

**NOTE: PUBLICATION OF NAMES, ADDRESSES, OCCUPATIONS OR
IDENTIFYING PARTICULARS OF YOUNG PERSONS AND THEIR
FAMILIES PROHIBITED.**

**ORDER PROHIBITING PUBLICATION OF NAMES, ADDRESSES, OR
IDENTIFYING PARTICULARS OF DRS A, B AND C.**

**ORDER THAT COURT FILE NOT TO BE SEARCHED WITHOUT THE
LEAVE OF A JUDGE OF THIS COURT. ANY APPLICATION FOR ACCESS
TO COURT FILE TO BE REFERRED TO PARTIES TO THE PROCEEDING.**

**IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY**

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

**CIV-2025-485-000869
[2026] NZHC 3248**

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

HUMAN RIGHTS COMMISSION |
TE KĀHUI TIKA TANGATA
Interested Party

Hearing: 13-15 July 2026

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Judgment: 21 October 2026

JUDGMENT OF LA HOOD J

Table of Contents

Introduction	[1]
Summary of parties' arguments	[8]
Summary of decision	[11]
Matters not in dispute	[12]
The legislative framework	[22]
<i>The purpose of the Medicines Act 1981</i>	[22]
<i>Relevant regulation making power</i>	[29]
Factual background	[39]
<i>The lead up to the Minister's decision</i>	[39]
<i>The Minister's decision</i>	[49]
<i>The parties' evidence</i>	[56]
<i>Overseas position</i>	[61]
<u>United Kingdom</u>	[62]
<u>Australia</u>	[65]
<u>Canada (including Alberta)</u>	[69]
<u>Europe</u>	[73]
Grounds of review	[78]
Ground one: failure to consult	[80]
<i>Submissions on issue (a): was there consultation on the proposed regulations?</i>	[83]
<u>PATHA</u>	[83]
<u>The Crown</u>	[86]
<i>Assessment of issue (a): was there consultation on the proposed regulation?</i>	[93]
<i>Submissions on issue (b): were the required bodies consulted?</i>	[108]
<u>PATHA</u>	[108]
<u>The Crown</u>	[109]
<i>Assessment of issue (b): were the required bodies consulted?</i>	[112]
Ground two: wrong decision-maker	[118]
<i>Submissions</i>	[118]
<u>PATHA</u>	[118]
<u>The Crown</u>	[133]
<i>Assessment</i>	[137]
Ground three: improper purpose	[148]
<i>Submissions</i>	[148]
<u>PATHA</u>	[148]
<u>The Crown</u>	[150]
<i>Assessment</i>	[152]
Some further legal principles applicable to the remaining grounds	[175]
<i>Overlapping grounds of review</i>	[176]
<i>Assessment of reasonableness/rationality</i>	[178]
<i>Material mistake of fact</i>	[181]
<i>Post-decision evidence</i>	[182]
<i>Approach to review when assessing Bill of Rights compliance</i>	[185]

Order of consideration of the remaining grounds	[189]
Ground eight: s 19 of the Bill of Rights (discrimination)	[192]
<i>Legal principles</i>	[192]
<i>Submissions on discrimination on the grounds of disability</i>	[203]
<u>PATHA</u>	[203]
<u>The Crown</u>	[216]
<i>Assessment of discrimination on the disability ground</i>	[220]
<u>Differential treatment or effects</u>	[220]
<u>Disadvantage</u>	[227]
<i>Justification</i>	[229]
<u>Margin of appreciation</u>	[229]
<u>Assessment of justification</u>	[233]
Grounds five to seven: ss 8, 9 and 10 of the Bill of Rights	[246]
<i>Ground five: s 8 (right to life)</i>	[248]
<i>Ground six: s 9 (torture or cruel treatment)</i>	[257]
<i>Ground seven: s 10 (medical experimentation)</i>	[262]
Grounds four and ground nine: mistake of fact, irrationality and failure to take into account mandatory relevant considerations	[263]
Conclusion and relief	[266]
Name suppression	[270]
Costs	[275]

Introduction

[1] The Professional Association for Transgender Health Aotearoa Inc (PATHA) challenges the lawfulness of regulations prohibiting new prescriptions of puberty blockers for the treatment of young people with gender-related health needs. PATHA says the decision to promulgate the regulations was a discriminatory and grossly disproportionate response to the potential harm caused by puberty blockers, and was made in breach of consultation obligations and fundamental rights. The Minister says that the regulations were an appropriate precautionary response to the potential harm caused by puberty blockers that aligns with the approach taken in other countries.

[2] In early 2024, the Ministry of Health advised the then Minister of Health, the Hon Minister Shane Reti, on potential regulatory options in relation to the prescribing of puberty blockers for young people. The Ministry noted that puberty blockers should remain available as a treatment option and endorsed current best practice, namely a cautious approach of prescribing with supervision from a multi-disciplinary team.

[3] In November 2024, the Ministry, on the direction of Minister Reti, engaged in public consultation on whether there should be additional safety measures for the

prescribing of puberty blockers in young people with gender-related health needs. The majority of public submissions opposed further restrictions on the prescribing of puberty blockers.

[4] In July 2025, the Minister of Health (the Minister), the Hon Simeon Brown, presented four potential regulatory options at a Cabinet meeting. A decision was made to prohibit new prescriptions of puberty blockers for young people, but to allow those who had already been prescribed them to continue to receive them.

[5] On 17 November 2025, the Minister exercised his power to recommend the Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations 2025 (the Regulations) be made by Order in Council.¹ The Regulations prohibited new prescriptions of puberty blockers to treat gender dysphoria or gender incongruence in children and adolescents. However, the prescription of puberty blockers remained available to pause puberty for young people with other medical conditions, and for use in gender-affirming care for those who had been prescribed them prior to the Regulations.

[6] The Regulations were due to come into effect on 19 December 2025. On 1 December 2025, PATHA applied for judicial review of the Regulations and an interim order directing the Minister to take all necessary steps to suspend the regulations pending further order of the Court. The application for interim relief was heard as a matter of urgency on 9 December 2025.

[7] In a decision delivered on 17 December 2025, Wilkinson-Smith J made interim orders preventing enforcement of the Regulations.² The Court of Appeal granted special leave to appeal but determined that the orders made were sufficiently effective to allow continued prescribing pending final resolution of this application for judicial review.³

¹ The Regulations were subsequently amended on 1 December 2025 to clarify that the restriction did not apply to adults but rather children and adolescents with gender dysphoria: see Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations (No 2) 2025.

² *Professional Association for Transgender Health Aotearoa Inc v Minister of Health* [2025] NZHC 4045.

³ *Professional Association for Transgender Health Aotearoa Inc v Minister of Health* [2026] NZCA 8.

Summary of parties' arguments

[8] PATHA says that its comprehensive challenge to the lawfulness of the Minister's decision reflects the significance of the decision for the young transgender and intersex people who are being denied access to clinically appropriate and necessary medical care.

[9] PATHA's grounds of review include allegations that the Minister breached his consultation obligations, abdicated his decision-making power to Cabinet, acted for an improper purpose, made material mistakes of fact, and reached an irrational decision. PATHA further alleges the decision contravenes ss 8, 9, 10 and 19 of the New Zealand Bill of Rights Act 1990 (the Bill of Rights). PATHA seeks declarations that the Regulations are unlawful and in breach of the Bill of Rights and an order setting them aside.

[10] In response, the Crown says that the Minister did not err in his decision.⁴ The Minister undertook a comprehensive consultation process, set aside any public and political discourse to exercise his statutory responsibilities for a proper purpose, and made a reasonable decision which reflected the undisputed evidence and an appropriately cautious option available to him. The Crown further submits that the Regulations do not limit any of the rights affirmed in the Bill of Rights and is not discriminatory on the basis of sex or disability.

Summary of decision

[11] I have concluded below that the Minister's decision was unlawful and that the Regulations should be set aside. The following is a summary of my conclusions:

- (a) The Ministry's consultation process was insufficient to meet the consultation obligations in s 105 of the Medicines Act 1981. Those who were consulted would not have understood that the Ministry was contemplating or proposing a prohibition on new prescriptions for young people with gender incongruence or gender dysphoria. There

⁴ For convenience, I have referred to the submissions of counsel for the Minister as the submissions of the Crown.

was also an insufficient timing imperative to justify the failure to undertake consultation directly with gender diverse young people. The effect of the Ministry failing to consult on the substance of the Regulations combined with the failure to directly consult with gender diverse young people breached the obligation to consult.

- (b) The Minister did not abdicate his decision-making power to Cabinet. I am not in a position to reject the Minister's unequivocal evidence that he made a decision to advise the promulgation of the Regulations himself. It was not unlawful for him to consult and seek approval from Cabinet and the Cabinet Social Outcomes Sub-committee, given the Executive Council must also provide their consent and advice to the Governor-General before an Order in Council can be made.
- (c) The Minister did not act for an improper purpose of advancing New Zealand First's (NZ First) "anti-woke" agenda. I am not in a position to reject the Minister's evidence that he made his own independent decision to promulgate the Regulations based on his assessment of puberty blockers' limited effectiveness and the risk of harm. The Minister had a rational basis to reach a different conclusion from the Ministry on the material before him, particularly in light of the United Kingdom position following the findings of the Cass Review.
- (d) The Regulations breached the right to freedom from discrimination under s 19 of the Bill of Rights on the prohibited ground of disability. While there was a rational basis for the Minister to impose restrictions on access to puberty blockers for this cohort, a complete prohibition on new prescriptions was a disproportionate response. The indefinite prohibition was an unjustifiable limit on the right to freedom from discrimination, given the targeted cohort were young people who are at high risk of seriously poor health outcomes, particularly self-harm and suicide.

- (e) Whether there were breaches of ss 8 (the right to life), 9 (torture or cruel treatment) and 10 (medical experimentation) of the Bill of Rights raises novel and difficult issues about the scope of these rights. Definitive conclusions on those issues should be left to a case where it will be determinative of the outcome.
- (f) As I have concluded that the Minister's decision to promulgate the Regulations breached s 19 of the Bill of Rights because it was discriminatory and disproportionate, it is unnecessary to separately consider whether the decision would have been grossly disproportionate or irrational if s 19 had not applied.

Matters not in dispute

[12] It is helpful at this point to set out some of the essentially uncontested background evidence relating to the issues for determination in this case.

[13] Transgender is the term for a person whose internal sense of their sex/gender does not align with their sex assigned at birth (natal sex). The term may be used to include people who are non-binary, where their identities are not firmly either male or female and other gender diverse people. The term may also be used for those whose identities are fully "opposite" to their natal sex (trans women/girls and trans men/boys). Intersex is a term used for people who have innate variations in their physical sex characteristics compared to the majority of the population.

[14] Takatāpui is a term that provides a useful framework for Māori to refer to aspects of sexuality, gender and cultural identity. It embraces all Māori with diverse genders, sexualities and sex characteristics. "Takatāpui transgender" refers to Māori who are transgender, non-binary, gender diverse, pan gender, whakawahine (to become a woman) and whakatāne (to show manly qualities, to act like a man).

[15] Transgender can be shortened to "trans", but trans and transgender are descriptions of identity. They are not references to the process of having transitioned or someone who is transitioning. Transitioning is not a reference to transgender people "changing" their sex or gender. Transitioning refers to the steps people take to live in

the sex or gender to which they belong. This will usually involve “social transitioning” (such as changing their names and pronouns, dress and appearance, and voice training). It may or may not involve medical assistance (“medical transitioning”) to help their bodies become more congruent with their sense of self (such as hormone therapy, surgery and hair growth treatment). Gender diversity does not equate to sexual orientation, and transgender people may be heterosexual or not, depending on their individual orientation.

[16] Gender dysphoria is a series of clinical diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, relating to clinically significant levels of gender identity related distress in adults or children.⁵ Gender incongruence is a series of clinical diagnoses under the World Health Organisation’s *International Statistical Classification of Diseases and Related Health Problems Eleventh Revision* under the category of “conditions relating to sexual health”.⁶ It describes gender incongruence as “a marked and persistent incongruence between an individual’s experienced gender and the assigned sex”. The parties have agreed there is no material difference between gender dysphoria and gender incongruence for the purposes of this proceeding.

[17] Gender-affirming healthcare can refer to both healthcare interventions that relate to a person’s gender or transition, and an approach to healthcare more generally that is inclusive and affirming of a person’s gender identity. The medications subject to the Minister’s decision are gonadotropin-releasing hormone agonists (GnRH agonists).

[18] Gender-affirming hormone therapy involves the prescription of sex hormones (oestrogen and testosterone) as part of medical affirmation of gender. These are not the same as puberty blockers and are only available to adults or older adolescents (usually over the age of 16) as part of gender-affirming healthcare in New Zealand.

⁵ American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (5th ed, American Psychiatric Publishing, Arlington (VA), 2013) at 452–453.

⁶ World Health Organisation *International Statistical Classification of Diseases and Related Health Problems Eleventh Revision* (2019) at HA60.

[19] GnRH agonists cause temporary suppression of sex hormones. When they are administered to young people going into or experiencing puberty, the suppression of sex hormones pauses puberty. When the medication is stopped, sex hormones restart and puberty resumes. GnRH agonists are also used for adults for the same purpose — to suppress the production of sex hormones — but for different reasons (such as patients with cancer, endometriosis or for IVF treatments). Puberty blockers used as a part of gender-affirming care are usually prescribed for young people aged around 12 to 15 years. Some young adults who are clear in their identity may then (generally over the age of 16) choose to take less reversible sex hormones (oestrogen or testosterone) to support a puberty that aligns with their internal sense of their sex. Others will decide to experience a natural puberty and may opt for hormone therapy at a later date, or not at all.

[20] The Minister accepts transgender identities are real, that transgender people are part of the natural diversity of human existence, and that being trans is not pathological or a mental illness. The Minister also accepts that gender dysphoria and gender incongruence meet the definition of a disability in the Human Rights Act 1993.

