NOTE: SUPPRESSION ORDERS AS SET OUT AT [189] – [192] OF THIS JUDGMENT

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE

CIV-2025-485-869
[2025] NZHC 4045

UNDER	the Judicial Review Procedure Act 2016 and Part 30 of the High Court Rules 2016
IN THE MATTER	of an application for judicial review
BETWEEN	PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH AOTEAROA INCORPORATED Applicant
AND	MINISTER OF HEALTH Respondent

Hearing: 9 December 2025

Appearances: V E Casey KC, T J Keenan and E B Moran for Applicant
K M Eckersley, V A Howell and C D Fuller for Respondent

Judgment: 17 December 2025

Reissued: 17 December 2025

JUDGMENT OF WILKINSON-SMITH J

This judgment was delivered by me on 17/12/2025 at 10 am
Pursuant to Rule 11.5 of the High Court Rules

Registrar/Deputy Registrar

Solicitors/Counsel:
Crown Law, Wellington
DLA Piper, Wellington

Introduction

[1] On 19 November 2025, the Government issued a press release announcing restrictions on the prescribing of gonadotropin-releasing hormone analogues, commonly known as "puberty blockers".

[2] Regulations banning the prescription of puberty blockers for the purpose of puberty suppression in a child or adolescent with gender incongruence or gender dysphoria are due to come into force on 19 December 2025.[1]

[3] The ban will not apply to any person who has been prescribed a puberty blocker for those purposes before 19 December 2025.[2]

[4] Puberty blockers will remain available for other purposes, including to treat precocious puberty in young children.

[5] The Professional Association for Transgender Health Aotearoa Inc (PATHA) has filed an application for judicial review seeking a declaration that the regulations are unlawful and an order quashing the regulations.

[6] Pending judicial review, PATHA applies for an interim order directing the respondent, the Minister of Health (Minister), to take all necessary steps to suspend the regulations pending further order of the Court.

[7] The respondent opposes the application for interim relief.

[8] The application for interim relief was heard as a matter of urgency on 9 December 2025.

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1 Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations 2025, reg 4; and Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2) 2025, reg 4.; Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations, reg 2; and Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2), reg 2.

2 Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations, reg 6.

Summary of findings

[9] Decisions about whether and when to prescribe puberty blockers to young people are complex and difficult decisions, and many people have strong views.

[10] The judicial review application which has been filed by PATHA is concerned broadly with who should make these complex decisions and, in particular, whether the secondary legislation lawfully removes the prescribing decision from doctors in a clinical setting.

[11] This interim judgment concerns what should happen in the period before the substantive judicial review can be heard.

[12] PATHA seeks to preserve the status quo before the regulations were passed — namely, that the prescription of puberty blockers for gender-based care should remain an individually focused medical decision made by doctors in consultation with affected families.

[13] PATHA seeks orders requiring the Minister to take active steps to prevent the regulations coming into force.

[14] I have concluded for the reasons set out in this judgment that the orders sought by PATHA would represent an extraordinary step and would likely be ineffective. I cannot make an order directing the Minister to advise the Governor-General to amend or repeal the regulations. Such an order would potentially pit the Court against the Executive Council and that is constitutionally inappropriate.

[15] However, in this judgment I make a declaration that the Crown should take no steps to enforce the regulations pending the judicial review being determined.

[16] I make that declaration because I am satisfied that the evidence presently before the Court establishes that there is a reasonable argument that the regulations are unlawful in a judicial review sense.

[17] There is also no evidence of a particular need to act urgently to prevent new prescriptions because of some immediate risk to physical health if young people commence treatment.

[18] Puberty blockers are reversible. There is no evidence that they affect fertility. If they did, they would hardly be prescribed for children with precocious puberty and they have been prescribed for that purpose for decades. They may alleviate distress for a child who is simply not ready to cope with puberty either because they are too young or because their mental health is such that a delay is recommended. The only evidence-based impact on physical health is on bone density and that impact results from long term use. A period of months until the Judicial Review can be heard is not said to create any issues with bone density for a young person commencing treatment.

[19] The evidence relating to mental health outcomes suggests negative outcomes from a ban are a far more immediate concern.

[20] My conclusion is fortified by my finding that the timing of the regulations coupled with the lack of notice that a ban was contemplated had the effect of taking PATHA and the whole transgender community by surprise. It prevented PATHA seeking interim relief under s 15 of the Judicial Review Procedure Act 2016. Such relief would have been unexceptional given the lack of any apparent urgency in bringing a ban into effect.

[21] For those reasons which are more fully set out in this judgment, standing back and looking at the overall justice of the situation, I am persuaded that a delay in enforcement of the regulations is the best option now available.

[22] The judicial review should be heard with all possible urgency.

Background

The parties

[23] PATHA is as an interdisciplinary professional organisation that works to promote the health, wellbeing and rights of transgender people. PATHA says that it

represents the vast majority of health professionals engaged with transgender healthcare in New Zealand.

[24] PATHA also supports transgender people and their families. Although not formally a representative body, PATHA advocates for the interests of this cohort and has strong links with the national support group New Zealand Parents and Guardians of Transgender and Gender Diverse Children (NZPOTC).

[25] The respondent is the Minister of Health, who is responsible for making recommendations to the Governor-General for the making of regulations under s 105 of the Medicines Act 1981.

Factual background

[26] On 21 November 2024, the Ministry of Health published a number of documents on its website including a Position Statement on the Use of Puberty Blockers in Gender-Affirming Care and a statement announcing that the Government had tasked the Ministry with consulting on whether there should be additional safety measures for the use of puberty blockers in young people with gender-related health needs.

[27] Between November 2024 and January 2025, consultation was initiated regarding the potential for restrictions on the prescribing and use of puberty blockers in the context of gender-affirming care. This included an online survey open to the public and consultation with targeted focus groups that had identified stakeholders.

[28] At the focus group meetings, attendees were asked if a regulation were put in place to "restrict prescribing and use of puberty blockers in the context of gender-affirming care, with the intention to lower the potential for longer-term unknown risks", what would be the impact on the attendee's organisation and professionals it represents, and what would be the impact on children and young people with gender-related health needs?

[29] The Ministry heard from generally concerned citizens, as well as members of the transgender community.

[30] The consultation form explained that the further measures being considered included the option to make regulations that could legally restrict prescribing of these medicines.

