction, or apply for release of the deceased's body).[312] The Supreme Court has confirmed that there is no residual discretion for the Coroner to appoint someone as senior next of kin who is *lower* in the hierarchy,[313] nor, in the context of a dispute between biological family members and 'chosen family' for release of a body under section 48(3) of the Act, to *dispense with* this hierarchy.[314]

295. Angela, Bridget's sister, noted at Inquest that the 'senior next of kin' hierarchy raised significant issues for her family following Bridget's death. She gave evidence that Bridget's father was her 'senior next of kin' under the Coroners Act (a 'parent' coming before a 'sibling' under the hierarchy in the Act). However, Bridget's father did not accept Bridget's gender identity and Angela reported difficulties in the course of the death investigation process in ensuring it proceeded in accordance with Bridget's affirmed identity, noting that '*I, in the background, have had … a lot of stress to try and make sure that what I thought*

[312] For definition of 'senior next of kin', *see* 3(1), 3(2) and 3(3) of the Act, providing for the 'senior next of kin' to be a spouse or domestic partner, or if none available, a son or daughter of or over the age of 18 years, or if none available, a parent, or if none available, a sibling of or over the age of 18 years, or if none available, a person named in the will as an executor, or if none available, a person who, immediately before the death, was a personal representative of the deceased person, or if none available, a person determined to be the 'senior next of kin' by a Coroner because of the closeness of the person's relationship with the deceased person immediately before the death. For the right to object to autopsy, *see* section 26(2) of the Act; for release of body, *see* section 48 of the Act.

[313] *Trinh v Coroners Court of Victoria* [2019] VSC 133, [5]; *Lawrence v Coroners Court of Victoria* [2013] VSC 77, [15].

[314] In commenting upon the 'mandatory hierarchy' imposed by section 48(3) of the Act (within which the 'senior next of kin' hierarchy is replicated by virtue of section 48(3)(b) of the Act), her Honour Justice Forbes in *Vallianos v Coroners Court (Vic)* (2023) 69 VR 276 noted at [87] that this '*may not assist those who are estranged from some or all of their family and who develop other close relationships in its place. I accept that the hierarchy may well be based upon assumptions that are less likely to hold true for groups including those who identify as LGBTQI*'.

was respectful to Bridget as a transgender woman happened and I had to fight our father for that on her behalf'.[315] Angela noted that LGBTIQA+ people may be estranged from their biological family and '*more likely to have chosen family',* and '*if there's any way of taking that into consideration it would again vastly improve an already really stressful situation*' when someone dies in reportable circumstances.[316]

296. This may have particular resonance where those to whom the deceased's body is released will be making funeral arrangements, as is usually the case. Commissioner Fernando noted that '*the former Commissioner [for LGBTIQA+ Communities] recalls going to funerals of young LGBTI people and families didn't know that they were queer or trans or gender diverse.*'[317] contributing to a further lack of visibility of members of this cohort.

297. I consider that the evidence at Inquest established that the 'senior next of kin' hierarchy under section 3(1) of the Act may create hurdles and undue distress for the loved ones of LGBTIQA+ Victorians who die in reportable circumstances. A pertinent recommendation will follow.

Other ways in which the Court has improved its approach to cultural safety and inclusivity

298. Finally, it is relevant to recall that the Coroners Court, over the past year, has taken a series of steps to enhance its approach to cultural safety for a number of groups in the community, including Aboriginal and Torres Strait Islander people, multifaith and multicultural groups, and members of the LGBTIQA+ community, in order to create a sense of cultural safety for court users from a range of backgrounds. To enhance cultural safety for investigations involving LGBTIQA+ deceased and their loved ones, the Court has:

[315] See evidence of A. Pucci-Love, T-83 line 27 to T-84 line 5. Angela also noted that the issue as that her father, as senior next of kin, was '*the ultimate decision maker and gatekeeper in whatever happened and so he'd get information first and even when it was about deciding where the body went once it left the Coroners Court, I had quite strong views based on my relationship with Bridget of what should happen with her and it was only through wearing him down that I got to make those decisions 'cause he would have made vastly different decisions. He did not refer to her by her lived name and the idea of him dealing with that process with anything else I found heartbreaking. … she left a note and in her note she made it very clear who she was in her note and to not have that reflected just would have broken my heart.*' – *see* T-91 line 19 to T-92 line 7.
[316] Evidence of A. Pucci-Love, T-84 lines 11-14.
[317] Evidence of Commissioner Fernando, T-416, lines 23-25.