[21] I have received a large volume of evidence relating to the use of puberty blockers in children and young people with gender dysphoria/incongruence. This is an area where strong and varied opinions are held both in New Zealand and globally. I accept the Crown’s submission that the strength of those views has led to calls, from those on both sides of the debate, for opposing views to be dismissed or invalidated without proper consideration of the scientific evidence or the best interests of the children and young people involved.⁷ I have been provided with comprehensive expert evidence and other evidence in this case to assist my understanding of the context of the Minister’s decision. The evidence is also said to be relevant to the

⁷ See Hilary Cass *Independent review of gender identity services for children and young people: Final report* (National Health Service England, April 2024). Baroness Dr Hilary Cass observed in her review: “Despite the best intentions of everyone with a stake in this complex issue, the toxicity of the debate is exceptional. I have faced criticism for engaging with groups and individuals who take a social justice approach and advocate for gender affirmation and have equally been criticised for involving groups and individuals who urge more caution. The knowledge and expertise of experienced clinicians who have reached different conclusions about the best approach to care are sometimes dismissed and invalidated. There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour. This must stop.” [Cass Review].

specific issues I am required to determine. However, I note that it is neither possible nor appropriate for me to attempt to resolve the differences in expert opinion on this complex and important issue. My role in these judicial review proceedings is to provide a constrained supervisory assessment of whether the Minister misconstrued his statutory power, acted unreasonably, committed procedural errors or contravened fundamental rights.⁸

The legislative framework

The purpose of the Medicines Act 1981

[22] The long title to the Medicines Act 1981 is “[a]n Act to consolidate and amend the law relating to the manufacture, sale, and supply of medicines, medical devices, and related products.”

[23] PATHA submits that as the Medicines Act is a technical piece of legislation with no express purpose statement, but is part of a suite of health-related legislation, its overall objectives can be discerned from the purpose section of the Healthy Futures (Pae Ora) Act 2022 (Healthy Futures Act):⁹

The purpose of this Act is to provide for the public funding and provision of services in order to—

- (a) protect, promote, and improve the health of all New Zealanders; and
- (b) achieve equity in health outcomes among New Zealand’s population groups, including by striving to eliminate health disparities, in particular for Māori; and
- (c) build towards pae ora (healthy futures) for all New Zealanders; and

...

[24] PATHA says other relevant provisions and policy statements include the health sector principles in s 7, the Government Policy Statement (GPS) issued under s 34 of the Healthy Futures Act, the Health Strategies issued under ss 41 to 46A, and the New

⁸ Philip A Joseph *Joseph on Constitutional and Administrative Law* (5th ed, Thomson Reuters, Wellington, 2021) at [22.1] citing *Stevenson v Office of Police Commissioner* [2015] NZHC 1408 at [6].

⁹ Medicines Act 1981, s 3. At the time of the hearing, the Act was called “Pae Ora (Healthy Futures) Act 2022”. Following the Healthy Futures (Pae Ora) Amendment Act 2026, the English and Māori phrasing of the legislation’s title was swapped.

Zealand Health Plan issued under s 50. These further confirm the goals of improving health outcomes and health equity, with a specific focus also on suicide prevention, especially youth suicide.¹⁰

[25] The Crown says the Medicines Act regulates the approval, classification, manufacture, distribution, advertising, and prescribing of medicines,¹¹ and the underlying purpose of the controls is the protection of public safety in the use of medicines.¹²

[26] The Crown notes the Healthy Futures Act is concerned with the long-term strategic direction and health needs of the overall health system. The Healthy Futures Act creates a new structure and accountability arrangements, such as establishing Health New Zealand/Te Whatu Ora (Te Whatu Ora) and de-establishing the District Health Boards. It sets out relevant health principles that apply to decisions made under that Act, and requires strategies to be developed. The Crown says the Healthy Futures Act does not deal with the detail of regulating medicines.

[27] I will return to the issue of the purpose of the Medicines Act when addressing the third ground of review, but I do not consider there is any material difference between the parties' positions. I accept the focus must be on the Medicines Act as the empowering statute. However, I also accept that the public safety powers in that Act should be exercised having regard to the overall purpose of the health system, expressly set out in the Healthy Futures Act, to protect, promote, and improve the health of all New Zealanders.¹³

¹⁰ For example, the Ministry of Health *Government Policy Statement on Health 2024-2027* (July 2024) at iii identifies suicide prevention as a “key priority”. The Ministry of Health *Every Life Matters — He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand* (September 2019) at 19 has a key action to increase wellbeing for children and young people, and recognises the particular issues faced by Māori and rainbow young people. At 20, the sixth action area has a strong focus on both promotion of wellbeing and prevention, especially “responding to suicidal distress”. The Health New Zealand Te Whatu Ora *New Zealand Health Plan Te Pae Waenga 2024-2027* (August 2025) at 16 similarly recognises that self-harm and suicide are one of the “biggest contributors to health loss” for children and young people, and that suicide particularly affects the rainbow community (at 24). The New Zealand Health Plan confirms that suicide prevention is a key government priority (at 24).

¹¹ *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health* [2021] NZHC 1107, [2021] NZAR 173 at [10].

¹² *New Health New Zealand Inc v Attorney-General* [2015] NZHC 2138, [2015] NZAR 1513 at [34].

¹³ Healthy Futures (Pae Ora) Act 2022, s 3(a).

[28] The Medicines Act is not a purely public protection statute aimed at regulating and curbing harm from otherwise lawful activity known to cause harm. Examples of such statutes include the regulation of the harm caused by smoking via the Smokefree Environments and Regulated Products Act 1990, regulation of gambling-related harm via the Gambling Act 2003, and regulation of alcohol-related harm via the Sale and Supply of Alcohol Act 2012.¹⁴ In contrast, the Medicines Act is concerned with promoting and protecting the health of New Zealanders through the regulation and approval of medicines. This necessarily entails balancing the potential benefits of a medicine against the risk of harm to ensure the public has access to effective and safe medicines.

Relevant regulation making power

[29] Section 105(1)(d) of the Medicines Act relevantly provides:

- (1) The Governor-General may from time to time, by Order in Council made on the advice of the Minister tendered after consultation with such organisations or bodies as appear to the Minister to be representative of persons likely to be substantially affected by the regulations, make regulations for all or any of the following purposes:

...

- (d) prohibiting, limiting, restricting, or imposing conditions on, either generally or in relation to particular cases or classes of case, or particular descriptions or classes of medicines, or particular classes of person, the prescribing, manufacture, packing, labelling, administration, sale, or supply of medicines pursuant to any provision of this Act:

[30] The Regulations in this case relevantly restrict any new prescriptions of GnRH agonists after 19 December 2025 as follows:¹⁵

44BA Restriction on prescribing gonadotropin-releasing hormone analogues

- (1) An authorised prescriber must not prescribe a prescription medicine that is a gonadotropin-releasing hormone analogue for the purpose of puberty suppression in a person who is a child or adolescent with—
 - (a) gender incongruence; or

¹⁴ See *One Foundation Ltd v Minister of Internal Affairs* [2023] NZHC 3869; *Woolworths New Zealand Ltd v Auckland Council* [2023] NZSC 45, [2023] 1 NZLR 113; and *B v Waitemata District Health Board* [2017] NZSC 88, [2017] 1 NZLR 823.

¹⁵ Medicines Regulations 1984.

- (b) gender dysphoria.
- (2) *See* Part 2 of Schedule 1AA for a transitional provision in respect of this regulation.

...

Schedule 1AA

...

Part 2

Provision relating to Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations 2025

3 Application of restriction in regulation 44BA

The restriction in regulation 44BA does not apply in respect of a person who has been prescribed a prescription medicine that is a gonadotropin-releasing hormone analogue for a purpose described in regulation 44BA before 19 December 2025.

[31] PATHA notes that the use of s 105(1)(d) of the Medicines Act to prohibit new prescriptions of an approved medicine to a specified cohort is unprecedented. This is confirmed by the Ministry of Health’s briefing paper to the Minister dated 3 April 2025, which explained: “Making regulations ... in order to manage clinical decision-making in relation to a particular medicine or class of medicines has not occurred before, except for controlled drugs under the Misuse of Drugs Act”.

[32] PATHA further notes that the Ministry’s Regulatory Impact Statement (RIS) dated July 2025 expresses the concern in stronger terms:

[This option will result in significantly] less trust and confidence in the health sector. A particular treatment using a medicine would be prohibited through regulation for the first time. There are many examples of other medicines used with a similar amount of evidence and/or even with much greater evidence of harm, without regulation. Regulatory exceptions also risk undermining the system.

[33] Section 21 of the Medicines Act sets out the procedure for approval of medicines. Medsafe is the responsible authority for approving medicines in accordance with the terms of the application made by the pharmaceutical manufacturer.

[34] Approval is given based on the specifics of a Medsafe-approved “data sheet”, which details what clinical indications the medicine can be used for, the approved population groups, and the approved mode(s) of administration. These reflect what has been applied for by the pharmaceutical company, not necessarily any limitation imposed by Medsafe. Any deviation from any of those specific matters will be an “unapproved” or “off-label” use.

[35] Section 25 of the Medicines Act allows the use of an unapproved or “off-label” use of an approved medicine. That provision sets out a general exemption to authorised prescribers to prescribe or administer medicines to “a particular patient of that authorised prescriber”, without any stated restrictions. The restrictions and constraints operating under s 25 are the clinical standards of care and professional and ethical obligations of practitioners operating within their scope of practice, including the Code of Health and Disability Services Consumers Rights.¹⁶ Prescribing an approved medicine for an unapproved or “off-label” use is different from prescribing an unapproved medicine (a medicine that has not been through the Medsafe approval process at all).¹⁷

[36] There is no dispute that “off-label” prescription is very common, especially in areas such as endocrinology, paediatrics, mental health and obstetrics. GnRH agonists have been in clinical use since the early 1980s. They have been in clinical use in New Zealand for young people with gender dysphoria or gender incongruence for around 15 years.

[37] There are two main GnRH agonist medicines approved for use in New Zealand: leuprolide/leuprorelin and goserelin. While both are similarly effective in suppressing sex hormones, only leuprolide/leuprorelin is approved for use in young people, and only for precocious puberty. Neither medicine is approved for use for young people for any other indication. Almost all uses of GnRH agonists for young people in New Zealand are off-label. Goserelin is generally not used for precocious puberty because of unwelcome side effects in administration.

¹⁶ Established by the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996.

¹⁷ This is still possible under ss 29 and 29A of the Medicines Act, but the supplier must notify the Director-General of Health (delegated to Medsafe) when this occurs under s 29B.

[38] The uses of GnRH agonists for children and young people (all off-label) include:

- (a) To pause puberty to improve final height for children with normally-timed puberty (short stature).
- (b) To pause puberty for young people with catamenial (hormone sensitive) epilepsy.
- (c) To pause puberty for young people with endometriosis or polycystic ovary syndrome.
- (d) To pause puberty for gender diverse young people who are suffering distress with the appearance of sex characteristics different to those aligned with their sense of their gender.
- (e) To pause puberty for young people with innate variations of sex characteristics (young intersex people) who are suffering distress with the appearance of sex characteristics different to those aligned with their sense of their gender.

Factual background

The lead up to the Minister's decision

[39] In 2022, the Ministry undertook a formal review of the latest scientific evidence regarding the impact of puberty blockers on clinical and mental health and wellbeing outcomes in adolescents with gender dysphoria. The review was published in the form of an evidence brief (Evidence Brief). The review was commissioned in response to correspondence received by the (then) Minister of Health, the Hon Andrew Little, which expressed concern about the safety and reversibility of puberty blockers when prescribed for gender incongruence. The Office of Chief Clinical Officers within the Ministry of Health considered that, while the review was being undertaken, the Ministry should remove from its website a statement that puberty blockers are “safe and reversible”.

[40] The Evidence Brief found that evidence about the impact of puberty blockers on clinical and mental health and wellbeing outcomes is scarce, with available evidence largely of poor quality. It found that for young people taking puberty blockers, bone mineral density was lower than what is expected for an individual's age or stage of pubertal development, when compared to a control group. Cardiometabolic outcomes were reported varyingly with some studies reporting a change in blood pressure, lipids and body composition. There was "no evidence" of any effect on renal function, liver function, onset of diabetes, executive function, or fertility, although the Evidence Brief did not include any studies examining fertility in "assigned females at birth" individuals.

[41] The Evidence Brief noted there was some evidence that indicated a significant improvement in depression, anxiety, and suicidal ideation, however, the quality of the evidence was low with a high risk of bias. Non-medical interventions were also said to show improvements in mental health and wellbeing of gender-dysphoric adolescents, but these generally relied on small, localised cohorts, making it difficult to extrapolate to other, larger cohorts.

[42] Overall, the Evidence Brief found:

... significant limitations in the quality of evidence for either the benefits or risks (or lack thereof) of the use of puberty blockers. This means there is insufficient basis to say that puberty blockers are safe or reversible (or not) for use as an intervention for gender dysphoria in adolescents.

[43] On 10 April 2024, the final report of the Cass Review was published in the United Kingdom. The report found that there was insufficient evidence about the long-term risks and benefits of the use of puberty blockers to suppress puberty early in children or adolescents with gender dysphoria or incongruence.¹⁸ This prompted emergency changes in the United Kingdom to restrict the prescribing of puberty blockers.

[44] Following the Cass Review, the Ministry provided a brief to the then Minister of Health, the Hon Dr Shane Reti, that puberty blockers should remain an available

¹⁸ A summary of the Cass report is set out at [168]–[170] below.

treatment option. After reviewing advice on potential regulatory options, Minister Reti decided to proceed with a regulatory option.

[45] In October 2024, Minister Reti submitted a paper to the Cabinet Business Committee and then Cabinet's Social Outcomes Sub-committee (SOU Sub-committee) proposing restrictions on prescribing. It states that access needs to be preserved for "children and young people with gender dysphoria who are at high risk of significant poor health outcomes if they do not receive puberty blockers as part of gender affirming care". On 13 November 2024, this sentence was removed on a tracked change version of the paper attached to an email from the Minister's office to officials. The email says that the changes "incorporate the discussion at the SOU and have been run past both NZ First and ACT".

[46] On 18 November 2024, Cabinet agreed to limit access to new prescriptions to a clinical trial only and directed public consultation.