[31] The consultation process closed on 20 January 2025.

[32] The Ministry of Health provided advice to the Minister in a Regulatory Impact Statement (RIS) finalised in July 2025. The identified policy problem was a concern that puberty blockers should only be prescribed for young people with gender incongruence or gender dysphoria for whom the benefits outweighed potential risks.

[33] The RIS included advice that, over the last two decades, there has been an increase in the use of puberty blockers in 11 to 16-year-olds in New Zealand and internationally. Despite the overall increase, prescribing has been reducing in New Zealand since it peaked in 2020, with an estimated 100 or fewer young people started on the treatment in 2024.

[34] Puberty blockers have been used for over 30 years to treat precocious puberty. In that context, they are started at a young age (in girls under eight years and boys under nine years). When used for gender incongruence or gender dysphoria, the medicines are prescribed "off-label" because they are used for an unapproved indication.

[35] It is not uncommon for medicines to be prescribed "off-label" in paediatrics.

[36] The RIS also advised that most public submissions and all affected groups supported continued access to puberty blockers for gender-related healthcare where clinically appropriate.

[37] Groups consulted considered there was no clear rationale to restrict prescribing through regulation. There were strong concerns about an increase in adverse mental health impacts on young people with gender incongruence or gender dysphoria and

their families, and wider harm to the transgender community though increased stigma and human rights implications.

[38] Restrictions on access, such as who could prescribe, minimum age requirements, or participation in clinical trials, were generally seen as impracticable or unethical.

[39] A minority group in the public submissions supported further restrictions, including a ban on puberty blockers to protect young people from harm. A lack of evidence of safe use for this group was cited as the main reason for supporting restrictions, along with the potential for later regret.

[40] For those that supported restrictions but not a ban, there was support for restrictions on who could prescribe, setting a minimum age for treatment, and requiring patients to be part of a clinical trial.

[41] Other nations including the United Kingdom have recently restricted, but not entirely banned, the use of puberty blockers for gender-related healthcare. In the United Kingdom, access to puberty blockers is available but only as part of a clinical trial which is expected to take place over the next five to six years.

[42] The RIS presented four policy options:

(a) Option one: decisions about prescribing puberty blockers would continue to sit with clinicians.

(b) Option two: non-regulatory options would provide further quality checks on prescribing puberty blockers for gender-related healthcare.

(c) Option three: regulatory options to strengthen prescribing requirements or to set and enforce new prescribing restrictions; or specific legislation setting out prescribing requirements to enable careful access to puberty blockers where needed.

(d) Option four — regulations to prohibit new prescriptions while making youth gender services more accessible.

[43] The Ministry advice was that option one (prescribing discretion to remain with clinicians) best met the policy objectives. Option four (ban on new prescriptions) was described as having a high risk of adverse health outcomes due to possible negative impacts on mental health.

[44] In September 2025, the Minister of Health took the proposals in the RIS to Cabinet but did not himself have a preferred option. The consensus of Cabinet was that option four (a ban on new prescriptions) should be preferred.

[45] On Wednesday 12 November 2025, the Cabinet Social Outcomes Committee authorised submission of the regulations to ban new prescriptions for treatment of gender dysphoria or gender incongruence to the Executive Council. The Executive Council met on Monday 17 November 2025 and provided advice the same day to the Administrator of the Government (the Governor-General being away).

[46] The Administrator signed the regulations on 17 November 2025, and they were published in the Gazette on 20 November 2025.

[47] The Minister did not seek a waiver of the 28-day rule, and the regulations will therefore come into effect on 19 December 2025.

[48] PATHA filed its application for judicial review on 1 December 2025. There are nine causes of action in its statement of claim, including causes of action claiming that there was a lack of consultation contrary to s 105 of the Medicines Act, and that the decision to make the regulations was made by the wrong decision-maker. Under s 105 of the Medicines Act, the Minister of Health is the statutory decision-maker. PATHA says that the decision was made by Cabinet and not the Minister or, alternatively, that the Minister acted "under dictation" from Cabinet.

[49] After PATHA filed proceedings, an amendment to the regulations was published in the Gazette on 4 December 2025.[3] The amendment ensures that the ban on prescribing puberty blockers does not inadvertently apply to adults who may use the medication to undergo gender transition.

Application for interim orders

[50] Also on 1 December 2025, PATHA filed an urgent on notice application for:

(a) interim orders directing the respondent to take all necessary steps to suspend the regulations pending further order of the Court;[4] and

(b) costs.

[51] The interim orders were sought on the following grounds:

(a) The regulations impose a total ban on the prescription by qualified health practitioners working within their scope of practice of medicines colloquially referred to as "puberty blockers" for transgender people diagnosed with gender dysphoria or gender incongruence who are not already receiving that treatment.

(b) The regulations were signed on 17 November 2025, gazetted on 20 November 2025 and come into force with immediate effect on 19 December 2025.

(c) The regulations were unheralded, and the decision to impose this ban was publicly announced on 19 November 2025, two days after the

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3 Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2).

4 PATHA's initial application was filed before the amendment to the Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations was amended by the Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2), and therefore only refers to the former regulations. However, it is clear that maintains its substantive claim and its application for interim orders in respect of both sets of regulations.

regulations were signed and the day before they appeared in the Gazette.

(d) The applicant has filed an application for judicial review seeking a declaration that the regulations are unlawful and an order quashing the regulations.

(e) The applicant has a strong case, as set out in the statement of claim.

(f) The applicant is a representative body supporting and advocating for health professionals and the transgender community. It and its constituent community have a position to be preserved, in that the regulations will:

(i) prevent health practitioners providing clinically appropriate care that they are currently able to provide; and

(ii) prevent transgender people accessing clinically appropriate care that is currently available to them.

(g) The orders sought are reasonably necessary to preserve these positions.

(h) The repercussions of granting interim orders favour the orders being made.

(i) Preserving the status quo will not cause any harm. This is evident from:

(i) the Ministry of Health's November 2024 evidence-based Position Statement, which endorses the current best-practice prescribing of these medicines for young people with gender dysphoria or gender incongruence; and

(ii) the fact that the regulations do not purport to restrict the use of this same medicine for cisgender people (including children) or

transgender people who have already been prescribed this treatment.