- Offered workshops to coroners and staff on Trans and Gender Diverse Awareness, to enhance cultural safety and promote awareness of the particular issues faced by the TGD community;
- Circulated for whole-of-Court use the 'Inclusive Language and Communication Guide', released by Court Services Victoria in May 2024; and
- Placed the details of 'Rainbow Door', the free specialist LGBTIQA+ helpline providing information, support, and referral to all LGBTIQA+ Victorians (run by Switchboard), on the Support Services page on the Coroners Court website.[318]

299. Finally, the State Coroner has sought to enhance the cultural safety and respect for participants within Court proceedings across a number of priority groups through issuing, under section 107 of the Act, '*Practice Note 1 of 2024 - Pronunciation of Names and Forms of Address in Coronial Proceedings*' to (i) provide guidance on expectations for the correct pronunciation of names and forms of address in coronial proceedings; and (ii) facilitate a simple process by which families, interested parties and legal representatives can provide, and the Court can seek, clarification on correct pronunciation of names and appropriate forms of address (including pronouns and honorifics).[319]

Analysis

300. It is crucial that the Coroners Court processes accord cultural safety, visibility, dignity and respect to all deceased persons and their loved ones. This is not only required as a function of section 8 of the Act but also, as this Inquest has demonstrated, it is a critical pillar in the Court's prevention function.

301. We cannot comprehensively identify appropriate initiatives aimed at reducing preventable deaths in the TGD community if we do not have the systems visibility to capture the identities of those whose deaths we are investigating. Therefore, improvements to the

[318] *See in this regard* 'Grief & bereavement counselling & support services' *Coroners Court of Victoria* (Web Page) <https://www.coronerscourt.vic.gov.au/families/supports-and-resources/services/grief-bereavement-counselling-support-services> and Proposed Recommendations of the Commissioner for LGBTIQA+ Communities, p. 2, Court File.
[319] *See* 'Practice Note 1 of 2024 – Pronunciation of Names and Forms of Address in Coronial Proceedings', issued on 17 June 2024 by his Honour State Coroner Judge John Cain.

Court's processes, when occurring in concert with other entities such as Victoria Police, will allow for greater visibility of preventable deaths in the TGD community and more targeted strategies to reduce them.

302. This Inquest has represented a concrete opportunity to assess, from the perspective of those in the TGD community, the degree of accessibility and cultural safety of Coroners Court processes and investigations, including identifying areas in which improvements are still required. Some areas include continuing staff education, accessible infrastructure (such as all-gender toilets) and broader facilitation of the use of pronouns and inclusive language in the courtroom. The ability to participate safely and comfortably in coronial proceedings that impact those in TGD communities is critical to the strategies advanced under the Court's prevention mandate, which must be informed, shaped and advanced by lived experience.

303. A pertinent recommendation will follow.

FINDINGS AND CONCLUSION

304. Having investigated the death of Heather Richelieu Pierard, and having held an Inquest in relation to Heather Richelieu Pierard's death from 27-29 November 2023 (inclusive) and 21 February 2024 at the Coroners Court at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

(a) that the identity of the deceased was Heather Richelieu Pierard, born 31 July 2000;

(b) that Heather Richelieu Pierard died on 11 May 2021 at Pascoe Vale South from *1 (a) sodium nitrite toxicity*;

(c) in the circumstances described above.

Determination as to intent

305. Having considered all of the circumstances of Heather's passing, including the lethality of the means chosen, I am satisfied that Heather intentionally ended her own life in the context of multiple stressors and longstanding mental health issues and suicidal ideation, which further deteriorated in the period prior to her death.

306. While I cannot conclusively identify the particular stressor or stressors that led her to take her life, is apparent from the evidence before me that she had recently experienced the loss of two friends to suicide, both of whom were also part of the TGD community – one of them just two days before she took her own life – and experienced significant resultant grief and distress. Heather had also experienced increasing isolation in the face of COVID-19 pandemic lockdowns.