[47] On 21 November 2024, the Ministry published its Position Statement on the use of puberty blockers in gender-affirming care (Position Statement) based on its Evidence Brief and addendum. The Position Statement endorsed current best practice, namely a cautious approach of prescribing with supervision from a multi-disciplinary team. The addendum included the final report of the Cass Review. The Ministry also announced 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.

[48] The public consultation occurred between 21 November 2024 and 20 January 2025. Consultation involved an online survey, targeted focus groups and an opportunity to email the Ministry. In relation to the targeted focus groups, the Ministry engaged with specific organisations and groups likely to be affected by any further safety measures, including PATHA. The Ministry received 5,800 online responses and 2,800 email submissions. The majority of the submissions opposed further restrictions on prescribing puberty blockers.

The Minister's decision

[49] In January 2025, Minister Brown became the Minister of Health. The Ministry briefed the Minister on the results of the consultation and provided the Minister with a draft Cabinet paper. The paper contained six options that generally supported continued prescribing with increasing levels of control and oversight.

[50] On 31 July 2025, the Minister provided a final paper to Cabinet, which included four options:

- (a) Option A: adopting the current baseline of close monitoring and adjustment.
- (b) Option B: adopting the baseline with pre-planned trigger points for further action.
- (c) Option C: regulating to prohibit new prescribing and at the same time increase other services.
- (d) Option D: adopting new legislation to create structures and processes to restrict prescribing.

[51] The RIS attached to the paper stated that Option A (status quo) best met policy objectives. It also stated that Option C carried high risk of adverse health outcomes, and significant loss of trust and confidence in the health sector.

[52] On 10 September 2025, the Minister chaired a meeting with the SOU Sub-committee on the proposed policy options. Following this, a decision was made to advance Option C. The SOU Sub-committee also directed the Minister to engage with Te Whatu Ora on increasing other gender-related health support services.

[53] The Ministry provided the Minister with three options for increasing support services. On 12 November 2025, the SOU Sub-committee and the Minister decided to implement a fourth option to not increase support services and instead create an online hub with links to existing services.

[54] On 17 November 2025, the Minister provided advice to the Government Administrator (acting in place of the Governor-General) to promulgate the Regulations. The Regulations were due to come into effect on 19 December 2025.

[55] On 19 November 2025, the Associate Minister of Health, the Hon Casey Costello, announced that the government had decided to ban new prescriptions of puberty blockers for people with gender dysphoria or gender incongruence. This was followed by an announcement from Minister Brown that “Cabinet has agreed to introduce new safeguards on the prescribing of [puberty blockers].”

The parties’ evidence

[56] PATHA has filed evidence from a number of experts, which is directed at the mistake of fact ground of review and alleged breaches of the Bill of Rights. PATHA’s evidence also includes 16 affidavits from 15 families with transgender children (one of the affidavits is from a transgender young person), who are or would have been directly affected by the Regulations.

[57] The Crown’s evidence consists of various affidavits, including three from Minister Brown. The Crown also provided expert evidence from Dr Alison Clayton and Emeritus Professor Charlotte Paul.¹⁹

[58] PATHA says that Dr Clayton and Emeritus Professor Paul had no involvement in the Minister’s decision, and they are neither qualified in endocrinology or paediatric medicine, and neither of them have ever been involved in prescribing this medicine.

[59] PATHA submits that the Minister has not answered any of the substantive questions and inferences raised in PATHA’s evidence about the decision-making process and the reasons for it. It says that the Crown has not given any explanation as to why Medsafe had no involvement in the Minister’s decision, or why no advice was sought from Medsafe or its expert advisory bodies. PATHA highlights that no

¹⁹ Dr Clayton is a Melbourne-based psychiatrist and psychotherapist. PATHA notes that she is affiliated with the Society for Evidence-Based Gender Medicine, a United States organisation that has been named as an anti-LGBTQI+ hate group by the Southern Poverty Law Centre. Emeritus Professor Paul is a retired public health expert.

evidence has been adduced from the Ministry's Gender Identity Expert Advisory Committee. Nor is there any evidence from key Ministry officials who advised the Minister on the decision or evidence from qualified staff members from the Ministry or Te Whatu Ora.²⁰

[60] PATHA submits that the Crown has not provided any evidence in response to PATHA's expert evidence, including on the impacts of the Regulations on the affected cohort and their whānau. It says that the one exception relates to safety information about the use of puberty blockers for cisgender young people compared to their use for transgender and intersex young people. This is addressed by PATHA's experts, Professor Hofman and Dr Cate Rayner.²¹

Overseas position

[61] The Minister's evidence is that his decision arose from aligning New Zealand with comparable overseas jurisdictions. I will therefore briefly summarise the approach taken in the UK, Australia, Canada (including Alberta) and Europe.

United Kingdom

[62] In December 2024, the United Kingdom decided to prohibit the supply of puberty blockers for the treatment of gender incongruence/dysphoria indefinitely in people aged under 18 years following the Cass review. The exception is prescribing as part of a clinical trial. The United Kingdom intends to review the indefinite prohibition in 2027.

[63] The National Health Service England (NHS) has also set up additional gender care services for young people (focused on providing biopsychosocial and psychological support and intervention) and announced funding for a clinical trial. Recruitment to the trial was delayed until 1 August 2026 due to the commencement of

²⁰ However, there is one affidavit from a Mr Steven Barnes, an Associate Deputy Director-General of Health, who gives evidence relating to the November 2024–January 2025 consultation process in which he was involved.

²¹ Professor Hofman is a paediatric endocrinologist with 35 years' experience prescribing puberty blockers, mainly for cisgender young people. Dr Rayner is a consultant paediatrician and adolescent physician and Head of Department, Adolescent Medicine, at The Royal Children's Hospital Melbourne.

judicial review proceedings that ultimately held that the decisions to approve the trial were lawful.²²

[64] After New Zealand's enactment of the Regulations, the NHS further restricted access to gender-affirming care by prohibiting new prescriptions for masculinising or feminising hormones until a final policy on prescriptions has been determined. Young people aged 16 or 17 years who are already receiving a prescription will continue to have access to the hormone therapy, and prescriptions in the private sector will remain available.

Australia

[65] In most Australian states and territories, the prescription of puberty blockers for people aged under 18 years of age requires consent from the young person, the treating clinician and all parties who have parental responsibility for the young person.

[66] In January 2025, the Queensland state government issued a healthcare directive restricting any new prescribing of puberty blockers for gender incongruence/dysphoria in people under 18 years for 12 months pending a services review. In December 2025, the State government published the findings of the independent review (the Vine Report) and announced that the restriction would remain in place until the results of the United Kingdom clinical trial are known in 2031. The restriction applies to prescriptions in the public health system, but prescribing will remain available in the private sector.

[67] The Vine Report reviewed the use of puberty blockers and gender-affirming hormones in the public health system. The Report agreed with the "near consensus among international reviews" that the evidence base underlying use of puberty blockers or gender-affirming hormone treatment for young persons with gender dysphoria is limited.²³ It concluded that:²⁴

²² *R (Bayswater Support Group and others) v Health Research Authority* [2026] EWHC 2043 (Admin).

²³ Ruth Vine and others *Independent Review Advice Report: Advice and evidence base regarding policy options for the use of puberty suppression (Stage 1) and gender affirming (Stage 2) hormones for children and adolescents with gender dysphoria in Queensland's public hospital system* (Queensland Health, 28 November 2025) at 36.

²⁴ At 14–15.

After analysing the evidence base, we have concluded that no overall positive risk-benefit decision for either PB [puberty blockers] or GAHT [gender affirming hormone treatment] may be made that applies to every young person with gender dysphoria in Queensland. Rather, that assessment will differ for each individual, and must be informed by each individual's presentation and circumstances, and their personal values and preferences.

Evidence reviews have found some (though limited) evidence of benefit in the short to medium term. They have found little evidence to support longer term psychosocial benefit. There is also not good evidence for harm in the short or medium term and little evidence of harm in the long term.

[68] Following the approach in Queensland, the Northern Territory Government announced in December 2025 that it would no longer fund access to puberty blockers and gender-affirming hormone treatment for those under 18 years of age through the public health system.

Canada (including Alberta)

[69] Canada (except for Alberta) is generally consistent with pre-Regulations best practice prescribing in New Zealand. The prescription of puberty blockers remains available through clinical processes involving individuals and their families as part of comprehensive gender-affirming care.

[70] In 2024, the Government of Alberta announced a ban on all gender-affirming treatments for people under the age of 18 (including prescribing of sex hormones as well as puberty blockers). In June 2025, the Court of King's Bench of Alberta granted an injunction to prevent the ban from coming into effect in *Egale Canada v Alberta*.

²⁵ The Judge held:²⁶

I find that there will be irreparable harm to gender diverse youth if an injunction is not granted. The evidence shows that the Ban will cause irreparable harm by causing gender diverse youth to experience permanent changes to their body that do not align with their gender identity. There is nothing speculative about this evidence.

[71] In November 2025, the Government of Alberta invoked the “notwithstanding clause” in the Canadian Charter of Rights and Freedoms to override the injunction and a partial ban was restored.

²⁵ *Egale Canada v Alberta* 2025 ABKB 394.

²⁶ At [205].

[72] The present position in Alberta is that clinicians are prohibited from initiating puberty blockers or cross-sex hormone therapy in anyone under 16 years of age with gender incongruence, with limited exceptions. These include:

- (a) A young person who has started puberty blockers or hormone replacement therapy for the treatment of gender dysphoria or gender incongruence on or before the date the ban came into effect.
- (b) A young person aged 16 or 17 may be prescribed puberty blockers or hormone replacement therapy for the treatment of gender dysphoria or gender incongruence with parental, physician and psychologist approval.

Europe

[73] Most European countries have emphasised consent processes and have continued to support professional guidance that promotes the range of supportive and mental health services that should be provided by a multidisciplinary team with puberty blocking treatment remaining an option.

[74] Practice guidelines in France (August 2024) support prescribing as part of a personalised approach that takes into account the needs of each young person. The French guidelines specifically address the issue of absence of long term data on the benefits and risks of puberty blockers:²⁷

... every new therapeutic proposal in medicine, and particularly in pediatrics, raises the question of the absence of long-term data. Moreover, a wait-and-see attitude in adolescence does not reduce psychological distress, increases the risk of committing suicide and can affect psycho-affective and cognitive development.

²⁷ François Brezin and others “Endocrine management of transgender adolescents: Expert consensus of the french society of pediatric endocrinology and diabetology working group” (2024) Archives de Pédiatrie at 2.

[75] The joint German, Swiss and Austrian Guidelines published in June 2025 support the continued availability of puberty blockers, and explicitly reject the more restrictive approach taken in the Cass Review.²⁸

[76] The Polish expert consensus published in February 2025 supports continued prescribing, and is particularly critical of the Cass Review.²⁹

[77] In Sweden, puberty blocking treatments can only be used in a clinical trial except in very exceptional circumstances. In Norway and Finland, puberty blockers may be used after non-medical options have been explored and deemed insufficient. Denmark has similarly shifted to a preference for non-regulatory supportive counselling over puberty blockers.

Grounds of review

[78] PATHA advances the following nine grounds of review:

- (a) Ground one: the Minister breached his consultation obligations under the Medicines Act.
- (b) Ground two: the Minister abdicated his decision-making power to Cabinet.
- (c) Ground three: the Minister acted for an improper purpose.
- (d) Ground four: the Minister made material mistakes of fact or failed to take into account mandatory relevant considerations.
- (e) Ground five: the Minister's decision contravened s 8 of the Bill of Rights, namely the right not to be deprived of life.

²⁸ German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy *Gender incongruence and gender dysphoria in childhood and adolescence: diagnosis and treatment* (2025).

²⁹ Aneta Gawlik-Starzyk and others "Framework guidelines for the process of caring for the health of adolescent transgender (T) and non-binary (NB) people experiencing gender dysphoria — the position statement of the expert panel" (2005) 76 *Endokrynologia Polska*.

- (f) Ground six: the Minister's decision contravened s 9 of the Bill of Rights, namely the right not to be subjected to torture or cruel treatment.
- (g) Ground seven: the Minister's decision contravened s 10 of the Bill of Rights, namely the right not to be subjected to medical or scientific experimentation.
- (h) Ground eight: the Minister's decision contravened s 19 of the Bill of Rights, namely the right to be free from discrimination.
- (i) Ground nine: the Minister's decision was unreasonable/irrational.

[79] I will address the first three grounds in order, but for reasons explained below, I will address the alleged breach of s 19 of the Bill of Rights before turning to the remaining grounds of review.

Ground one: failure to consult

[80] Section 105 of the Medicines Act provides that regulations may be made on the advice of the Minister "tendered after consultation with such organisations or bodies as appear to the Minister to be representative of persons likely to be substantially affected by the regulations".

[81] PATHA says the duty to consult under s 105 was not complied with for two reasons:

- (a) The consultation that occurred was not on the proposed regulations. The Ministry never indicated that a regulation prohibiting new prescriptions of puberty blockers for young people with gender dysphoria or incongruence was an option being considered.
- (b) The consultation did not include any body or person representative of the young people affected by the Regulations.

[82] I will deal with each of these issues separately.

Submissions on issue (a): was there consultation on the proposed regulations?

PATHA

[83] The consultation process commenced on 21 November 2024 and ended on 20 January 2025. The consultation started with the Ministry publishing its Evidence Brief, addendum and Position Statement, which supported continued prescribing and endorsed current best practice (a cautious approach with a multidisciplinary team). At the same time, the Ministry announced that the government had directed them to undertake a consultation on whether the new precautions in the Position Statement should be backed up by additional safeguards such as regulations to strengthen these changes in prescribing expectations.

[84] PATHA says that none of the Ministry's consultation documents indicated that a prohibition on new prescriptions was under consideration (probably because it was not under consideration, at that stage); nor was this option proposed by the Ministry during the consultation meetings.

[85] The Crown submits that the various references in the written consultation to "restrictions" on prescribing would have been understood as including a prohibition on new prescriptions. PATHA says that that interpretation is not open to the Minister on the evidence. The PATHA witnesses who attended the meetings are all unequivocal that they did not consider references to restrictions included the potential for a prohibition on new prescriptions. This is confirmed, PATHA says, by the absence of contradictory evidence from Dr Joe Bourne, the Chief Medical Officer at the Ministry, who led the consultation meetings for the Ministry.