(j) Allowing the regulations to come into effect will cause direct and serious harm to the small cohort of people diagnosed with gender dysphoria or gender incongruence who will be unable to access clinically appropriate medical treatment. The adverse consequences for young people in that cohort include those outlined in the statement of claim.

(k) The RIS was, at the time of filing, still not publicly available, nor were the relevant decision papers and advice relating to the decision to make the regulations. The application for judicial review was accordingly not ready for hearing as discovery from the respondent was required for the matter to be fairly determined.

[52] By the time of the hearing before me on 9 December 2025, the RIS was available.

[53] PATHA's position is that the RIS strongly supports the granting of interim relief as it makes it clear that the Minister of Health did not present any preferred option to Cabinet. PATHA says the Minster was not the decision-maker in respect of the regulations. The RIS also makes it clear that the Ministry of Health advice was that a ban carries a high risk of adverse health outcomes.

The evidence filed by the applicant

[54] PATHA has filed affidavits from four witnesses, including two health professionals.[5]

[55] Jennifer Shields is the president of PATHA and provided an affidavit on behalf of PATHA.

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5 Permanent name suppression is sought for these health professionals and interim orders for name suppression were made at the hearing.

[56] Ms Shields says that PATHA was given no notification or prior warning of the decision announced on 19 November 2025. PATHA was not consulted about the proposed regulations, nor informed that draft regulations were being developed. PATHA is not aware of any other health professional or expert in this field who was notified or consulted.

[57] PATHA was only made aware that there had been a decision made about puberty blockers from an X post on the morning of 19 November 2025.

[58] Julia de Bres is a community-engaged researcher on transgender health and a member of the leadership team of NZPOTC.

[59] Ms de Bres says parents were deeply shocked with the Government announcement on 19 November 2025 and there is widespread panic and distress within NZPOTC.

[60] Dr A is a medical professional who says that restricting access to this medication is likely to pose ethical challenges to health professionals who can no longer deliver what is accepted to be best-practice care.

[61] Dr A says there has always been a small but real cohort of children and young people who experience a sense of their gender identity and expression that is different from the sex they were assigned at birth. Many will not want or need any medical support but for some it will be vital for their wellbeing. These children are usually insistent, consistent and persistent in their gender identity and may exhibit distress or discomfort with their physical body.

[62] Dr A explains that puberty blockers pause the effects of puberty, and crucially, are time-limited in their effects. Use results in a reversible pause in the development of secondary sexual characteristics, such as breast growth, voice deepening, hair growth or facial masculinisation. Dr A says use of puberty blockers often relieves profound distress associated with these bodily changes for young people with gender dysphoria or gender incongruence.

[63] Puberty blockers have been used for decades for children undergoing an early puberty (precocious puberty). The same medications are also commonly used to treat certain cancers, endometriosis and menstrual problems, both in young people and adults.

[64] In New Zealand, puberty blockers have also been used for around 15 years for the purpose of reversible pubertal suppression in young people expressing gender incongruence.

[65] Dr A says that reversible pubertal suppression allows time for pausing of the physical effects of puberty, consideration of gender and identity development, and cognitive and emotional maturity development. This pause allows for a more careful approach and safer care, rather than young people feeling an urgency to rush into decisions which are irreversible.

[66] Dr A says that there seems to be a fear that puberty blockers set an irreversible life course. That has not been observed over Dr A's many years in practice. Dr A says she has certainly seen young people who, after being on a puberty blocker, have decided that this medication is no longer needed for them. These young people stop the puberty blocker, and puberty restarts as it would have done without the medication.

[67] Other young people continue treatment including hormone therapy, which is a separate stage of treatment. Unlike puberty blockers, hormone therapy does result in irreversible changes to the body.

[68] Dr A describes hearing about and seeing the long-term benefits of pubertal suppression regularly in clinical practice.

[69] In Dr A's opinion, using puberty blockers when clinically appropriate upholds the ethical principle of beneficence, defined in her affidavit as follows:

> The principle of beneficence is the obligation of a physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger.

[70] Dr A says that puberty blockers are not a universal or even widely used treatment for transgender young people — they are a carefully considered medication, offered where clinicians consider the potential benefits outweigh potential risks, and involve a careful process of informed consent.

[71] Dr A's affidavit says that parent/guardian consent is required alongside a child's consent or assent to access puberty blockers but only if the young person is not considered to have Gillick competency.

[72] I take that to mean that some young people under sixteen, and those aged over sixteen, could access puberty blockers without parental consent.

[73] Dr A's affidavit sets out that figures released by pharmaceutical data published in 2024 show that in 2023, around 650 young people between the ages of 0 and 19 were being prescribed puberty blockers. This included approximately 400 in the 12 to 17-year age range. This total figure includes those with precocious puberty or uses for other (non-gender-related) health conditions. There were approaching 125 new prescriptions in 2023 for the 12–17 age group.

[74] The pharmaceutical prescribing figures show that the number of young people who access care for reversible pubertal suppression has increased over the years. Dr A says this is to be expected given the increased awareness of gender diversity and the availability of medical intervention, and the improvement in access to gender-affirming care. Overall, the number of people accessing this care is still small, but Dr A says the impact on those who will lose access to such care will be significant.

[75] Dr A says that in people treated with puberty blockers, bone density appears to increase at less than the expected rate for individual stage of development. Bone density usually improves either when stopping puberty blockers or initiating gender-affirming hormones. When prescribing puberty blockers, clinicians provide advice on optimising bone health with Vitamin D supplements, ensuring adequate calcium intake and promoting weight-bearing exercise.

[76] Dr A says there is no evidence of impact on renal or liver function, onset of diabetes, or fertility.

[77] Dr A acknowledges that whilst there are some studies that suggest an improvement in depression, anxiety and suicidal ideation for individuals treated with puberty blockers, the quality of evidence is deemed poor.

[78] Dr A says that a reduction in the decline of mental health is a positive outcome for those with a baseline which may already demonstrate poor mental health. Improvements in mental health are usually seen when people are older and when those who choose to have started hormone therapy which results in changes to the body that align with their experienced gender.

[79] Dr A is very concerned about the negative consequences of the regulations for transgender young people and the lack of alternative evidence-based treatments for them.

[80] Dr A refers to statements of concern about the regulations which have been issued by the following health professional organisations:

(a) The Royal Australasian College of Physicians.