307. As a result of this constellation of factors, I find that Heather was facing increased suicidal ideation in the weeks and days before her passing, that led her to ingest a substance she had pre-purchased with the intention of taking her own life. Noting her diagnosis of borderline personality disorder, which brought with it impulsivity and a degree of reactivity of mood and affect, the decision to ingest the substance appears to have been a spontaneous one. However, I am satisfied in all of the circumstances that Heather was aware that the ingestion of sodium nitrite was a final act in the context of others in her community also using this method to take their own lives.

308. Further, I note that Heather was using her prescribed antidepressant prior to death in gradually increasing doses (desvenlafaxine), the presence of which was apparent upon examination of the toxicological results. At the time of her passing, she was also prescribed gender-affirming hormone medications and the anti-psychotic medication olanzapine, amongst others, though had indicated to doctors that she had ceased taking gender-affirming hormone medications in the week prior to her death. Notwithstanding, there is an insufficient cogency of evidence to make any finding as to whether, or how, the use of these prescribed medications may have affected her state of mind. Heather's decision to take her life was preceded by a long history of mental ill health and a number of stressors.

Adequacy of mental health services engaged by Heather in lead-up to her passing

309. In terms of the adequacy of the care provided to Heather, I find that Heather was actively help-seeking and well-supported by her loved ones. The support, care and treatment provided by the multiple clinicians and persons involved in her care was extensive, responsive to her needs and relatively well-coordinated. Heather had serious mental illnesses, engaged in treatments and with practitioners, and remained engaged with mental health services

proximate to her death. Heather's risk of suicide was chronic and existed prior to the commencement of her gender-affirming treatment.

310. As a final point, I note that, in the days prior to her death, Heather declined an admission to the adult Prevention and Recovery Care (PARC) service (a public, community-based, short-term supported residential services for people experiencing a mental health problem). While the reasons for this cannot now be known, I consider this brings into sharp relief the importance of public and other health services being responsive to the needs of trans and gender diverse patients, which I have addressed elsewhere in this Finding.

Mental ill health and suicidality in the trans and gender diverse community

311. The expert evidence at Inquest demonstrated that those in the TGD community face disproportionate rates of distress, mental ill health, and suicidality compared to the population as a whole. The reasons for this are multifactorial, intersecting, and are frequently linked to extrinsic factors associated with the broader community's responses to TGD people, which can include discrimination, violence and exclusion, that erode the TGD community's wellbeing, and can contribute to mental ill health and suicidality.

312. There is nothing inherent in being TGD that comprises or causes mental ill health or suicidality.

313. While noting that there is clear evidence of disproportionate mental ill health, distress and suicidality amongst the TGD population, the data on this issue is widely considered to be incomplete, including in relation to the incidence of completed suicides. Robust data (including population level data on the number of TGD people in Victoria) is needed as a matter of priority to inform health, wellbeing and suicide prevention initiatives in the TGD community.

Provision of culturally-appropriate gender-affirming care

314. The expert evidence at Inquest demonstrated that significant barriers still exist for TGD people affirming their identities, particularly via a medical pathway, including due to issues

of cost, access and long waitlists in the face of increasing demand for access to gender-affirming care.

315. Given the evidence I heard that delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive, I consider these ongoing barriers to gender-affirming care to raise serious and unacceptable concerns in relation to the health and wellbeing of TGD Victorians.

316. I find there is a clear need for improved access to gender-affirming healthcare, including gender-affirming medical care, to TGD people in the state of Victoria.

Provision of suicide prevention and postvention supports

317. The expert evidence at Inquest demonstrated the critical importance of ensuring culturally-appropriate suicide prevention and postvention supports are available to the LGBTIQA+ community and in particular, the TGD community, given the high rates of self-harm and suicidality in these communities.

318. I find this to be particularly critical given the impacts of suicide contagion on and in TGD communities. Suicide contagion was a factor in at least three out of five suicides in the present cluster proceedings.

Provision of social and emotional wellbeing supports

319. I find that the risks to the wellbeing of TGD patients from long waitlists for gender-affirming care, high costs, and ongoing workforce issues are compounded by the fact that mainstream health services are often not genuinely accessible or culturally safe for many in the TGD community.