The Crown

[86] The Crown submits the Ministry undertook a comprehensive consultation over a two-month period in relation to proposed safety measures, including regulatory measures under s 105 of the Act.

[87] The Crown notes that where a consultation duty is provided for in legislation, the question is what the statute requires for it to be fulfilled.³⁰ The degree and nature of consultation required will be case-specific,³¹ and the content of a statutory obligation to consult will be affected by the context.³²

[88] The Crown says that from the beginning of the consultation, the Ministry explained that a further safety measure could be a regulation restricting the prescribing of puberty blockers in the context of gender-affirming care, without affecting prescribing for other conditions.

[89] The Crown notes the consultation form explained that the further measures being considered includes the option of regulations that could legally restrict prescribing of puberty blockers, such as a regulation made under the Medicines Act.

[90] The Crown highlights that slides presented at the meetings that explained the purpose of the consultation was to inform what, if any, further safety measures were required for prescribing of puberty blockers in the context of gender-affirming care. The slides stated that one option was to make regulations that could legally restrict who can prescribe puberty blockers and who may receive a prescription for puberty blockers; that prescribing for other indications, including precocious puberty and endometriosis, would continue; and that some groups of children and young people with gender-related health needs may still need access. At the 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:
 - your organisation and professionals you represent?

³⁰ GDS Taylor Judicial Review: A New Zealand Perspective (4th ed, LexisNexis, Wellington, 2018) at [13.86], citing *Port Louis Corporation v Attorney-General of Mauritius* [1965] AC 1111 (PC).

³¹ Ross Carter, Jason McHerron and Ryan Malone *Subordinate Legislation in New Zealand* (LexisNexis, Wellington, 2013) at 238 (citations omitted).

³² *New Zealand Pork Industry Board v Director-General of the Ministry for Primary Industries* [2013] NZSC 154, [2014] 1 NZLR 477 at [168].

- children and young people with gender-related health needs?

...

[91] In addition to the meetings, the Ministry provided an opportunity for public submissions. The Ministry heard from generally concerned citizens, as well as members of the transgender community.

[92] The Crown says that it is incorrect for PATHA to describe the regulations as a “ban” because puberty blockers remain available for other clinical indications and for those already receiving them. However, it accepts that what is provided for in the regulations is properly described as a prohibition on new prescriptions for the affected cohort (young people with gender dysphoria or incongruence). This is unsurprising given this is the way it is described in the Ministry’s own documents. For example, in the final regulatory impact statement dated July 2025, the document describes Option 4 as “regulations under s 105(1)(d) of the Medicines Act would be put in place to provide for an *immediate prohibition on new prescribing*” (emphasis added). The Crown says the decision to prohibit new prescriptions was within what the Ministry described in its consultation documents as “regulations to restrict prescribing”. This is because prescribing is still available for other clinical indications and for those already prescribed puberty blockers.

Assessment of issue (a): was there consultation on the proposed regulation?

[93] There are a number of problems with the Crown’s submission that those consulted would have understood that a prohibition on new prescriptions was in contemplation by the Ministry’s references to restrictions on prescribing.

[94] First, s 105(1)(d) draws a distinction between “prohibiting” and “restricting”, by providing that regulations may be made “prohibiting, limiting, restricting, or imposing conditions on” medicines.

[95] Second, the consultation was expressly only in relation to the prescribing of puberty blockers for gender-affirming care in young people. Thus, the inference is that any “restriction” would allow some continued prescribing for those in the targeted cohort rather than some other cohort to which the consultation did not apply. In other

words, the clear inference is that any “restriction” would allow for some continued prescribing for gender incongruence/dysphoria.

[96] Third, the Ministry’s consultation slides indicated that a “restriction” would still allow for some prescribing for gender incongruence/dysphoria. The slides stated that one option is to make regulations restricting who can prescribe puberty blockers and who may receive a prescription for puberty blockers. I accept that the final statement on the same slide that “some groups of children and young people with gender-related health needs may still need access” might suggest that something akin to a prohibition on new prescriptions for gender-affirming care was in contemplation, but the preceding statements make this ambiguous. Indeed, the Ministry’s April 2025 document summarising the consultation responses states:

People generally told us the regulatory proposal was unclear, and this made it difficult to provide feedback on potential impacts and design. It was raised that it was unclear whether regulations would aim to reduce medical risks or to stop poor prescribing practices.

[97] Fourth, it is only a very technical interpretation of the regulations that would allow them to come within the concept of a “restriction”. The Crown says the Regulations are a restriction rather than a prohibition because they do not apply to young people already receiving puberty blockers. However, the wording of the Regulations and the Ministry’s own materials do not support the Crown position. Regulation 44BA uses the language of a prohibition, namely that a “prescriber must not prescribe” the medicine. Regulation 44BA is then modified in sch 1AA, pt 2, cl 3, to clarify that it does not apply to a person who has already been prescribed the medicine.³³ Further, the 31 July 2025 Cabinet paper, prepared by the Ministry, describes “Option C” as “Regulate to *prohibit puberty blocker prescribing* to treat gender incongruence or dysphoria in *new patients* ...” (emphasis added). Thus, the Ministry’s own description of what is now contained in the Regulations was a *prohibition* on puberty blocker prescribing in new patients.

³³ I note that the Schedule 1AA, pt 2, cl 3 describes r 44AB as a “restriction” rather than a “prohibition”, but as I have said, r 44AB employs the language of a prohibition, which is then modified by cl 3.

[98] Fifth, the documentary record supports the proposition that a prohibition on new prescription was not consulted on because it was not actually in contemplation at the time. The November 2024 Cabinet minute does not contemplate a total prohibition on prescription for new patients. As noted above, the final version of the paper following input from ACT and NZ First, removed the option of preserving access for those at high risk of significant poor health outcomes, but still referred to preserving access as part of an approved clinical trial. Further, I accept PATHA's submission that the Ministry's consultation did not even reflect this position. As noted above, the Ministry's announcement (strengthening the prescribing expectations in the Position Statement) provides no hint of what Cabinet had decided. There was also an important change made to the proposals to be consulted on. Cabinet originally directed consultation on the question: "which groups of young people with gender-related health needs, *if any*, should be able to access puberty blocking treatment" (emphasis added). The wording was later changed in the consultation documents to: "which young people should be able to receive treatment with puberty blockers for gender dysphoria?".

[99] Sixth, PATHA's evidence is clear that those who attended did not consider a prohibition on new prescriptions was in contemplation. There is no evidence from any Ministry official who attended the consultation meetings to contradict that evidence.

[100] The Crown submits it was clear from the responses received that many people understood that the Ministry was contemplating the proposal that is now contained in the Regulations. For example, PATHA said they were concerned that any measures that restricted access would have a significant impact on families. This view was shared by groups who said there may be increased harm for young people who wish to access puberty blockers as part of their gender-affirming care and are unable to due to restrictions. The problem with this submission is that these concerns clearly addressed restricted access rather than a proposal that went as far as prohibiting new prescriptions.

[101] The high point of the Crown's argument is a sentence in PATHA's written submission to the Ministry during the consultation process. Under the heading "Effect

of Restricting Puberty Blockers”, PATHA addressed the consultation question posed by the Ministry, namely: “If prescribing of puberty blockers is restricted by regulation, how might this affect you and/or the people that you represent?”. PATHA said that restricting access would lead to consequences which are lifelong, irreversible and significantly harmful to transgender young people. It said that this applies whether that restriction is in the form of restricting who can prescribe them, who is eligible for them or through other means. Throughout this part of the submission PATHA repeatedly refers to the consequences of “restricting” access to puberty blockers. However, at one point it says: “[b]anning or restricting access to puberty blockers would go against best-practice recommendations from major medical bodies”.

[102] I do not accept the Crown submission that this single reference to a “ban” in the full context of this submission is inconsistent with PATHA’s position in these proceedings. If anything, the form of the question posed by the Ministry, and repeated reference to the word “restriction” in PATHA’s reply, tends to support its position. I also accept PATHA’s submission that the well-known calls for a ban from certain groups both in New Zealand and overseas explain this single reference to a ban.

[103] I therefore accept that those consulted would not have understood that regulations prohibiting new prescriptions for the affected cohort were proposed or in contemplation.

[104] This leaves the issue of whether the proposal actually consulted on (restrictions that would allow some access to those not already receiving puberty blockers) was sufficiently similar to the regulations that it could still amount to consultation “on the regulations”. I am unaware of any authority directly on point.

[105] In *One Foundation Ltd v Minister of Internal Affairs*, the Court of Appeal upheld a statutory consultation process in respect of regulations made under the Gambling Act 2003.³⁴ The process involved a requirement to consult with “representative” bodies who received the draft regulations but did not extend to other bodies who could be considered “interested persons”.³⁵ In any event, the interested

³⁴ *One Foundation Ltd v Minister of Internal Affairs* [2025] NZCA 500.

³⁵ At [21] and [24].

bodies that did not receive the draft regulations had previously been provided with material that set out the substance of the draft regulations.³⁶ They also had the opportunity to submit on an earlier discussion document that formed part of the policy development for the regulations. Thus, all bodies had been consulted on the substance of the regulations.³⁷

[106] I accept PATHA's submission that, irrespective of the technicalities, what occurred cannot be considered consultation on the substance of the regulations. I consider those consulted would have contemplated restrictions on who could prescribe and be prescribed puberty blockers, and in what circumstances, but not a total prohibition on new prescriptions for gender-affirming care. A prohibition on new prescriptions was a far more serious and concerning step than anything that had been proposed. It has deprived vulnerable young people suffering from the acute symptoms of a clinically recognised mental disorder of *any* access to a medicine that has the overwhelming clinical support of the medical profession in appropriate cases.

[107] I accept that had there been consultation on the substance of the regulations, those consulted are likely to have made materially different submissions, including providing some of the extensive expert material now provided in these proceedings, or taken steps to obtain pre-emptive declaratory relief in the High Court.

Submissions on issue (b): were the required bodies consulted?

PATHA

[108] PATHA submits that where the Ministry planned a consultation process to meet its obligation but failed to complete it, this is a strong indication that the obligation has not been met. Cabinet directed that there should be consultation with gender diverse young people, including rangatahi Māori and young Pasifika people, and families and whānau of gender diverse young people. This was critical consultation that the Ministry accepts did not occur. Thus, even if the consultation had related to the substance of the Regulations, the requirements of s 105 were not met.

³⁶ At [28] and [33].

³⁷ At [42].

The Crown

[109] The Crown highlights that s 105 requires consultation with “such organisations or bodies *as appear* to the Minister to be representative of persons likely to be substantially affected by the regulations”. This means the Minister was required to act reasonably in selecting who to consult. He had the discretion as to the material he would provide as part of the consultation and the extent of the opportunity he would afford to be heard.³⁸

[110] The Crown says the Ministry identified and met with several groups who represented persons likely to be substantially affected by the regulation, including PATHA. The other groups included: NZ Parents and Guardians of Transgender and Gender Diverse Children (NZPOTC); Qtopia;³⁹ RainbowYOUTH;⁴⁰ the Gender Identity External Advisory Group (an independent external group that provides advice to the Director-General of Health on current issues relating to gender identity services); and regulatory authorities including the Medical Council of New Zealand, the New Zealand Psychologists Board, and medical and nursing colleges.

[111] The Crown accepts that the Ministry had planned to hold specific sessions for gender-diverse young people and their families and that these did not proceed. They did not occur due to stakeholder groups advising that the online group format was not a safe or appropriate forum for those young people and their families. The Ministry also explored the possibility of engaging with young people via focus groups facilitated by the Children's Commissioner. However, the Crown says the available timeframes were insufficient to design and deliver sessions that would be appropriate.

Assessment of issue (b): were the required bodies consulted?

[112] There is a Cabinet minute dated 18 November 2024 recording Cabinet's decision to consider regulations that restricted the prescription of puberty blockers. The minute states that Cabinet agreed, among a list of other groups, that:

³⁸ *New Zealand Airline Pilots' Association Industrial Union of Workers Inc v Director of Civil Aviation* [2016] NZHC 1528 at [155].

³⁹ Qtopia is an advocacy, social change, and social support service for the LGBTQIA+ rainbow community. It is based in Ōtautahi Christchurch.

⁴⁰ RainbowYOUTH is a registered charity that provides support services and peer support to young rainbow youth aged 13-27.

... the Ministry should consult on any proposed regulation with groups representative of:

...

13.3 gender diverse young people, including rangatahi Maori and Pacific young people;

13.4 families and whānau of gender diverse children and young people;

...

[113] The records of meetings with rainbow support organisations establish that those organisations made it clear they did not represent or speak on behalf of this community. The Ministry accepted that position and attempted to arrange an appropriate process to meet with those who could speak as representatives of this cohort, including offers of assistance from the Children’s Commissioner. However, the Ministry decided that there was insufficient time to set up these meetings before the consultation was due to finish under the time frame it was working to. I accept PATHA’s submission that there was no actual timing imperative for the Ministry to complete the consultation process by January 2025 given the decision to promulgate the Regulations was not made until September 2025.

[114] I also accept PATHA’s submission that it was insufficient for the Ministry to rely on responses received, via the public consultation “form”, from persons who said they were gender diverse and/or had gender diverse family members. The Ministry had no processes in place to assess or authenticate these claims. It is also difficult to see how these individual submissions could amount to consultation with organisations or bodies that could speak as representatives of gender diverse young people or families of gender diverse young people. The Ministry itself did not consider this to be the case and said in its consultation summary document (dated April 2025) that public consultation “was intended to inform the context in which the consultation was occurring.” Moreover, in the 18 November 2024 minute Cabinet described public consultation as providing an opportunity for “the general public” to express their views, in addition to the targeted consultation with the affected communities.