(b) Te Kāhui Korowai Rangatahi | Youth Health Aotearoa.

(c) The Royal Australian and New Zealand College of Psychiatrists.

(d) The New Zealand Nurses Organisation | Tōpūtanga Tapuhi Kaitiaki o Aotearoa.

(e) The New Zealand Society of Endocrinology.

(f) The Association of Salaried Medical Specialists | Toi Mata Hauora.

(g) Te ORA Māori Medical Practitioners.

(h) Sexual Wellbeing Aotearoa.

[81] Dr A anticipates an increase in distress, anxiety and depression in relation to pubertal changes in young people with gender incongruence, including self-harm, as a result of the regulations.

[82] Dr A says many transgender adults who did not access puberty blockers seek surgery due to the physical changes they went through in puberty. For example, trans masculine people commonly seek a bilateral mastectomy to remove their breast tissue. Trans feminine people may seek voice surgery, facial feminisation surgery or tracheal shave surgery.

[83] Dr A's affidavit sets out that unwanted physical changes for young people can lead to:

(a) not speaking due to distressing voice changes;

(b) struggling with self-care; for example, showering and shaving;

(c) attempting to remove body parts — self-mutilation of breasts and genitals;

(d) withdrawal from social interaction — family, peers, activities; and

(e) withdrawal from school.

[84] Dr A says that whilst puberty blockers simply put a pause on puberty and are reversible, gender-affirming hormone therapy results in irreversible physical effects.

[85] Dr A says that one of the great benefits of puberty blockers is the time it gives people to pause puberty while they psychologically mature and develop, so that they do not have to make any decisions with permanent consequences until they are older.

[86] In Dr A's opinion, there is no evidence of clinically significant harm from pubertal suppression to support recommending a ban of this medication; however, the risk of harm from denial of care is immediate, significant and profound.

[87] Dr B is another medical professional. Dr B's evidence also refers to statements published by medical bodies following the announcement of the regulations.

[88] On 24 November 2025, the New Zealand College of Public Health Medicine published a media release expressing concern at the decision to ban new prescriptions of puberty blockers and stating that removing this treatment option could cause significant additional harm to the mental health of young people with gender incongruence and dysphoria.

[89] On 25 November 2025, the Royal New Zealand College of General Practitioners issued a position statement and member guidance on puberty blocker prescribing. The College acknowledged that there are diverse individual views across the membership on the use and prescribing of puberty blockers but stated that patient care and patient safety must be the top priority when serving the health needs of communities. The College expressed concern that the announcement of the ban represented political intervention in a medical matter.

[90] On 2 December 2025, Te Kāhui Mātai Arotamariki o Aotearoa, the Paediatric Society of New Zealand, released a position statement in response to the Government's announcement on restricting new prescriptions of puberty blockers. It supports treatment decisions that are grounded in clinical evidence and expert medical guidance, and says prescribing decisions should remain between clinicians, patients and their whānau.

[91] A statement published by the Association of Psychotherapists Aotearoa New Zealand opposes the regulations, saying judgments and decisions around prescribing puberty blockers are clinical decisions which involve important and complex considerations. The proper people to assess the appropriateness of the use of puberty blockers are clinicians in collaboration with young people and their families.

[92] On 5 December 2025, Dr B received a letter from the clinical director of paediatrics in the Capital, Coast and Hutt Valley region about an alert he and the director of mental health services made to the risk register about the anticipated increased distress they expect following the regulations.

The evidence filed by the respondent

[93] The Minister of Health, the Hon Simeon Brown, has sworn an affidavit dated 8 December 2025.

[94] The Minister says he made the decision to recommend to Cabinet that it agree to progress policy options to respond to the issue of poor evidence either for or against any long-term benefits or risks from puberty blocker treatment.

[95] The Minister says while puberty blockers are approved by Medsafe for some indications (including treatment for precocious puberty and endometriosis), they are not approved in New Zealand to delay puberty in gender-affirming care. Where puberty blockers are prescribed for this indication, this is "off-label" prescribing.

[96] "Off-label" prescribing is permitted by s 25 of the Medicines Act, which allows authorised prescribers to supply any medicine to a patient under their care.

[97] The Minister says that, if there are unknown consequences of using a medication for an indication different from what it has been approved for, allowing use under s 25 would undermine the Medicines Act. While this can, and often is, left to medical practitioners to manage, it is equally open to the Minister to decide there should be a proper assessment of safety for the intended indication.

[98] The Minister's affidavit says medicine dispensing data shows a steady growth in use of puberty blockers for children and young people aged 11–16 years between 2010 and 2020. He says the number of young people starting to receive this treatment each year increased up to approximately 140 in 2020, followed by a fall-off towards 2024.

[99] In 2022, the Ministry of Health undertook an evidence review to inform the approach and position on prescriptions for puberty blockers.

[100] The Minister's affidavit says that the evidence brief found a scarcity of quality evidence on the impacts of puberty blockers in terms of clinical and mental health and wellbeing outcomes, both positive and negative. The evidence reviewed was found to be of low quality with studies presenting a high risk of bias and significant limitations.

[101] There was some evidence that for young people taking puberty blockers, their bone mineral density is lower than what is expected for the individual's age or stage of pubertal development when compared to a control group. There was no evidence on longer-term effects on bone density nor on other health outcomes, including mental health outcomes.

[102] The Minister's affidavit says that while there were some studies that suggested an improvement in depression, anxiety and suicidal ideation for individuals treated with puberty blockers, the quality of the evidence was found to be poor.

[103] The evidence brief considered the interim Cass Report from the United Kingdom and the final findings of the Cass Review.[6] The Minister's affidavit sets out that the Cass Review found the rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health. The Cass Review stated that the adoption of a treatment with uncertain benefits without further scrutiny was a significant departure from established practice.

[104] Based on the outcomes of the Cass Review, the NHS in England and the NHS in Scotland paused new prescribing of puberty blockers for the treatment of gender dysphoria or gender incongruence in children and young people under the age of 18.

[105] In March 2024, NHS England published a clinical policy which took the position that new prescriptions of puberty blockers would only be accessible for young

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6 An independent review of gender identity services for children and young people commissioned by the National Health Service (NHS) England.

people with gender incongruence or gender dysphoria when used as part of a clinical trial. The United Kingdom has passed secondary legislation to prohibit the use of puberty blockers for the purposes of treating gender dysphoria, gender incongruence or a combination of both outside of clinical trials.