320. I find that the evidence at Inquest has established a clear need to devise and implement a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD persons. This is

critical to ensuring that mainstream services are genuinely accessible for TGD people, including those presenting in crisis.

321. I find there is also a need to ensure provision of culturally-appropriate supports for TGD people and their families as a means to reduce social isolation, improve connectedness and address wellbeing in the context of the community's high rates of suicide, distress and mental ill health.

Further prevention opportunities

322. It is crucial that the Coroners Court processes accord cultural safety, visibility, dignity and respect to all deceased persons and their loved ones. This is not only required as a function of section 8 of the Act but also, as this Inquest has demonstrated, it is a critical pillar in the Court's prevention function.

323. Improvements to the Court's processes, when occurring in concert with other entities such as Victoria Police, will allow for greater visibility of preventable deaths in the TGD community and more targeted strategies to reduce them.

COMMENTS

I make the following comments connected with the deaths under section 67(3) of the Act:

1. Access to healthcare is a fundamental human right. Under article 12 of the International Covenant on Economic, Social and Cultural Rights (**ICESCR**), which Australia ratified in 1975 (and thus has undertaken to be bound by its terms under international law), everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.[320]

[320] *See* International Covenant on Economic, Social and Cultural Rights, opened for signature 16 December 1966, 993 UNTS 3 (entered int force 3 January 1976) art 12(1). Accessible at <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>. *See generally in this regard* Ronli Sifris and Paula Gerber 'Sexual and Reproductive Health Care For Trans and Gender Diverse People: Imagining a Human Rights Based Approach' (2013) 48(3) *Alternative Law Journal* 159-165. (**Sifris and Gerber 2023**). DOI: https://doi.org/10.1177/1037969X231188066.

2. In 2000, the United Nations Committee on Economic, Social and Cultural Rights issued General Comment 14, stating that the right to health '*must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*', which should be accessible '*without discrimination*'. Paragraph 43(a) then sets out a core obligation of non-discrimination on the part of States Parties (including Australia) to ensure '*the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups*'.[321]

3. While Australia has not incorporated the ICESCR into domestic law, and the Victorian *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**the Charter**) does not explicitly include a right to healthcare, the *Equal Opportunity Act 2010* (Vic) precludes discrimination on the basis of certain attributes (including gender identity) in the provision of services (including health services), and contains a positive duty to eliminate discrimination.[322] There exists, therefore, a duty on the part of health service providers to prevent discrimination from occurring in the provision of those services.

4. Further, a human-rights based approach to healthcare for the TGD community requires '*availability, accessibility, acceptability, participation, non-discrimination, transparency and accountability*'.[323] The rights to autonomy and equality are thus engaged in provision of healthcare, which necessitates consideration of what may constitute 'substantive' over mere 'formal' equality. Substantive equality is '*premised on the basis that rights, entitlements, opportunities and access are not equally distributed throughout society and that a one size fits all approach will not achieve equality*'.[324]

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[321] *See* Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000): The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN ESCOR, 22nd sess, Agenda Item 3, UN Doc E/C.12/2000/4 (11 August 2000) [9], [12b] and [43a]. Accessible at: <https://www.refworld.org/legal/general/cescr/2000/en/36991>.

[322] *See in this regard Equal Opportunity Act 2010* (Vic) s 6(d), Part 3.

[323] Sifris and Gerber 2023 p 161, referring to Sofia Gruskin, Dina Bogechi, Laura Ferguson '"Rights-based approaches" to health policies and programs: articulations, ambiguities, and assessment' (2010) 31(2) *Journal of Public Health Policy* 124-145. DOI: 10.1057/jphp.2010.7.

[324] Sifris and Geber 2023 referring to Australian Law Reform Commission, *Pathways to Justice: Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report 133, 9 January 2018) Executive Summary.

5. In this connection, in its General Comment on article 18 of the *International Covenant on Civil and Political Rights* (**ICCPR**) (which enshrines the principle of non-discrimination and upon which the right to equality in section 8 of the Charter is based),[325] the Human Rights Committee stated that *'[t]he enjoyment of rights and freedoms on an equal footing, however, does not mean identical treatment in every instance*.' In the context of access to gender-affirming health care for TGD people, a substantive equality approach would entail recognition that while the majority of the population does not require access to such care, access to gender-affirming care '*may be essential for TGD people to achieve the highest attainable standard of physical and mental health*'.[326]

6. I consider that this human rights framework ought to be borne in mind in resourcing, planning, and designing health services in Victoria, including in actively ensuring that such services are culturally safe, accessible, and inclusive, and not directly or indirectly discriminating against TGD people.