[115] I do not need to consider whether the Ministry’s failure to follow through with the process of directly consulting with gender diverse young people would on its own

have been sufficient to render the Regulations in breach of s 105 given my findings on issue (a). I accept the Crown submission that consultation cannot continue indefinitely and there must be a point at which the Minister can be reasonably satisfied that the obligation has been met. However, I also accept that once Cabinet and the Ministry correctly identified this was a cohort that should be consulted under s 105, and was aware of a process that would enable consultation to take place, stronger evidence of a timing imperative would be required to justify the failure to undertake the consultation.

[116] Ultimately, the question I must determine is what the consultation obligations in the statute required as a matter of procedural fairness. The overall question is whether the consultation obligation has been fairly and reasonably met.

[117] I am satisfied that the combined effect of the failings under issues (a) and (b) of this ground of review mean the Ministry's consultation was insufficient to meet the requirements of s 105. I will return to address the appropriate relief for this breach later.

Ground two: wrong decision-maker

Submissions

PATHA

[118] Section 105 provides that the "Governor-General may from time to time, by Order in Council made on the advice of the Minister ..." make regulations.

[119] PATHA says the Regulations are unlawful because they were made by the wrong decision-maker. PATHA argues that Cabinet made the decision to make the Regulations, rather than the Minister. Even though the Minister implemented that decision by providing the required advice to the Governor-General, he was acting under the directions of Cabinet.

[120] PATHA accepts that under s 105 Cabinet has a role to play. However, as Te Whatu Ora recorded in an email to the Ministry on 4 October 2024, it is highly unusual for Cabinet to be involved in decisions regarding the operational details of the

Medicines Act. PATHA says, in accordance with the Cabinet Manual 2023, if the Minister considers that a matter warrants engagement by Cabinet, then referral to Cabinet may be appropriate. But obtaining endorsement from Cabinet to a proposed course of action is a different matter from asking Cabinet to make a decision instead of the Minister. PATHA submits a decision made by the Minister and endorsed by Cabinet may be an appropriate exercise of a statutory decision-making role, but a decision made by Cabinet *instead* of the Minister is not.

[121] PATHA says this is not a superficial distinction, especially in this case, because the Minister has responsibility for the statutory powers he exercises under the Medicines Act. He has the benefit of advice from the Ministry and is assumed through the exercise of his responsibilities to have a level of understanding and exposure to expert advice to allow him to make informed decisions. As a Minister, he is accountable to the House of Representatives for his decisions, and answerable to the Court in any challenge to the lawfulness of the exercise of those powers. In contrast, Cabinet exists only by convention and has no legal powers and no formal accountability.⁴¹ Conventions of Cabinet confidentiality and collective responsibility make its decision-making processes obscure, and it has no obligation to give reasons for its decisions. Further, the supervisory jurisdiction of the High Court over Cabinet decisions is limited.⁴²

[122] PATHA says that the Cabinet Manual makes it clear that where a statute vests a decision-making power in the Minister, the role of Cabinet is to be informed of the intended decision. This allows “the Minister’s colleagues to understand the basis on which the Minister intends to make the decision, and to defend the decision publicly and collectively.”⁴³ The Cabinet Manual further states:⁴⁴

Special considerations apply to protect the integrity of the statutory decision-making process when a Minister brings an item to Cabinet on a statutory decision or action they intend to make. Cabinet cannot make, or appear to make, a decision that the statute requires a Minister to make. Accordingly:

⁴¹ Cabinet Office *Cabinet Manual 2023* at [5.3].

⁴² *Richards v Attorney-General* [2025] NZHC 2833, [2025] 3 NZLR 440 at [65]–[69]; and *MKD v Minister of Health* [2022] NZHC 1997 at [95]–[97].

⁴³ Cabinet Office *Cabinet Manual 2023* at [5.35].

⁴⁴ At [5.36].

- (a) the Cabinet paper should be presented in the form of an informative briefing for Ministers;
- (b) Cabinet may provide a forum for Ministers other than the decision-maker to comment on and provide information on the intended decision, but the decision-making Minister may legitimately take into account only the information and comments that are relevant; and
- (c) the Minister's intended decision should be noted rather than agreed by Cabinet.

[123] PATHA says it is clear from the documentary record that the decision was made by Cabinet's SOU Sub-Committee at the meeting on 10 September 2025 (and later endorsed by Cabinet), and not by the Minister either before, during or after that meeting.

[124] PATHA relies on the following evidence in support of this submission. The Minister's Cabinet paper to the SOU Sub-Committee of 31 July 2025 outlined four options, with no recommended option by the Minister. The Minister expressly states in the paper that "I propose that [the] Ministers decide on which of four policy options should be implemented ...". The RIS annexed to the Cabinet Paper similarly says that "[t]he Minister of Health does not have a preferred option". The minutes of the SOU Sub-Committee meeting on 10 September 2025 record that four policy options were put forward by the Minister, and that the Committee agreed to regulate to prohibit puberty blockers to treat gender incongruence or dysphoria in new patients (Option C). That minute further records that the Committee authorised the Minister to make further decisions about the detail of the Committee's decision, including issuing drafting instructions for regulations. The subsequent Cabinet paper authorising the submission of the Regulations to the Executive Council and the 12 November 2025 minute deciding against any increase in support services for gender diverse young people who would be affected, both similarly refer to the SOU Sub-Committee having made this decision back on 10 September 2025.

[125] PATHA says other records at the time are consistent with the conclusion that the Minister did not make the decision. In particular the media release by the Hon Casey Costello (NZ First and Associate Minister of Health, and a member of the SOU Sub-Committee) stated that the decision only happened because NZ First "fought for it", indicating that NZ First was centrally instrumental in the decision. This is

further confirmed by the social media posts by the Hon Winston Peters (also a member of the SOU Sub-Committee), who similarly stated that the decision was due to NZ First's "commonsense" campaign: "Promise made. Promise kept." The Minister's own press release on 19 November 2025 announced: "Cabinet has agreed to introduce new safeguards on the prescribing of [puberty blockers] ...".

[126] Further, PATHA submits that the Minister's evidence on this point is not credible, and should not be accepted by the Court. PATHA says the Minister's first affidavit filed in December 2025 in opposition to application for interim orders initially aligns with the contemporaneous records, but becomes slightly ambiguous towards the end.

[127] The Minister's initial evidence is that he "made the decision to recommend to Cabinet that it agree to progress policy *options*" (PATHA places emphasis on the fact that "options" is plural). PATHA says this is correct as the Minister set out four options (although PATHA notes that one of the options was the status quo). He then goes on to say: "[i]n this affidavit I describe how and why I made the decision to recommend regulatory action, as an option, to Cabinet". PATHA accepts that these statements are not technically inconsistent with the record if they are understood to mean that the Minister's proposed options included regulatory action, but he did not recommend any of the other options.

[128] PATHA says that the Minister makes a subtle shift in his evidence when he says he recommended policy options (plural) to Cabinet and:

chaired discussions with my Cabinet colleagues ... The outcome of that discussion was strong support for restriction of prohibit (sic) puberty blocker prescribing ... This decision is recorded in the Cabinet sub-committee minute...

[129] PATHA says this is consistent with the record, but the Minister appears to claim that he made the decision, apparently at some (unrecorded) point in time after the Cabinet meeting, informed by the consensus reached at the meeting.

[130] PATHA submits that, in his second affidavit, intended to be the full "duty of candour" affidavit, the Minister's evidence is less ambiguous but now wholly

inconsistent with the contemporaneous record. The Minister describes what happened at the SOU Sub-Committee meeting on 10 September 2025, in terms that do not reflect the minutes of that meeting. The Minister's evidence now appears to be that his Cabinet paper, while on its face inviting Cabinet to make a decision between four options, was in fact a consultation document to seek the views of his colleagues. According to this second affidavit, the SOU Sub-Committee meeting that followed was in the nature of a consultation discussion rather than a decision-making process by the Committee. PATHA says it is notable that the Minister was unable or unwilling to make a decision during the process, throughout 2025, of receiving advice and preparing his advice to Cabinet, and went into the meeting proposing that his colleagues make the decision. However, he now says that at some point during the meeting he changed his mind about this, made up his mind on which option he preferred, and made the decision himself to regulate to prohibit future prescriptions.

[131] PATHA submits that this means the Court has not heard any evidence about the actual decision. The Minister has not given evidence about what happened at the Cabinet meeting, and how Cabinet reached this decision. Nobody else has given evidence about how the decision was reached, and there is only one other source of information: the press release and social media posts from the two other Ministers who were at the meeting, the Hon Casey Costello and the Hon Winston Peters.

[132] PATHA says the Minister has given no explanation of the differences between his first affidavit, his second affidavit, his own media release, his papers to Cabinet and the Cabinet Secretary's record of the meeting. The Minister has also not addressed the contrary public statements by the Hon Casey Costello and Hon Winston Peters that this decision by the SOU Sub-Committee was the result of NZ First's political clout as a coalition partner, despite this being a matter directly at issue in the case. PATHA says they were all matters within the Minister's knowledge, and it is not satisfactory for these matters to be left to be addressed through submissions of counsel. PATHA argues that this does not comply with the duty of candour to ensure that "disclosures

and evidence are full and frank and that the relevant decision and the reasons for it are transparent.”⁴⁵

The Crown

[133] The Crown notes that the Governor-General is empowered to make regulations under s 105 of the Act on the advice of the Minister, and on the advice and with the consent of the Executive Council.⁴⁶ However, the Minister cannot unilaterally advise the Governor-General. The Executive Council must also provide their consent and advice to the Governor-General before an Order in Council may be made,⁴⁷ which by constitutional convention, may only be given with the approval of Cabinet. The necessary implication is that the Minister required the consensus of Cabinet before he could recommend the making of the Regulations to the Governor-General.

[134] Further, the Crown notes that one of the options under consideration by the Minister was restricting prescribing by way of primary legislation. This option would also have required the consensus of Cabinet. Thus, there was nothing improper with the Minister consulting with his Cabinet colleagues in coming to his decision to advise the making of the Regulations.

[135] The Crown says that while the Minister required the agreement of Cabinet before he could advise the Governor-General to promulgate the regulations, that does not result in an abdication of discretion. The Minister is clear in his evidence that he came to his decision to progress the regulations during a meeting with his Cabinet colleagues on 10 September 2025.

[136] The Crown says the Minister took into account the range of views of his colleagues, the feedback he had received from organisations and bodies representative of those substantially affected by such a regulation, as well as the Ministry’s recommendation to adopt a non-regulatory option. Despite that, the Minister decided

⁴⁵ *Wallace v Chief Executive of the Department of Corrections* [2023] NZHC 2248 at [9]. Also see *New Zealand Fishing Industry Association Inc v Minister of Agriculture and Fisheries* [1988] 1 NZLR 544 (CA) at 554 and 568; and *Healthcare Providers New Zealand Inc v Northland District Health Board* HC Wellington CIV-2007-485-1814, 7 December 2007 at [166].

⁴⁶ Constitution Act 1986, ss 3A and 3B.

⁴⁷ Sections 3A and 3B.

that the uncertainty of harm required a cautious approach in line with the approach taken in other jurisdictions. As the Minister notes in his affidavit, he recognised that he was ultimately responsible for deciding whether to advance the regulatory option and he did so.

Assessment

[137] I accept the Crown's submissions that there was nothing improper in the Minister consulting Cabinet. The Minister of Health cannot unilaterally advise the Governor-General. The Executive Council must also provide their consent and advice to the Governor-General before an Order in Council may be made.⁴⁸ By constitutional convention, that consent may only be given with the approval of Cabinet.⁴⁹

[138] I accept the Crown's submission that PATHA's emphasis on the passage of the Cabinet Manual addressing how a Minister should bring statutory decisions to Cabinet is misplaced.⁵⁰ The passage indicates that where a Minister is exercising a statutory power, this should only be presented to Cabinet for noting (rather than seeking Cabinet's approval). I accept the Crown submission that the guidance appears to relate to matters that are solely within the discretion and control of the Minister. As the Crown notes, examples would be where the Minister is empowered to exercise a statutory power in their own capacity, such as issuing a notice, or making some other administrative decision within their discretion.⁵¹

[139] Where a Minister proposes to advise the Governor-General to make regulations by Order in Council, that appropriately requires the approval of Cabinet. The Cabinet Manual states:⁵²

In some cases, a Minister's statutory decision can be effected only by the Governor-General acting on the advice and with the consent of the Executive Council. The Executive Council is the formal institution through which the government collectively advises the Governor-General, and it is Cabinet that

⁴⁸ Sections 3A and 3B.

⁴⁹ Cabinet Office *Cabinet Manual 2023* at [1.40]. However, in some rare cases, there are matters which are submitted directly to the Executive Council, for instance where the item for submission is to give effect to the determinations of a statutory body (see [1.41]). That is not the case here.

⁵⁰ Cabinet Office *Cabinet Manual 2023* at [5.34]–[5.37].

⁵¹ For example, the cancellation of an individual's passport under s 27GA of the Passports Act 1992, or to issue a surrender order under s 50 of the Extradition Act 1999.

⁵² Cabinet Office *Cabinet Manual 2023* at [5.38].

authorises the submission of items to the Executive Council. An individual Minister, therefore, can take an item to Executive Council only with Cabinet's collective agreement ...

[140] I also accept the Crown's submission that a requirement to obtain the agreement of Cabinet before advising the Governor-General to make regulations increases rather than reduces accountability. The requirement to gain the support of Cabinet increases the level of political accountability and scrutiny of the proposed regulations before they are promulgated.⁵³ Here, there was the additional factor that one of the proposed options was to legislate, which clearly would have required Cabinet approval. I also accept that, in this context, the Minister was entitled to consult with Cabinet's SOU Sub-Committee. A decision-maker does not fail to exercise their discretion by seeking consultation and advice,⁵⁴ especially in circumstances where those consulted must ultimately agree with the decision.

[141] Although there was nothing unlawful about consultation with, and seeking agreement from, Cabinet's SOU Sub-Committee, the Minister was still required to come to his own decision that he should advise promulgation of the Regulations.