[106] In Scandinavian countries, prescriptions of puberty blockers are limited to those enrolled in a clinical trial, except in exceptional circumstances (Sweden) or after non-medical options have been explored and deemed insufficient (Norway and Finland).

[107] The Minister says it is not possible to categorically say whether puberty blockers for the treatment of gender dysphoria and incongruence in children and adolescents is safe or reversible (or not). He says the lack of evidence means there is a risk of unintended consequences for gender dysphoric children and adolescents.

[108] After balancing the risk of restricting the medicine against the uncertainty and risk of potential harm for those patients, the Minister says he was satisfied that a cautious approach was required.

[109] I note that, on the Minister's evidence, the New Zealand position is now more restrictive than that of the United Kingdom, Sweden, Norway and Finland. After 19 December 2025 there will be no path for a young person in New Zealand to be prescribed puberty blockers for the purpose of treating gender dysphoria or gender incongruence.

[110] The Minister says that he recommended policy options to Cabinet to respond to the issue of poor evidence either for or against long-erm benefits or risks from puberty blockers. The options included regulations to restrict prescribing of puberty blockers. The Minister chaired discussions with his Cabinet colleagues on 10 September 2025. The outcome of that discussion was strong support for restricting or prohibiting puberty blocker prescribing to treat gender incongruence or dysphoria.

[111] The Minister says that whether to restrict new prescriptions of puberty blockers is a difficult question of health policy, and one on which there are inevitably differing viewpoints.

[112] The Minister is ultimately responsible for making recommendations on regulations to the Governor-General under s 105 of the Medicines Act and says he is well placed to do so after receiving advice from officials and considering the submissions and views received.

[113] The Minister says that although there were benefits of maintaining the status quo with the Ministry's Position statement in Place, he also took into consideration the consensus of Cabinet behind restriction of the medication. Ultimately, the Minister says he was satisfied that the uncertainty of harm required a cautious approach, consistent with the approach in other jurisdictions. As noted, however, the New Zealand ban is more complete than in other jurisdictions referred to by the Minister.

[114] The Minister says the approach can be revisited when more information on the benefits and risks of this medication becomes available.

[115] The timing of the regulations coming into force followed a typical timeframe, according to the Minister. The Minister says there was no evidence or rationale that would have justified a departure from this timeline or variation to the commencement date for the regulations.

[116] Steven Barnes, Associate Deputy Director-General in the Office of the Deputy Director-General at Manatū Hauora — Ministry of Health, also provided an affidavit.

[117] Mr Barnes set out that on 8 November 2024, following the Minister's recommendation, Cabinet agreed to the Ministry commencing consultation on whether further safety measures were needed for use of puberty blockers in young people with gender-related health needs.

[118] The consultation opened on 21 November 2024 and closed on 20 January 2025.

[119] The Ministry held a series of consultation meetings with organisations and groups representing people likely to be affected by any further safety measures. These meetings were intended to be the primary method for gathering views about:

(a) whether additional safety measures are needed, and if so which measures; and

(b) the impacts that could occur as a result of the safety measures being considered.

[120] The purpose of this consultation was to inform what, if any, further safety measures were required for the prescribing of puberty blockers in the context of gender-affirming care.

[121] Mr Barnes' affidavit sets out that as part of the consultation process, PATHA was asked whether further safety measures were needed to protect against unintended harms from use of puberty blockers for children and young people, and if so, what measures.

[122] PATHA was also asked if a regulation were put in place to "restrict prescribing and use of puberty blockers in the context of gender-affirming care, with the intention to lower the potential for longer-term unknown risks", what would be the impact on PATHA and professionals they represent, and children and young people with gender-related health needs.

[123] Mr Barnes says that PATHA representatives raised several concerns in the consultation meeting, including that regulations would restrict the number of people accessing puberty blockers and those who can prescribe, and that any measures that restricted access would have a significant impact on families.

[124] PATHA also questioned the rationale for restricting access to puberty blockers for transgender people but not for others. They were also concerned about the public-facing element of the consultation.

[125] PATHA made a written submission on 20 January 2025 and submitted that restricting access to puberty blockers through regulations would lead to consequences which are lifelong, irreversible and significantly harmful to transgender young people. PATHA said this applies whether that restriction is in the form of restricting who can prescribe them, who is eligible for them, or imposing restrictions through other means. Banning or restricting access to puberty blockers would go against best-practice recommendations from major medical bodies.

[126] An opportunity was provided for public submissions through the Ministry of Health website, via an online submission form and a dedicated email address for people who wished to make submissions via email.

[127] The online submission form explained that the Ministry was considering whether further measures needed to be put in place to restrict prescribing of puberty blockers in the context of gender-affirming care. This included the option to make regulations that could legally restrict prescribing of these medicines, such as a regulation made under the Medicines Act.

[128] The Ministry received 7103 online submission form responses and 2768 email submissions. Of the online submission form responses, 1263 submissions were identified as being automatically generated and were excluded, leaving a total of 5840 submissions.

[129] The content of the responses is set out in the RIS provided to the Minister.

[130] Dr Sarah Hill, Deputy Chief Science Advisor for the Ministry of Health provided an affidavit for the Crown.

[131] Dr Hill deposes that self-reported gender incongruence occurs in around one to two per cent of adolescents in high-income countries. Only a small minority of

these adolescents present to health services with gender dysphoria; recent evidence from the United Kingdom estimates that fewer than one in 200 young people aged 17–18 years have a clinical diagnosis of gender dysphoria.

[132] Use of puberty blockers for treatment of gender dysphoria is a relatively recent development in clinical practice, having been used for this indication for around 15 years. Puberty blockers are a well-established treatment for some other conditions including precocious puberty in children, endometriosis, and some hormone-sensitive cancers.

[133] In children with precocious or early-onset puberty, puberty blockers are used at an earlier age (typically under 10 years of age) than for puberty suppression in young people with gender dysphoria (typically 11 years or older). In both cases, treatment may continue for 2–3 years, although this may be considerably longer in the case of precocious puberty.

[134] New puberty blocker prescriptions for 11 to16-year-olds in New Zealand increased substantially from 2016–2020, followed by a decline. Recent data indicates around 100 young people per year are starting new prescriptions for puberty blockers.