7. Indeed, the evidence at Inquest has demonstrated that the rights of TGD people in Victoria are often imperilled in a healthcare setting.

8. I heard evidence from Professor Zajac of the experience of a young transman who was '*scarred for years*' after being yelled at to '*get out*' of a dermatologist's waiting room.[327] I heard from Ms Elisabeth Lane, the Court's lived experience expert, that, when her regular GP went on leave in 2016, she explicitly directed Ms Lane not to approach two other GPs at the clinic, and circled the names of those who would be safe for Ms Lane to see.[328] In relation to the other GPs, Ms Lane stated '*She told me, do not see them… they will not look after you*'.[329]

9. I also heard evidence of what can constitute culturally-appropriate, affirming care for the TGD community in a healthcare setting. Ms Lane noted the value of visible signs of inclusion

[325] Explanatory Memorandum, Charter of Human Rights and Responsibilities Bill 2006 (Vic) 2.
[326] Sifris and Geber 2023 referring to Human Rights Committee, *CCPR General Comment No 18: Non-Discrimination*, 37th sess, CCPR/C/21/Rev.1/Add.1 (10 November1989) [8].
[327] Evidence of Professor Zajc, Austin Health, T-309 lines 20-26.
[328] Evidence of Ms E. Lane, T-31 line 23 to T-32, line 6.
[329] Evidence of Ms E. Lane, T-34 lines 12-14.

such as rainbow flags and lanyards, appropriate use of pronouns, and of training for clinicians '*so that the medical profession can understand life through the transgender lens. They can understand that the community has extra barriers*'.[330] In her view, and as has been demonstrated by multiple witnesses at Inquest in relation to access to healthcare, '*the community has been explicitly excluded and you have to explicitly include them, so they know it's safe*.[331]

10. I consider that, in 2024, it is wholly unacceptable that a TGD person should have to consider which clinicians are 'safe' and which are 'unsafe' to consult with. As a TGD person, you should not, as Mr Elliot McMahon stated, '*feel profound fear and dread'* at the thought of encountering *'a doctor or a person who's in a position of power [who] looks at you and says "You don't know who you are, I do"'*.[332] There should not be a '*myriad of horror stories that circulate in [the TGD] community about what can happen if you go through the wrong door to get support*.[333]

11. In 2024, there must be 'no wrong door' for TGD people to receive healthcare or referrals to healthcare that affirm their identity, dignity and personhood. This is the right of every TGD person attending upon a GP or any other clinician in Victoria, and I intend to make a series of recommendations on this front.

12. On the subject of recommendations, pursuant to section 72(2) of the Act, I note that I am only empowered to make recommendations that are '*connected with a death or deaths*'. I received an abundance of proposed recommendations from Counsel Assisting, Interested Parties and submitting organisations in the lead-up to and at closing submissions – by my count, a total of 65 proposed recommendations were sought – some of which overlapped in subject matter, aims and intention, some of which include specific resourcing proposals, and not all of which I am empowered to make.

13. Nevertheless, I consider that the evidence at Inquest and concomitant recommendations sought by Interested Parties and organisations contain invaluable guidance on the ways in

[330] Evidence of Ms E. Lane, T-35 lines 21-23.
[331] Evidence of Ms E. Lane, T-34 line 30 to T-35 line 3.
[332] Evidence of Mr E. McMahon, Drummond Street Services, T-469, lines 9-29.
[333] Evidence of Mr E. McMahon, Drummond Street Services, T-469 lines 27-29.

which gender-affirming healthcare, mental health and social and emotional wellbeing supports for TGD people could be strengthened in Victoria. As noted by Mr Ball of Switchboard, a form of '*needs analysis*'[334] was conducted through the unfolding of this evidence that I strongly believe should be reviewed by the Department of Health (whose approach to these proceedings has been commendable) and other entities in considering the operationalisation of the coronial recommendations I intend to make.