[142] Despite the Minister's Cabinet paper referring to the Ministers collectively deciding on which policy option to pursue, the Minister's evidence is that he made his decision during the meeting, in consultation with his colleagues. His evidence indicates that he recognised he was ultimately tasked with making the decision, and he says that he did so. However, he says it was also necessary for him to understand the consensus of his Cabinet colleagues, as the Regulations required the approval of Cabinet, as would the enactment of primary legislation if that was the option he opted to pursue. The Minister is clear in his evidence that he came to his decision to progress

⁵³ At [5.24]: "The principles of collective responsibility underpins the system of Cabinet government. It reflects democratic principle: the House expresses its confidence in the collective whole of government, rather than in individual Ministers. Similarly, the Governor-General, in acting on ministerial advice, needs to be confident that individual Ministers represent official government policy. In all areas of their work, therefore, Ministers represent and implement government policy."

⁵⁴ Joseph, above n 8, at [23.3.4(3)], citing *Wellington International Airport Ltd v Commerce Commission* HC Wellington CP151-02, 31 July 2002 at [46], and *Walsh Pharmaceutical Management Agency* [2010] NZAR 101 (HC) at [161]. Joseph notes that consultation undertaken by a decision-maker may be acceptable even where a statute explicitly provides that a decision-maker must act "independently" in coming to their decision, citing *Elston v State Services Commission* [1979] 1 NZLR 193 (SC).

the Regulations during the SOU Sub-Committee meeting with his Cabinet colleagues on 10 September 2025.

[143] The applicant initially filed an application to cross-examine the Minister but that was not progressed. This was because the Crown confirmed that if PATHA established an evidential foundation for the Court to reject the Minister's evidence, it would not rely on the absence of cross-examination to suggest that the Court cannot reject parts of the Minister's affidavit.

[144] PATHA submits that I should reject the Minister's evidence that he came to the decision himself as untrue because it is contradicted by the documentary record. However, I am not satisfied that I can reach that conclusion on the material before me and having heard no oral evidence from the Minister. I do not accept that media releases by political colleagues in a coalition Government are a sound basis for doing so. As already noted, in this context, there was nothing unlawful about taking into account the views of Cabinet colleagues at the SOU Sub-Committee meeting and seeking their approval (which was required in any event), provided the Minister also made a decision to advise the making of the Regulations himself, which he says he did.

[145] The fact that the SOU Sub-Committee's agreement on the appropriate option was sought and reached, does not mean the Minister, who chaired the meeting, failed to come to an independent decision about progressing regulations informed by the Committee's views. In addition to regulating, the policy options being considered included both the status quo and legislating. The Minister's evidence is that there was no point making a recommendation to the Governor-General to regulate without Cabinet's approval because by convention Cabinet's approval would be required. He says that through his discussions in the 10 September 2025 meeting and taking into account a range of views, he decided to progress the proposal that became the Regulations.

[146] I also do not accept that the Minister's failure to provide the details of confidential Cabinet discussions is in breach of his duty of candour simply because there is no separate record of his decision. I was referred to no authority in support of

this proposition and I think it would seriously undermine the important policy considerations underpinning Cabinet confidentiality.⁵⁵ The duty of candour did not require the Minister to breach Cabinet confidentiality in the course of providing the reasons for his decision.

[147] I am therefore unpersuaded that I should reject the Minister’s evidence that he made a decision to advise the promulgation of the Regulations himself, or that there was anything unlawful about his decision to consult and seek agreement from Cabinet’s SOU Sub-Committee.

Ground three: improper purpose

Submissions

PATHA

[148] There is some overlap between ground two and ground three. Under ground three, PATHA says that the Minister was required to make any decision under s 105 based on clinical evidence relating to the risks, benefits and effectiveness of medicines. PATHA submits that instead the Minister made the Regulations for non-clinical reasons, namely to advance NZ First’s anti-trans, “anti-woke”, “commonsense” fundraising and voter support campaign, and/or as part of a political deal between coalition partners.

[149] Alternatively, PATHA says there was simply no clinical evidence whatsoever to support the Minister’s decision and thus it cannot have been made in accordance with s 105.

The Crown

[150] The Crown says the Medicines Act focuses on the safety and efficacy of medicines,⁵⁶ and that the Regulations fall squarely within that purpose. The Crown

⁵⁵ Cabinet Office *Cabinet Manual 2023* at [5.23] and [3.82]; and see Joseph, above n 8, at [10.5.1(c)]: “Ministers must be able to speak freely in Cabinet and contest their views vigorously, without fear of recrimination. Knowledge that cabinet discussions may be disclosed to media would inhibit free and frank debate.”

⁵⁶ *New Health New Zealand*, above n 12, at [34].

submits there was poor evidence available on the benefits and harm arising from use of puberty blockers for the treatment of gender dysphoria/incongruence. Therefore, the Minister took a precautionary approach and restricted the use of puberty blockers until further evidence on the benefits and risks of the medications became available. The Minister considered the approach taken in international jurisdictions, particularly in the United Kingdom following the Cass Review, and will review the regulatory settings once the results of the United Kingdom clinical trial became available. The decision was also supported by the clinical evidence available to the Minister, including the Ministry's Evidence Brief, which considered the findings of the Cass Review.

[151] The Crown emphasises that Parliament has entrusted the Minister to make these decisions and not, for example, the Director-General of Health or a Medical Officer of Health. There is not a "best evidence available" test or an objective clinical standard which the Minister is required to meet. He is entrusted as a politically accountable Minister to make these decisions.

Assessment

[152] The starting point for whether a statutory power has been lawfully exercised under the empowering statute has recently been confirmed by the Supreme Court in *Climate Clinic Aotearoa Inc v Minister of Energy and Resources*:⁵⁷

It is well established that public decision makers must exercise statutory powers in accordance with, and to promote, the policy and objects of the relevant section and the statutory scheme of which that section is a part ...

[153] The Supreme Court referred to its previous decision in *Unison Networks Ltd v Commerce Commission*, where it said:⁵⁸

[50] ...[the] ultimate question is whether the [decision-maker] exercised its powers in accordance with the requirements of the statute. It must act within the scope of the authority conferred by Parliament and for the purposes for which those powers were conferred.

⁵⁷ *Climate Clinic Aotearoa Inc v Minister of Energy and Resources* [2025] NZSC 197, [2025] 1 NZLR 1021 at [51].

⁵⁸ *Unison Networks Ltd v Commerce Commission* [2007] NZSC 74, [2008] 1 NZLR 42 at [50]–[54].

[51] Public bodies must exercise their statutory powers in accordance with the statutes which confer them. If they make decisions that are outside the limits of their powers they abuse them. The courts control any misuse of public power through judicial review.

[52] It is unnecessary in this case to attempt a comprehensive description of all circumstances in which the exercise of a statutory power will amount to an abuse. Two conventional instances have been raised for consideration. The first is where the power is exercised for a purpose that is not within the contemplation of the enabling statute ...

[53] A statutory power is subject to limits even if it is conferred in unqualified terms. Parliament must have intended that a broadly framed discretion should always be exercised to promote the policy and objects of the Act. These are ascertained from reading the Act as a whole ...

[54] Ascertaining the purpose for which a power is given is an exercise in statutory interpretation which is not always straightforward. This is partly because legislative regimes differ in the specificity with which they grant powers. In this area the courts are concerned with identifying the legal limits of the power rather than assessing the merits of its exercise in any case. They must be careful to avoid crossing the line between those concepts.

[154] The Crown referred to authority that emphasises the need for the Court to exercise restraint when considering the lawfulness of policy decisions within the constitutional domain of the executive.⁵⁹ This raises a broader issue of the proper approach to judicial review in this case. PATHA says that the Court need not go beyond a traditional approach, and I need not apply any type of heightened or anxious scrutiny test to find the decision unlawful. However, PATHA does say that in the statutory context of the Medicines Act, the Minister's discretion was limited to a technical, evidence-based clinical decision about the safety and potential effectiveness of puberty blockers for gender-affirming care in young people.

[155] As I have said in other decisions,⁶⁰ I favour Cooke J's framing of the proper approach to judicial review, namely that the Court's role does not change depending on the context of the decision.⁶¹ Rather, the Court's role in every case is to ascertain

⁵⁹ *CREEDNZ Inc v Governor-General* [1981] 1 NZLR 172 (CA) at 197–198; *Movement v Waka Kotahi* [2023] NZHC 342 at [2]; and *All Aboard Aotearoa Inc v Auckland Transport* [2022] NZHC 1620 at [175], citing *Unison Networks*, above n 58, at [54].

⁶⁰ For example, *One Foundation*, above n 14; and *Kim v Minister of Justice* [2024] NZHC 3662 at [15].

⁶¹ A framing endorsed in at least one Court of Appeal decision and High Court decisions: *Christian Congregation of Jehovah's Witnesses (Australasia) Ltd v Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions* [2024] NZCA 128; [2024] 2 NZLR 534 at [29]; and *New Zealand Steel Ltd v Minister of Commerce and Consumer Affairs* [2021] NZHC 966 at [72].

the legal limits or controls on the power conferred by the statute.⁶² I prefer Cooke J's formulation to the use of terms such as deference or intensity of review, as it better reflects the Court's constitutional role. It is the lawful boundaries of a decision that vary between cases not the intensity with which the Court goes about its task. It seems to me this aligns with the Supreme Court's approach in *Climate Change* and *Unison*. I also note that the Supreme Court in *Chief of Defence Force v Four Members of the Armed Forces*, when discussing the approach to judicial review if protected rights are engaged, recognised that various descriptions are used for affording a margin of appreciation to a decision-maker, including deference, leeway, and weight.⁶³ The Court did not find it appropriate to insist that courts use particular language to describe its task.⁶⁴

[156] I consider this is no practical difference between Cooke J's framing and the language of intensity or review, deference, leeway or weight. The Court's role is to determine whether, having regard to the statutory scheme, the nature of the decision, the nature of the decision-maker, and any other applicable statutory or common law constraints (such as the Bill of Rights) the decision was either: within the legal limits imposed on the decision-maker (Cooke J's formulation), or within the margin of appreciation afforded to the decision-maker (the language adopted in *Four Members*), or whether the decision is lawful having regard to the appropriate intensity of review. These are essentially different ways of describing the same approach.

[157] Under this ground of review, I am not concerned with whether the Minister's decision complied with the Bill of Rights, or was irrational, or was based on material mistakes of fact (those grounds are addressed separately below). This ground of review is based solely on whether the decision was within the scope of the decision-making power conferred on the Minister under s 105 of the Medicines Act.

⁶² I agree with Cooke J that the Court's approach to judicial review is governed by the express and implied legal limits or controls on the power conferred by the statute: *Patterson v District Court, Hutt Valley* [2020] NZHC 259 at [14]–[16]; *New Zealand Council of Licensed Firearms Owners Inc v Minister of Police* [2020] NZHC 1456 at [83]–[85]; *Unison Networks Ltd v Commerce Commission*, above n 58, at [53]–[55]; and *One Foundation*, above n 14, at [14]–[17].

⁶³ *Chief of Defence Force v Four Members of the Armed Forces* [2025] NZSC 34, [2025] 1 NZLR 21 at [102].

⁶⁴ At [102].

[158] I accept PATHA’s submission that, unlike *Unison*, the Court in this case is not dealing with broadly expressed powers to achieve objectives which themselves are expansively expressed.⁶⁵ This is not a case about competing health funding priorities or the structure of how services are delivered. As already noted, it also can be contrasted with broad public protection powers aimed at regulating and curbing harm from otherwise lawful activity. This is a decision about how a particular medicine should be prescribed to a particular cohort of health consumers by clinicians acting within the scope of their practice and subject to their professional, clinical and ethical standards of practice.

[159] Further, as already noted, I accept that the s 105 power in the Medicines Act should be exercised having regard to the overall purpose of the health system, to protect, promote, and improve the health of all New Zealanders. It necessarily entails balancing the potential benefits of a medicine against the risk of harm to ensure the public has access to effective and safe medicines.

[160] However, I consider PATHA overemphasises the technical nature of the Minister’s decision and the level of justification required by the clinical evidence. I accept the Crown submission that there is no “best evidence available” test or an objective clinical standard that the Minister is required to meet. The Minister must have regard to expert advice but may be faced with competing and difficult clinical evidence. The Minister has been entrusted with making a complex and multi-factored predictive assessment that appropriately balances the potential benefits against the risk of harm. There is unlikely to be an obviously correct answer about allowing access to medicines where the clinical evidence is uncertain. Provided there is a rational basis for the Minister to conclude that restricting or prohibiting access to a medicine is required because the risk of harm outweighs the potential benefits, the decision will come within the scope of s 105.

[161] The Crown has relied on the well-established precautionary principle that decision-makers may take a measure to address a significant risk to public health even

⁶⁵ *Unison Networks*, above n 58, at [55].

if the evidence of harm and beneficial effect is uncertain.⁶⁶ However, application of that principle to these circumstances is difficult. The principle normally applies where a particular group is subjected to restrictions to provide wider public health benefits. For example, the regulation of alcohol and gambling, and the imposition of COVID-19 vaccine mandates.⁶⁷ I consider its application is fraught in a situation where the decision involves removal of access to medicines, which are themselves aimed at improving public health outcomes. Here, there is a risk of harm to a single group (rather than any wider public benefit) in both providing and removing access to the medicine. The Minister says it is a precautionary measure in the best interests of that group to prevent them having access to puberty blockers given the uncertainty about their effectiveness and the potential harm to that group. However, as the decision has not been made to protect the public generally from any adverse effects on people outside that group, and the adverse effects on the group can occur in both providing and removing access, I doubt that the precautionary principle adds anything to the weighing of potential benefits and risks required in this case.⁶⁸

[162] I have set out the approach to review based on the statutory context in some detail at this point because it is relevant to both this ground of review and the grounds that follow. However, under this ground of review, PATHA first asks me to reject the Minister’s evidence that he reached the decision based on his concerns about the effectiveness of puberty blockers and their potential harm. PATHA says he instead made a decision to promote NZ First’s “anti-woke” agenda irrespective of the clinical evidence. This argument faces the same hurdles as ground two. I am simply not in a position to reject the Minister’s evidence that he made his own independent decision to promulgate the Regulations based on his assessment of puberty blockers limited effectiveness and the risk of harm.