[135] In November 2024, the Ministry of Health published an Evidence Brief (the Brief) and an Addendum to the Evidence Brief (the Addendum) that assessed scientific evidence on the impact of puberty blockers in gender dysphoric adolescents.

[136] The Evidence Brief and Addendum found that:

(a) Overall, evidence on the impacts of puberty blockers on adolescents is scarce and the quality of this evidence is low. An absence of randomised controlled trials (the "gold standard" for assessing the effectiveness and safety of medicines) means evidence is limited to other forms of research that are prone to error from bias and confounding. Most clinical studies are also based on a small number of participants, which means findings may be due to chance.

(b) There is some evidence that bone density accumulates at a lower rate than expected in young people receiving puberty blockers, but no evidence that puberty suppression has a long-term impact on bone density. Receipt of puberty blockers also influences the eventual height reached by adolescents with gender dysphoria, depending on their age and physical development at the time these are started. For natal males, those starting puberty blockers at an earlier stage of development have lower final height; while for natal females, early initiation of puberty blockers is associated with greater final height.

(c) There is no clear evidence that puberty suppression impacts cardiovascular function, renal function or onset of diabetes.

(d) There is very little research examining the long-term impacts of puberty blockers on fertility when taken for gender-affirming care.

(e) There is some evidence that receipt of puberty blockers reduces depression, anxiety and suicidal ideation in adolescents with gender dysphoria, although the quality of this evidence is low with a high risk of bias.

[137] Dr Hill says that the absence of robust evidence on efficacy and safety is not unusual for relatively new treatments in children and adolescents, particularly where the condition being treated is uncommon. Most randomised controlled trials are conducted in adults and require a large number of study participants to reduce the risk of error. Randomised controlled trials in children and adolescents present significant logistical and ethical challenges and are often conducted only after a medicine is already well established for use in adults.

[138] Until recently, randomised controlled trials have not been undertaken for puberty suppression in young people with gender dysphoria. While a randomised controlled trial is expected to start soon in the United Kingdom, it will take several years to complete and for findings to become available. In the meantime, assessment of the likely efficacy and safety of puberty suppression relies on evidence from use of

the same drugs for other conditions and age groups alongside the limited research on their use in adolescents with gender dysphoria.

[139] In the absence of evidence from randomised controlled trials specific to the condition in question, Dr Hill says it is not unusual for clinicians to offer drug treatment based on the balance of probable benefits and risks. Clinical practice and evidence on the safety and efficacy often develop in parallel. Decision-making in the context of uncertainty is an inherent aspect of clinical practice.

[140] Clinicians are expected to be aware of clinical guidelines relating to their area of practice and to reflect these in their practice. Clinical guidelines for management of gender dysphoria in adolescents have been developed with the input of relevant experts, with reference to available evidence.

[141] There is limited evidence on the effects of introducing measures restricting access to puberty blockers. While restrictions have been introduced in several jurisdictions (including the United Kingdom and some parts of the United States), the changes are relatively recent and very few published studies have examined their impacts.

[142] There is some evidence that introduction of restrictions causes increased mental distress among people with gender dysphoria and their families. Preliminary evidence from the United States and the United Kingdom shows increased distress, anxiety and suicidal ideation following introduction of restrictions on puberty blockers for gender dysphoria, with one US study reporting an increase in suicide attempts among young people with gender incongruence.

[143] These findings may be due to a number of factors, and the limited research available is not able to directly attribute increased mental distress to participants not being able to access puberty blockers. Negative mental health outcomes may reflect increased experiences of social marginalisation, stigma and loss of autonomy among young people with gender incongruence.

[144] Dr Hill says that the findings reinforce the importance of ensuring young people with gender dysphoria have access to timely and appropriate care, including psychological and social support.

[145] Depending on the young person's individual needs and goals, gender-affirming healthcare for adolescents can include:

(a) psychosocial support;

(b) peer and kaiawhina support;

(c) permanent or semipermanent hair removal;

(d) gender-affirming hormone therapy;

(e) voice training; and

(f) rongoā Māori.

Legal principles

[146] Section 15 of the Judicial Review Procedure Act provides:

> (1) At any time before the final determination of an application, the court may, on the application of a party, make an interim order of the kind specified in subsection (2) if, in its opinion, it is necessary to do so to preserve the position of the applicant.
>
> (2) The interim orders referred to in subsection (1) are interim orders—
>
> (a) prohibiting a respondent from taking any further action that is, or would be, consequential on the exercise of the statutory power:
>
> …
>
> (3) However, if the Crown is a respondent,—
>
> (a) the court may not make an order against the Crown under subsection (2)(a) or (b); but
>
> (b) the court may, instead, make an interim order—

(i) declaring that the Crown ought not to take any further action that is, or would be, consequential on the exercise of the statutory power:

(ii) declaring that the Crown ought not to institute or continue any proceedings, civil or criminal, in connection with any matter to which the application relates.

…

[147] Where the relief sought is against the Crown, an order under s 15(3) is not coercive in nature but is a declaration of what the Crown ought not to do pending determination of the substantive application for review. The Crown is not bound to observe the terms of such an order but usually such an order will achieve the object of interim relief.[7]

[148] In this case no order under s 15 is possible. That is because the ban on puberty blockers was not publicly known until two days after the regulations were signed by the Administrator, and late in the afternoon of the day before they were published in the Gazette.

[149] The regulations having been signed and gazetted, there are no further steps to be taken by the Minister to bring the regulations into force.

[150] PATHA therefore relies on the inherent jurisdiction of the Court to grant a mandatory injunction to require the Minister to take active steps to prevent the regulations coming into force.

[151] The Court has jurisdiction to make mandatory interim orders, but such orders will be exceptionally rare where the effect of the order would be to suspend a regulation or make it unenforceable pending judicial review to determine validity.[8] It

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7 *Carlton & United Breweries Ltd v Minister of Customs* [1986] 1 NZLR 423 (HC).

8 *NZ Federation of Commercial Fishermen Inc v Minister of Fisheries* HC Wellington CIV-2008-485-2016, 26 September 2008 at [86].

has been said that there are strong policy reasons against a court making mandatory interim orders or declarations requiring positive action.[9]

[152] Lord Goff in R v Secretary of State for Transport, ex parte Factortame Ltd (No 2) observed: [10].