14. I make one final comment in relation to the five TGD people whose deaths I have investigated as part of this cluster, and of the impact of gender-affirming care in the context of the ultimate decision each made to take their own lives. It is worth recalling that I received evidence of improved mental wellbeing and/or increased happiness upon commencing a gender affirmation process in four out of the five people in the cluster.[335]

15. However, as cautioned by Switchboard, the provision of gender-affirming medical care is not the 'full picture' when it comes to providing affirming care to TGD people who may be suicidal:

> *Gender affirming care helps people live affirming lives. However – and this is imperative in understanding trans and gender diverse suicide prevention – for people already experiencing suicidal distress, gender affirming care can significantly help mental health and well-being – it does not prevent suicide. It can deeply help and support trans people experiencing suicidality – but significantly – hormones alone do not create protection against suicidality. People who have medically affirmed their gender may still experience suicidal distress. What is needed is affirming culture around their gender.*[336]

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[334] Evidence of Mr J. Ball, Switchboard, *'[The evidence of the Medical Panel at Inquest] was a needs analysis that took place like I've never seen before with that panel of experts who identified needs and gaps…. So I think – I just want to say that there was one done yesterday, I feel, and I would like…[that] to be used hopefully in the future by the Victorian government*' – *see* T-405 line 25 to T-406 line 4. This is in part why I have elected to draft the finding in such granular detail.

[335] In relation to **Bridget**; *see* statement of H. Leigh, CB, p. 39 and evidence of A. Pucci-Love, T-55 line 10-11; in relation to **Natalie**; see statement of C. Wilson, CB, pp. 16-18; in relation to **Heather**, *see* CIS of K. Pierard, Court file; in relation to **Matt**, *see* statement of Dr P. Wong, CB, p.42. There is a dearth of evidence in relation to the positive experience of '**AS**' upon commencing her gender affirmation process, noting this occurred in Queensland.

[336] Submissions of Switchboard, Collated Brief, p. 158.

16. I consider this throws into sharp relief the need for a broad conception of care that is affirming of all gender identities – inclusive of mental healthcare, and social and emotional wellbeing supports – and of a broader recognition of the impacts of discrimination, isolation and violence on TGD people's wellbeing. I make this comment acknowledging that this is – or should be – a very basic proposition that is already recognised as such within TGD communities and those who deliver services to them.

17. Ultimately, the way in which members of our TGD communities in Victoria are engaged with through health services and by the community at large is a measure of our respect for human rights, dignity, and our collective humanity. As noted very simply by Dr Nguyen at Inquest, '*being trans and gender diverse is a wonderful part of human diversity, to be celebrated'*.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

1. That the **Assistant Minister for Mental Health and Suicide Prevention, The Honourable Emma McBride**, investigate in conjunction with other appropriate Ministers, Departments and Agencies of the Commonwealth, ways to further restrict the online sale and distribution of sodium nitrite in Australia, noting that three of the five deaths in the TGD suicide cluster were attributable to sodium nitrite toxicity.

2. That **Victoria Police**, in accordance with Priority Area 3 of 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32' progress, as a matter of priority, steps to improve data collection in relation to TGD people to capture all gender identities, by amending the Law Enforcement Assistance Program (**LEAP**) or as otherwise deemed appropriate. This should include amending the Form 83 'Police Report of Death for the Coroner' to include fields to capture all gender identities, to assist in improving the accuracy of data on deaths in the TGD communities, and specify a timeframe for this to be carried out.

3. That the **Victorian Department of Health** as lead, in conjunction with the **Department of Families, Fairness and Housing** and any other relevant Victorian Government

departments, consider urgently increasing resourcing to meet the growing demand for publicly funded health services delivering gender-affirming care to TGD patients, in order to reduce the current waitlists and to support and expand the existing health workforce delivering such care. The Department may consider whether this should involve revision of the existing framework for delivery of gender-affirming healthcare and supports to TGD Victorians.

4. That the **Victorian Department of Health**, under the guidance of experts from TGD communities, consider devising and implementing a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD patients.