⁶⁶ *Wellington City Council v Woolworths New Zealand Ltd* [1996] 2 NZLR 537 (CA); *One Foundation*, above n 14; and *Four Members of the Armed Forces*, above n 63; and *R (on the application of Transactual CIC) v Secretary of State for Health and Social Care* [2024] EWHC 1936 (Admin) at [178]–[180].

⁶⁷ *Woolworths*, above n 66; *One Foundation*, above n 14; and *Four Members of the Armed Forces*; above n 63.

⁶⁸ I note that the England and Wales High Court applied the principle in *R (on the application of Transactual CIC) v Secretary of State for Health and Social Care*, above n 66, at [180], but that case involved circumstances that more clearly engage the precautionary principle: the use of an emergency power to address the potential harm from obtaining prescriptions from overseas providers using unethical and unsafe practices.

[163] Next, under this ground of review, PATHA says there was simply no clinical evidence to support the decision, which means it was not within the scope of s 105. PATHA highlights that the Ministry’s review of the evidence regarding overseas use of puberty blockers for treatment of gender incongruence gave detailed consideration to the Cass Review, the lack of research on long-term impacts, and the issue of “low quality” evidence on benefits and harms. Based on that review, the Ministry and its experts put together a formal Position Statement that endorsed continuation of the then current best practice of prescribing. Thus, PATHA submits, the Ministry, based on its expert review, did not consider that the evidence warranted a prohibition on prescriptions for new patients.

[164] PATHA further submits that Regulations that bring a high risk of adverse health outcomes to an already disadvantaged population group does not accord with the purpose of the Medicines Act, which is focused on *improving* health outcomes in accordance with the objectives and principles of the Healthy Futures Act. The Ministry advised that a prohibition on new prescriptions brought a high risk of adverse health outcomes for the affected cohort, as well as significant loss of trust and confidence in the health sector.

[165] I accept the Crown’s submission that this is not a situation where there was simply *no* clinical evidence to support the Minister’s decision. The Minister was not bound to accept the conclusions reached by the Ministry provided there was a rational basis to reach a different conclusion. The Minister says the Ministry’s review provided the evidential basis to reach a different conclusion. It highlighted the poor quality of evidence and the position taken in other countries, particularly the United Kingdom following the Cass Review.

[166] The Crown highlights that the High Court of England and Wales in *R (on the application of Transsexual CIC and another) v Secretary of State for Health and Social Care* has recently upheld United Kingdom Ministerial decisions to restrict access to puberty blockers for young people experiencing gender dysphoria or gender incongruence.⁶⁹ The statutory context of that decision was different to this case

⁶⁹ *R (on the application of Transsexual CIC and another) v Secretary of State for Health and Social Care and another*, above n 66.

because it involved a challenge to the use an emergency procedure to prohibit the sale, supply or importation of medicinal products “to avoid a serious danger to health”.⁷⁰ The power was exercised to prevent private and unregulated overseas prescriptions being issued to young people in a manner that would evade restrictions recommended by the Cass Review and implemented by the NHS.⁷¹

[167] The Court considered the clinical evidence, including the Cass Review, which it noted was an intensive review of existing research and that it had commissioned further research over a number of years.⁷²

[168] The Court set out the findings from the Cass Review Interim Report:

Medical pathways

80. The original rationale for use of puberty blockers was that this would buy ‘time to think’ by delaying onset of puberty and also improve the ability to ‘pass’ in later life. Subsequently it was suggested that they may also improve body image and psychological wellbeing.
81. The systematic review undertaken by the University of York found multiple studies demonstrating that puberty blockers exert their intended effect in suppressing puberty, and also that bone density is compromised during puberty suppression.
82. However, no changes in gender dysphoria or body satisfaction were demonstrated. There was insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychosocial wellbeing, cognitive development, cardio-metabolic risk or fertility.
83. Moreover, given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinising/feminising hormones, there is no evidence that puberty blockers buy time to think, and some concern that they may change the trajectory of psychosexual and gender identity development.
84. The Review’s letter to NHS England (July 2023)⁴ advised that because puberty blockers only have clearly defined benefits in quite narrow circumstances, and because of the potential risks to neurocognitive development, psychosexual development and longer-term bone health, they should only be offered under a research protocol. This has been taken forward by NHS England and National Institute for Health and Care Research (NIHR).
85. The University of York also carried out a systematic review of outcomes of masculinising/feminising hormones. Overall, the

⁷⁰ At [130].

⁷¹ At [11].

⁷² At [190].

authors concluded that “There is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow-up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health. There is suggestive evidence from mainly pre-post studies that hormone treatment may improve psychological health, although robust research with long-term follow-up is needed”.

86. It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion.
87. The percentage of people treated with hormones who subsequently detransition remains unknown due to the lack of long-term follow-up studies, although there is suggestion that numbers are increasing.
88. A problem, that has become increasingly apparent as the Review has progressed is that research on psychosocial interventions and longer-term outcomes for those who do not access endocrine pathways is as weak as research on endocrine treatment. This leaves a major gap in our knowledge about how best to support and help the growing population of young people with gender-related distress in the context of complex presentations.

[169] The Court then set out the following recommendations from the Cass Review Final Report:⁷³

- i) Clinicians should apply the assessment framework developed by the Review’s Clinical Expert Group to ensure children and young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan. This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment. The framework should be kept under review and evolve to reflect emerging evidence (Recommendation 2).
- ii) The evidence base underpinning medical and non-medical interventions in this clinical area must be improved, and a full programme of research should be established. This should look at the characteristics, interventions and outcomes of every young person presenting to the NHS gender services. The puberty blocker trial should be part of a programme of research which also evaluates outcomes of psychosocial interventions and masculinising/feminising hormones. Consent should routinely be sought for all children and young people for enrolment in a research study with follow-up into adulthood (Recommendation 6).

⁷³ At [42].

- iii) Every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team (MDT) hosted by the National Provider Collaborative replacing the Multi Professional Review Group (MPRG) (Recommendation 9).
- iv) The DHSC should work with the GPhC to define the dispensing responsibilities of pharmacists of private prescriptions and consider other statutory solutions that would prevent inappropriate overseas prescribing (Recommendation 27).

[170] The Court summarised the Cass Review as follows:

- 196. Puberty blockers were first used with the intention of pausing development to allow patients to “buy time to think” and lead to better cosmetic outcomes. But the evidence was that puberty blockers were not “buying time to think” (paragraph 14.25); and neither of the two studies looking at gender dysphoria and body satisfaction reported any change before and after puberty suppression (paragraph 14.26).
- 197. There was insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health (paragraphs 14.27 – 14.29). Blocking hormonal surges might dampen distress in the short-term, but that might not be an appropriate response to pubertal discomfort: paragraph 14.51.
- 198. It was unclear how helpful puberty blockers were in improving “passing” in adult life. They did not seem to lead to substantially reduced height in transgender females or increased height in transgender males: paragraphs 14.30-14.32.
- 199. There was “a very narrow indication for the use of puberty blockers” for transgender females, to stop irreversible pubertal changes such as a lower voice and facial hair; but that needed balancing against adequacy of penile growth for vaginoplasty. Any other benefits remained unproven: paragraphs 14.57-14.58.
- 200. The Final Report also “set out the very complex events that take place in the adolescent brain during puberty. Neuroscientists believe that these changes are driven by a combination of chronological age and sex hormones. Blocking the release of these sex hormones could have a range of unintended and as yet unidentified consequences”: paragraph 14.35. Such risks included that:
 - i) “There is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered [by the use of puberty blockers]” (paragraph 14.37).
 - ii) “A further concern ... is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a

significant impact on the young person's ability to make complex risk-laden decisions, as well [as] having possible longer-term neuropsychological consequences." (paragraph 14.38). There was very limited research on this: paragraphs 14.39-14.40.

- iii) Puberty suppression started too early in birth-registered males could make subsequent vaginoplasty more difficult (paragraph 14.41).
 - iv) Multiple studies had found that bone density is compromised during puberty suppression and height gain may lag behind that seen in other adolescents. Much more longer-term follow-up was required to determine whether there was full recovery in adulthood (paragraph 14.43).
 - v) The same was true of other short-term physical effects of puberty suppression, with little knowledge about whether it leads to any long-term effects, such as on metabolic health and weight (paragraph 14.44).
201. A known side effect of puberty blockers was to reduce psychological functioning (paragraph 14.52).
202. The Final Report considered the strongly-held belief that gender-affirming treatment reduces suicide risk. It noted widespread fear in parents and clinicians that delayed access to medical treatment might lead to suicidal thoughts and behaviours (paragraph 15.43). It observed nevertheless that suicide risk in the cohort of children and young people with gender dysphoria remained comparable to other young people with a similar range of mental health and psychosocial challenges, and the evidence did not support the conclusion that gender-affirming treatment reduced suicide risk: paragraphs 15.36-15.43.
203. The Interim Report was critical of the service provided by GIDS, and it led to the closure of the Tavistock, as it was no longer safe or viable, to be replaced by a different service model. In her Foreword, Dr Cass observed that:
- "Some practitioners abandoned normal clinic approaches to holistic assessment, which has meant that this group of young people have been exceptionalised compared to other young people with similarly complex presentations. They deserve very much better."
204. The Final Report concluded that "the adoption of a treatment with uncertain benefits without further scrutiny is a significant departure from established practice" (paragraph 23).
205. Paragraph 84 of the Final Report confirmed the Cass Review's earlier conclusion that, because puberty blockers only had clearly defined benefits in quite narrow circumstances, and because of the potential risks to neurocognitive development, psychosexual development and longer-term bone health, they should only be offered under a research

protocol. The Final Report also recommended that every patient considered for treatment should be discussed at a national multi-disciplinary team.

[171] The Court concluded:⁷⁴

... the Cass Review’s findings about the very substantial risks and very narrow benefits associated with the use of puberty blockers, and the recommendation that in future the NHS prescribing of puberty blockers to children and young people should only take place in a clinical trial, and not routinely, amounted to powerful scientific evidence in support of restrictions on the supply of puberty blockers on the grounds that they were potentially harmful.

[172] In determining that the decision was rational, the Court applied an “anxious scrutiny” test, as the European Court of Human Rights has held that issues of gender identity are likely to engage art 8 (right to respect for private life) of the European Convention on Human Rights.⁷⁵ The Court found that it was appropriate and reasonable for the Minister to decide that the future care of the cohort should be undertaken by United Kingdom-registered GPs and mental health services for young people, and that each patient would need an individualised assessment.⁷⁶ The Court was satisfied the decision was rational, as it required a “complex and multi-factored predictive assessment, involving the application of clinical judgment and the weighing of competing risks and dangers, with which the Court should be slow to interfere”.⁷⁷

[173] It is important to again note that this part of PATHA’s argument does not allege that the Minister’s decision was in breach of the Bill of Rights, or unreasonable/irrational, or based on material mistakes of fact (grounds addressed separately below). It alleges that there was simply no relevant evidence at all to support the exercise of the s 105 power. I do not accept that the evidence was so deficient as to reach this threshold. I consider the material in the evidence review, including in particular the position in the United Kingdom following the Cass Review, provided an evidential basis for the decision to come within the scope of s 105.

[174] It follows that ground three is not established.

⁷⁴ At [210].

⁷⁵ European Convention for the Protection of Human Rights and Fundamental Freedoms 213 UNTS 221; ETS 5 (1953).

⁷⁶ At [225].

⁷⁷ At [228].

Some further legal principles applicable to the remaining grounds

[175] Before turning to the remaining grounds of review, it is convenient to set out some further general principles applicable in this case.

Overlapping grounds of review

[176] As Professor Dean Knight has recently noted, grounds of review have evolved from the overarching “tripartite” grounds famously formulated by Lord Diplock in 1985, namely illegality, procedural impropriety and irrationality. This aligns with Lord Cooke’s later statement that the “substantive principles of judicial review are simply that the decision-maker must act in accordance with law, fairly and reasonably”. Professor Knight notes that reasoning through grounds of review is the dominant tradition in New Zealand, and that the tripartite grounds carry with them more particularised sub-grounds.

[177] PATHA accepts that there is considerable overlap between its grounds of review. The grounds should not be treated as if they are the equivalent of separate causes of action in a private law proceeding. As Professor Knight notes, in *Ririnui v Landcorp Farming Ltd* the Supreme Court signalled they were agnostic about whether an alleged error was one of law or fact as it was sufficient the “exercise of public power ... was based on a material error”.⁷⁸ Discrete grounds of review are a helpful organising device for assessing whether a decision has been made within its lawful boundaries, but care should be taken to avoid complexities that can detract from assessment of the overarching issues. This accords with judicial review being a “simple, untechnical and prompt” procedure.⁷⁹

⁷⁸ Dean Knight “The (forbidden) lyrics of deference: relativity in judicial supervision of administrative action in Aotearoa New Zealand” (paper presented to Administrative Law Forum, Stockholm, June 2025), citing *Ririnui v Landcorp Farming Ltd* [2016] NZSC 62, [2016] 1 NZLR 1056 at [54] and [90] per Elias CJ and Arnold J, and Glazebrook and O’Regan JJ concurring on this point at [147] and [150].

⁷⁹ *Attorney-General v Dotcom* [2013] NZCA 43, [2013] 2 NZLR 213 at [39].

Assessment of reasonableness/rationality

[178] PATHA notes the Court of Appeal has recently set out an approach to assessing the reasonableness/rationality of regulations in *One Foundation Ltd v Minister of Internal Affairs*:⁸⁰

[58] The focus of the Court’s analysis of the reasonableness of regulations is whether they are ultra vires the empowering statute:

The duty of the Court is to search for the intention of Parliament and to support regulations that keep within that intention, and to disallow such as do not. The intention of the Legislature as revealed by its enactments is the controlling factor.

In ascertaining Parliament’s intention, regard can be had to the effects of the Regulations. Unreasonableness is a high standard; only if the Regulations’ effects are “outrageous” is “a strong inference available that Parliament did not intend to permit such Regulations”. Whether the Regulations are reasonable is ultimately “a question of opinion and degree”.

[179] I am not sure that this summary adds much to the approach discussed in the authorities referred at [152]–[156] above.