> It is impossible to foresee what cases may yet come before the courts; I cannot dismiss from my mind the possibility (no doubt remote) that such a party may suffer such serious and irreparable harm in the event of the law being enforced against him that it may be just or convenient to restrain its enforcement by an interim injunction even though so heavy a burden has not been discharged by him. In the end, the matter is one for the discretion of the court, taking into account all the circumstances of the case. Even so, the court should not restrain a public authority by interim injunction from enforcing an apparently authentic law unless it is satisfied, having regard to all the circumstances, that the challenge to the validity of the law is, prima facie, so firmly based as to justify so exceptional a course being taken

[153] Interim orders will only be granted if the order is "reasonably necessary" to preserve the position of the applicant. In that case, the Court has a wide discretion to consider all the circumstances of the case.[11]

[154] An order should not go further than reasonably necessary to protect an applicant's current position so that they are not prejudiced from the delay in the hearing of their application.[12]

[155] The Courts take a generous approach to questions of standing in a public law case where the legality of State action is in issue.[13]

Issues

[156] The issues are:

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9 *Taylor v Chief Executive of the Department of Corrections* [2011] 1 NZLR 112, [2010] NZCA 371.

10 *R v Secretary of State for Transport, ex parte Factortame Ltd (No 2)* [1991] 1 AC 603 at 674, as cited recently in *R (Hussain) v Secretary of State for Health and Social Care* [2020] EWHC 1392 (Admin).

11 *Carlton & United Breweries Ltd v Minister of Customs*, above n 7..

12 *Woodhouse v Auckland City Council* (1984) 1 PRNZ 6 (HC).

13 *Auckland Pride v Minister of Immigration* [2023] NZHC 758, [2023] 2 NZLR 651.

(a) Does the Court have jurisdiction to make orders of the kind sought by PATHA;

(b) Is the order reasonably necessary to preserve the position of the PATHA;

(c) If so, should the Court exercise its "wide discretion" to make an order, in light of:

(i) the apparent strengths or weaknesses of the claim;

(ii) the public and private repercussions of granting interim relief;

(iii) any other relevant circumstances and where the overall justice lies.

Analysis

Jurisdiction

[157] In the notice of opposition, the Minister stated that the Court does not have jurisdiction to make mandatory interim orders of the kind sought.

[158] At the hearing, the Crown accepted that there is power to grant a mandatory injunction, the effect of which is to suspend a regulation or make it unenforceable pending a judicial review to determine validity. But the Crown says that the circumstances would need to be exceptional before such an injunction could be granted. The Crown's position is that the relief sought is unavailable or constitutionally inappropriate.

[159] The Crown also says that the actual order sought by PATHA would be ineffective. The regulations are subordinate legislation which passed into law on 17 November 2025. As delegated legislation, the regulations are subject both to Parliamentary review and judicial review but unless declared invalid, they remain the law. The Minster of Health has no power to unilaterally change or disapply the law. His statutory power was to recommend the making of the regulations under the

Medicines Act, but the Administrator, as the Sovereign's representative in the Executive Council, was responsible for the promulgation of the law and the only way the regulations can cease to be law is through being amended by further regulation, being disallowed by Parliament, or by being declared invalid by the Court.

[160] In this case, PATHA only became aware of the regulations after they had been signed into law. The Minister's statutory power at that stage was spent. There is no further action that the Minister is required to take, and there is no prohibitive injunction that can provide relief.

[161] Mandatory injunctions may be appropriate where a respondent has "stolen a march" on an applicant.[14] In this case that is the effect of the timing of these regulations, whether intended or not. But that fact does not alter the constitutional issues that arise. As the Crown points out, the Minister has no power to advise the Governor-General to amend the commencement date of the Regulations. Any such amendment would need to go through Cabinet and then the Executive Council. The Court cannot direct the making of legislation.

[162] The Crown position is that, at most, the Court could make a declaration that the regulations ought not to be enforced pending the judicial review hearing and the judicial review hearing should be expedited. The Crown does not support that form of interim relief and says such a declaration should only be made in exceptional circumstances.

[163] PATHA says that the material now provided, including the RIS, makes it clear beyond any doubt that the Minister was not the decision-maker in respect of the regulations. Rather, the Minister abdicated his decision-making power to Cabinet. That resulted in a purely political decision which is unlawful because the statutory power rests with the Minister and he is expected to exercise it. That is one of the safeguards of secondary legislation which has a much easier path to enactment than primary legislation. It is expected that the Minister will make a decision in light of advice from his Ministry rather than for purely political reasons. In this case, the

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[14] Jessica Gorman and others *McGechan on Procedure* (online ed, Thomson Reuters) at [HR7.53.16].

advice from the Ministry was that a ban on new prescriptions was associated with worse health outcomes.

[164] PATHA says that what has happened here is exceptional. The regulations are clearly invalid and were passed into law without announcement, to prevent legal action pending judicial review. PATHA says that if the Minister has stepped outside the bounds of what Parliament has authorised in terms of making secondary legislation, then the Court not only has the jurisdiction, but the duty, to intervene.

[165] On the basis of the law set out earlier, I am satisfied that the power exists to grant mandatory injunctive relief. Whether that should occur and in what form depends on the answers to the remaining issues.

Do the applicants have a position to preserve?

[166] Interim orders are directed at keeping or placing an applicant in the position it would have been in but for the illegality alleged. In *Kapa-Kingi v Tamihere* it was said that the Court is willing to take a liberal approach to the preservation threshold.[15]

[167] The Crown says that PATHA has not identified anything about its own position that gives rise to any position to preserve. The relief is sought to preserve the position of health practitioners who will be prevented from prescribing puberty blockers in situations where they think such medication is clinically indicated and in the best interests of their patient.

[168] In relation both to health practitioner and transgender youth, the Crown says that that the position PATHA seeks to preserve is a hypothetical future position. Health practitioners, the Crown says, are unaffected by the regulations. They are required to follow the law when prescribing medication and cannot be professionally or ethically criticised for doing so.

[169] At the hearing, PATHA offered to join an individual health practitioner or the parents of a directly affected transgender young person but said this should not be

[15] *Kapa-Kingi v Tamnihere* [2025] NZHC 3776.

necessary. The Court should not require the token addition of an individual applicant or the formulation of a class action before allowing urgent interim relief.