5. That the **Victorian Department of Health**, as lead, in conjunction with the **Department of Families, Fairness and Housing** and any other relevant Victorian Government departments, consider ongoing funding options available to ensure that TGD people and their families have appropriate access to culturally appropriate: (i) social and emotional wellbeing supports; and (ii) suicide prevention, postvention and bereavement supports, as a means by which to address the high levels of suicidality, social exclusion and mental ill health in the TGD community.[337]

6. That the **Royal Australian College of General Practitioners (RACGP)** and **Royal Australian and New Zealand College of Psychiatrists (RANZCP)**, under the guidance of experts from TGD communities, develop and offer training and support to all healthcare professionals under their remits, including those who provide or want to provide care to TGD people, with the aim of ensuring cultural safety for TGD people accessing health services across these settings and which includes training on the factors that can contribute to the risk of suicide in these communities.

[337] To assist in identifying culturally-appropriate TGD-led strategies to achieve this, the Victorian Department of Health should consider its very helpful 'Table of Proposed Recommendations' contained at Annexure 1 of the Department of Health's 'Outline of Submissions of the Secretary to the Department of Health', dated 13 February 2024, which contains a summary of all proposed recommendations made by Interested Parties and community-controlled organisations following this Inquest.

7. That the **State Coroner of the Coroners Court of Victoria, Judge John Cain**, under the guidance of experts from TGD communities, consider introduction of a LGBTIQA+ awareness training module, with a TGD-specific component, into the induction training for all staff and Coroners, specifically addressing the factors that can contribute to the risk of suicide in these communities.

ACKNOWLEDGEMENTS

I convey my sincerest sympathy to Heather's family, chosen family, friends and broader community. I acknowledge the grief and devastation that you have endured as a result of your loss. I read and listened carefully to the coronial impact statements provided in connection with Heather's passing, and was greatly assisted and moved by the personal reflections made in those statements. I thank Heather's mother and partner for their active participation and assistance in these proceedings with such grace, dignity and patience, and I acknowledge the great difficulty in undertaking this so long after her passing. I also thank the Family Liaison Officers for supporting Heather's family with dedication over the past years.

I thank Counsel Assisting, Ms Cafarella, and the counsel and solicitors who represented the interested parties for their assistance, comprehensive submissions and collegial approach to these proceedings. I also acknowledge and thank George Carrington, Janet Lee, Kajhal McIntyre and Olivia Collings at the Coroners Court for their invaluable assistance in this investigation, and for striving to ensure that these proceedings could be as culturally safe as possible for the members of the LGBTIQA+ community in attendance.

I also acknowledge the work of my colleagues who previously had carriage of this investigation and who worked tirelessly to progress it long before I assumed carriage of these proceedings. I thank the CPU for its excellent ongoing assistance, including for obtaining the statements and submissions that formed the backbone of the Inquest. In this connection, I also wish to thank each and every witness who provided statements and/or came to give evidence at Inquest, and who shared their personal and professional experiences for the purposes of assisting the Court's understanding of the issues.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

I direct that the Registrar of Births, Deaths and Marriages amend the cause of death to the following, *"1(a) sodium nitrite toxicity'*, in accordance with section 49(2) of the Act.

I further direct that a copy of this Finding be provided to:

Greyson Moyle
Kedra Pierard
Chief Commissioner of Police, c/o Victorian Government Solicitor's Office
Victorian Department of Health, c/o Department's in-house lawyers
Monash Health, c/o K&L Gates
Austin Health, c/o Lander & Rogers
Transgender Victoria, c/o Allens
Detective Senior Constable Marc Gilbert
Elisabeth Lane
The Office of the Chief Psychiatrist of Victoria
Thorne Harbour Health
The Royal Children's Hospital Melbourne
Royal Australian College of General Practitioners
Australian Psychological Society
Royal Australian and New Zealand College of Psychiatrists
Drummond Street Services
Victorian Commissioner for LGBTIQA+ Communities
Switchboard Victoria
Australian Bureau of Statistics
Eastern Health
Therapeutic Goods Administration

Those to whom recommendations are directed (and who are not otherwise listed above):

Assistant Minister for Mental Health and Suicide Prevention, The Honourable Emma McBride

Department of Families, Fairness and Housing

State Coroner of the Coroners Court of Victoria, Judge John Cain

Findings in relation to the other deaths investigated as part of this cluster inquest are available on the Coroners Court website at https://www.coronerscourt.vic.gov.au/inquests-findings/findings.

Signature:

INGRID GILES
Coroner

Date: 29 August 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.