[170] I agree that PATHA is an organisation well placed to advocate for both health practitioners practising in this area and transgender young people and their families. There is no dispute as to PATHA's standing to bring the application for judicial review. The position that PATHA seeks to preserve is that the prescription of puberty blockers for gender-based care should remain an individually focused medical decision made by clinicians in consultation with affected families.

[171] Essentially, PATHA seeks to preserve what was the status quo before the regulations were passed.

[172] The issue is not whether any individual health practitioner should or should not prescribe puberty blockers in a particular case. Nor is it whether a particular young person should be prescribed puberty blockers. The broad public interest issue is whether the ability to prescribe puberty blockers for gender affirming care should be removed from doctors. The specific issue for judicial review will be whether that ability was lawfully removed in this case by way of secondary legislation.

[173] PATHA is an organisation that advocates for and supports healthcare professionals and transgender youth, and their families. It is not very different from any public interest group seeking to judicially review a decision affecting the group it represents. To that extent it has a position to preserve.

The strength of the applicant's case

[174] The Crown accepts that two of the causes of action are arguable, namely the claim that there was a lack of consultation and the claim that the wrong decision-maker exercised the statutory power to make the regulations.

[175] There was consultation about the potential for restrictions to be placed on the prescribing of puberty blockers by the passing of regulations. It does not appear from the evidence that there was consultation about a complete ban on new prescriptions

for gender-based care. Whether the extent and nature of the consultation was sufficient, I cannot decide, but I agree that PATHA's position is arguable.

[176] The second cause of action is also clearly arguable and perhaps more than arguable given the material that has become available since the proceedings were filed. The Minister did not take a preferred position to Cabinet. Rather, he chaired a meeting at which strong views were expressed and appears to have accepted the views of Cabinet. The views of Cabinet do not reflect the medical advice set out in the RIS. Whether that suffices as an exercise of the Minister's statutory power will need to be decided, but the factual picture is now quite clear, and it supports PATHA's position that this was a political decision and contrary to advice from the Ministry which also feeds into the third cause of action.

[177] The remaining causes of action are also not without some apparent merit. The total ban imposed by the regulations goes further than the restrictions implemented recently in the United Kingdom and in Scandinavia. The evidential justification for such a ban is scant. There may well be individual cases where puberty blockers are shown to have negative consequences. Equally, there will no doubt be cases where puberty blockers are beneficial for a particular individual. But focusing on individual outcomes can mislead. As I have said, the real issue is whether the ability to prescribe puberty blockers based on individual clinical assessment by medical practitioners should continue.

[178] The total ban appears to make negative consequences inevitable for some transgender youth and there is an argument that it is discriminatory. That is because there is no doubt that puberty blockers are regarded as sufficiently safe to treat precocious puberty, and children begin puberty blockers earlier and remain on them for longer when used for that purpose. The concerns about bone density do not apparently justify a ban on puberty blockers generally but only when used for gender dysphoria or gender incongruence.

[179] There is also no evidence of a particular need to act urgently to prevent new prescriptions because of some immediate risk to physical health if young people commence treatment. Puberty blockers are reversible. There is no evidence that they

affect fertility. If they did, they would hardly be prescribed for children with precocious puberty and they have been prescribed for that purpose for decades. They may alleviate distress for a child who is simply not ready to cope with puberty either because they are too young or because their mental health is such that a delay is recommended. The only evidence-based impact on physical health is on bone density and that impact results from long-term use. A period of months until the judicial review can be heard is not said to create any issues with bone density. The evidence relating to mental health outcomes suggests negative outcomes from a ban are a far more immediate concern.

[180] For that reason, if I can grant relief until the substantive hearing, I would do so.

[181] Given that the regulations have passed into law, the question is what form any relief can take.

The orders sought

[182] PATHA seeks orders requiring the Minister to take active steps to prevent the regulations coming into force. Its position is that it is not necessary for the Court to dictate the precise steps that the Minister should take but says an obvious step would be to advise the Governor-General to amend the commencement date of the regulations or repeal them altogether.

[183] The orders sought by PATHA would represent an extraordinary step and would likely be ineffective. The Minister has no power to direct the Governor-General. The Court, in granting injunctive relief against the Crown in ordinary circumstances, is limited to making a declaration that the Minister should not do something. I need not decide if an order of the type sought by PATHA would ever be available. I do not think that the circumstances here are so exceptional that I can or should make an order directing the Minister to advise the Governor-General to amend or repeal the regulations. Such an order would potentially pit the Court against the Executive Council, and I do not think it is constitutional.

[184] I am prepared, however, to grant interim relief in a different form. That is because that the timing of the regulations coupled with the lack of notice that a ban was contemplated had the effect of taking PATHA and the whole transgender community by surprise. It prevented PATHA seeking interim relief under s 15 of the Judicial Review Procedure Act. Such relief would have been relatively unexceptional given the lack of any apparent urgency in bringing a ban into effect. As I have said, puberty blockers are reversible; they have no apparent adverse health effects in the short term.

[185] Standing back and looking at the overall justice of the situation, a delay in enforcement of the regulations is the best option now available. The potential for lack of enforcement is likely to be relied on only in extreme circumstances, but it is the potential for an extreme circumstance to arise that persuades me that there must be some path available for a clinician to decide to prescribe puberty blockers in the period before the judicial review can be heard.

Result

[186] The application for interim relief is granted.

[187] I make a declaration that the Crown should take no steps to enforce the Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations 2025 and the Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2) 2025 pending the judicial review being determined.

[188] The judicial review should be heard with all possible urgency.

Suppression

[189] PATHA applies for permanent name suppression of the medical witnesses.

[190] Because of the need to release this decision as a matter of urgency I reach the view that the issue of permanent name suppression should be dealt with at the same time as the judicial review hearing.

[191] I grant interim suppression of the names of the witnesses referred to in this decision as Dr A and Dr B pending further order of the Court.

[192] I order pursuant to r 5(2) of the Senior Courts (Access to Court Documents) Rules 2017 that the court file in this proceeding and all the material contained therein is not to be accessed nor searched without the written permission of a Judge of this Court.

Costs

[193] I direct the parties to attempt to agree costs.

[194] If costs are not agreed, I grant leave for the filing of submissions as to costs in the usual way.

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Wilkinson-Smith J