[180] I accept PATHA’s submission that in assessing rationality it is appropriate to focus on well-established principles. These include whether the decision was unreasonable in the traditional *Wednesbury* sense of being capricious or outside the range of reasonable responses.⁸¹ They also include applying the test for whether conclusions of fact amount to errors of law articulated by the Supreme Court in *Bryson v Three Foot Six Ltd*, namely whether there has been a conclusion of fact “so insupportable — so clearly untenable — as to amount to an error of law.”⁸²

Material mistake of fact

[181] The Court of Appeal has recently confirmed the distinction between the two types of mistake of fact. The first type, established in *Bryson*, is a flawed evaluation of incontrovertible facts that makes an ultimate conclusion insupportable.⁸³ The

⁸⁰ *One Foundation*, above n 34, at [58], quoting from *F E Jackson and Company, Ltd v Collector of Customs* [1939] NZLR 682 (SC) at 721, as cited in *Brader v Ministry of Transport* [1981] 1 NZLR 73 (CA) at 80 per McMullin J (other citations omitted).

⁸¹ *Associated Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 (CA).

⁸² *Bryson v Three Foot Six Ltd* [2005] NZSC 34, [2005] 3 NZLR 721 at [26].

⁸³ *Bryson*, above n 82; *New Health New Zealand*, above n 12, at [26]; and *New Health New Zealand Inc v Minister for Covid-19 Response* [2025] NZCA 592, [2025] 3 NZLR 877 at [91]–[93].

second is where there has been a mistake about a factual matter that has had a material impact on the decision-maker's reasoning, or influenced the decision.⁸⁴ In the second situation, the decision-maker may have reached a conclusion that was supportable on the evidence before them, but evidence that was not before them renders the conclusion insupportable or suspect.⁸⁵

Post-decision evidence

[182] The parties have adduced extensive expert and other evidence that was unavailable to the Minister. The starting point is that judicial review applications are normally decided on the basis of the material before the decision-maker.⁸⁶ Expert opinion evidence is admissible only if it is substantially helpful to the court in determining whether the decision was lawful.⁸⁷ This can include contextual evidence or evidence explaining technical concepts the court may not be familiar with.

[183] Post-decision expert evidence challenging the quality of the decision-making, or the substantive reasonableness of an expert decision-maker's assessments, is inadmissible because generally it is not relevant to the issues for determination on judicial review.⁸⁸ However, as the Court considers Bill of Rights consistency at the time the decision was made, post-decision evidence addressing Bill of Rights consistency that was reasonably available when the decision was made may be admissible.⁸⁹

[184] Further, post-decision evidence can be admitted to determine whether the material before the decision-maker was sufficient to reach a reasonable decision.⁹⁰ Where a decision-maker is alleged to have made a defective inquiry,⁹¹ or a mistaken

⁸⁴ *New Health New Zealand*, above n 83, at [91]–[93].

⁸⁵ At [98]–[100]; and *E v Secretary of State for the Home Department* [2004] EWCA Civ 49, [2004] QB 1044.

⁸⁶ *Lawyers for Climate Action New Zealand Inc v Climate Change Commission* [2025] NZCA 80, [2025] 2 NZLR 808 at [59].

⁸⁷ At [59].

⁸⁸ At [59].

⁸⁹ *New Health New Zealand*, above n 83, at [116]–[117].

⁹⁰ *Chief Executive Land Information New Zealand v Te Whanau O Rangiwhakaahu Hapu Charitable Trust* [2013] NZCA 33, [2013] NZAR 539 at [117].

⁹¹ *New Health New Zealand*, above n 83; and *Chief Executive Land Information New Zealand v Te Whanau O Rangiwhakaahu Hapu Charitable Trust*, above n 90.

evaluation of incontrovertible facts (the first category of mistake),⁹² it may be necessary to have regard to the evidence that would have been considered had further inquiries been made.

Approach to review when assessing Bill of Rights compliance

[185] In *Four Members*, the Supreme Court confirmed the well-established principle that it is for the Court to determine Bill of Rights consistency. The Court should not defer to the decision-maker's assessment.⁹³

[186] However, the Court also provided guidance on the proper approach to determining Bill of Rights consistency when any limitation on a right is said to be demonstrably justified under s 5 of the Bill of Rights.⁹⁴ The Court noted that the New Zealand Courts usually adopt the structured methodology developed by the Supreme Court of Canada in *R v Oakes* and subsequent cases.⁹⁵ This means that once it is established that a measure limits a protected right, the Court asks:⁹⁶

- (a) Does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?
- (b) Is the limiting measure rationally connected with its purpose?
- (c) Does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose?
- (d) Is the limit in due proportion to the importance of the objective?

[187] The Court said that under this approach the Court affords the legislature a reasonable “margin of appreciation” in the choice of measure, as it suffices if the

⁹² *Bryson*, above n 82.

⁹³ *Four Members of the Armed Forces*, above n 63, at [99].

⁹⁴ At [96].

⁹⁵ At [96], citing *R v Oakes* [1986] 1 SCR 103 at 138–140 per Dickson CJ, Chouinard, Lamer, Wilson and Le Dain JJ as cited in *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [64] per Blanchard J and [103]–[104] per Tipping J, and *Attorney-General v Chisnall* [2024] NZSC 178, [2024] 1 NZLR 768 at [86] and [195]–[197] per Winkelmann CJ, O'Regan, Williams and Kós JJ. For Canadian jurisprudence post-*Oakes* see, for example, *R v Edwards Books and Art Ltd* [1986] 2 SCR 713 at 768–769 per Dickson CJ, Chouinard and Le Dain JJ; and *R v Chaulk* [1990] 3 SCR 1303 at 1335–1336 per Dickson and Lamer CJJ, La Forest and Cory JJ.

⁹⁶ See the discussion by the Supreme Court of the variations in approach to establishing justification in *Four Members of the Armed Forces*, above n 63, at [96]–[105], citing *Oakes*, above n 95 (footnotes omitted).

measure does not exceed reasonable limits.⁹⁷ The Court noted that the approach has been justified on democratic grounds and by reference to the respective institutional competencies of the legislature and the Court, particularly when assessing matters of social policy.⁹⁸

[188] The Court held that a range of factors will determine the margin of appreciation afforded to the decision-maker when protected rights are engaged. These include the particular right engaged, the nature and extent of any limitation on it, the nature of the justification, the scope of legislative authority to make the decision, and the knowledge and expertise of the decision-maker relative to the Court.⁹⁹ The Court then went on to identify the matters in favour of, and in opposition to, affording the decision-maker a margin of appreciation in that case. The Court said that the various terms used to describe a margin of appreciation do not signify the Court is abandoning its duty to make its own assessment, but that a decision may be lawful if it “lies within a range of reasonable alternatives.”¹⁰⁰

Order of consideration of the remaining grounds

[189] As it is alleged that the Regulations limit rights protected by the Bill of Rights, I must reach my own assessment of whether the Minister’s decision complied with those rights, including whether any limitation is demonstrably justified under s 5. However, two of the rights that PATHA alleges have been breached, ss 8 (right to life) and 9 (freedom from torture or cruel treatment) are absolute rights incapable of justification under s 5. Although s 8 contains its own internal calibration,¹⁰¹ as it

⁹⁷ *Four Members of the Armed Forces*, above n 63, at [97] citing *Hansen*, above n 95, at [64] and [79] per Blanchard J and [104], [118]–[119], [123] and [126] per Tipping J. See also *Chisnall*, above n 95, at [248]–[251] per Winkelmann CJ, O’Regan, Williams and Kós JJ.

⁹⁸ *Four Members of the Armed Forces*, above n 63, at [97], citing *Hansen*, above n 95, at [112], [118]–[119] and [124] per Tipping J. See also Grant Huscroft “Reasonable Limits on Rights” in Paul Rishworth and others *The New Zealand Bill of Rights* (Oxford University Press, Melbourne, 2003) 168 at 189; *Hansen*, above n 95, at [268] per Anderson J; *Edwards Books and Art Ltd*, above n 95, at 794–796 per La Forest J; *Canada (Attorney General) v JTI-Macdonald Corp* 2007 SCC 30, [2007] 2 SCR 610 at [43]; and *Bank Mellat v Her Majesty’s Treasury (No 2)* [2013] UKSC 39, [2014] AC 700 at [75] per Lord Reed SCJ dissenting.

⁹⁹ *Four Members of the Armed Forces*, above n 63, at [105].

¹⁰⁰ At [102].

¹⁰¹ *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556 at [164].

provides that there will be no interference with a person’s right to life if the state action is “established by law” and “consistent with the principles of fundamental justice.”¹⁰²

[190] If the Minister’s decision is unlawful because it breached protected rights, it would be artificial to go on to determine whether the decision would nonetheless have been irrational even if those rights were not engaged. I will therefore address the Bill of Rights grounds of review first.

[191] For reasons that will become apparent, I have also decided to address the discrimination ground of review before the other Bill of Rights grounds.

Ground eight: s 19 of the Bill of Rights (discrimination)

Legal principles

[192] Before turning to the parties’ arguments under the discrimination ground, I will outline the applicable legal framework, which I have gratefully adopted from Gwyn J’s recent summary in *New Zealand College of Midwives Inc v Attorney-General*.¹⁰³

[193] Section 19(1) of the Bill of Rights provides:

Everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993.

[194] The test for unlawful discrimination is the analysis settled by the full court of the Court of Appeal in *Ministry of Health v Atkinson* as follows:¹⁰⁴

- (a) Is there differential treatment or effects as between persons or groups in analogous or comparable situations (“the comparator group”) on the basis of a prohibited ground of discrimination?

¹⁰² At [169]–[175].

¹⁰³ *New Zealand College of Midwives Inc v Attorney-General* [2026] NZHC 405 at [474]–[475], citing *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456.

¹⁰⁴ *J v Attorney-General* [2023] NZCA at [104] applying *Atkinson*, above n 103.

- (b) If there is, has it resulted in a material disadvantage for the person or group differentiated against?
- (c) If it has resulted in material disadvantage, can the discrimination be justified under s 5 of the Bill of Rights?

[195] The onus of proof to establish the first two elements is on the plaintiffs. It is then for the Crown to justify the discrimination under s 5.

[196] Gwyn J noted the following in respect of establishing a prima facie case of discrimination:¹⁰⁵

[477] Establishing prima facie discrimination requires only that a plaintiff prove they have been treated differently from a comparator group on the basis of a prohibited ground and that the different treatment resulted in material disadvantage. Value judgements about the nature of the discrimination and questions about the purpose or justification of a policy are not relevant to the existence of prima facie discrimination. These inquiries should occur at the s 5 stage. As Butler and Butler argue, “entertaining such issues at the stage of identifying the appropriate comparison may risk prematurely justifying discriminatory treatment before it can be subject to thorough scrutiny under s 5”.

[197] The first step in *Atkinson* requires a determination of whether:¹⁰⁶

- (a) there is differential treatment or effects; and

that differential treatment is on the basis of the prohibited ground of discrimination.

[198] Gwyn J discussed some limitations in the use of comparator analysis to determine differential treatment:¹⁰⁷

[485] The comparator exercise is “simply a tool” and is not to be treated “as a formula”. The exercise involves a comparison with a group “whose treatment is *logically relevant* to the person or group alleging discrimination”. A comparator may be a real person or a hypothetical person. It is not necessary to fix a single conclusive comparator. The exercise must not become “circular”, producing an “inevitable answer” favourable to the Crown. And,

¹⁰⁵ *New Zealand College of Midwives*, above n 103, at [477] (footnotes omitted).

¹⁰⁶ At [481].

¹⁰⁷ At [485] (footnotes omitted).

finally, the comparator exercise should take its proper place in the overall discrimination inquiry with it being important that the exercise does not “effectively cut out the inquiry into potential discriminatory action too soon”.

[199] In relation to the second step in *Atkinson* of assessing material disadvantage, Gwyn J noted that this is substantially the same as asking if there is “real” or “more than trivial disadvantage”.¹⁰⁸

[200] PATHA has pleaded that the ban is discriminatory in three ways. The first two allege discrimination on the basis of sex. The first is that puberty blockers remain available for clinically appropriate treatment of young people whose gender identity aligns with their sex assigned at birth, but are banned as clinically appropriate treatment for young people whose gender identity does not align with their sex assigned at birth. The second is that medications for use by transgender people are subject to different thresholds and requirements for evidence of safety, and greater interference by the state, than equivalent medications for use by cisgender people.

[201] The third ground relies on discrimination on the basis of disability. The argument is that puberty blockers are banned as treatment for young people diagnosed with gender dysphoria or gender incongruence (clinically recognised mental disorders) but remain available as treatment for people (including young people) diagnosed with other conditions. This ground is referred to as an “intra-ground” as it involves differential treatment based on different types of disability.

[202] The first two grounds raise the difficult issue of whether the prohibited ground of “sex” in s 21(1)(a) of the Human Rights Act encompasses discrimination on the grounds of gender diversity and/or innate variations of sex characteristics. As I have determined below that the Regulations are discriminatory and in breach of s 19 of the Bill of Rights on the disability ground, I will not address the issue of the proper interpretation of “sex” in s 21(1)(a). I acknowledge the parties and Human Rights Commissions’ thorough and careful submissions on the point, but given the wider implications of the issue, I consider it should be left to a case where it will be determinative of the outcome, if it is not settled by legislative amendment in the meantime.

¹⁰⁸ At [557] citing *Atkinson*, above n 104, at [109].

Submissions on discrimination on the grounds of disability

PATHA

[203] Under s 21(1)(h) of the Human Rights Act, disability is a prohibited ground of discrimination. Disability includes physical illness or impairments as well as psychiatric illness or psychological impairment. PATHA notes that being transgender or gender diverse is not a disability. However, gender dysphoria and gender incongruence qualify as a disability under this ground as they are clinically recognised and diagnosable conditions.

[204] PATHA submits that there is differential treatment on the basis of disability between comparator groups, namely:

- (a) young people with gender dysphoria or gender incongruence who are banned from being prescribed this medication when it is clinically appropriate; and
- (b) young people with a different health condition (short stature, endometriosis, precocious puberty, catamenial epilepsy) who are not banned from being prescribed this medication when it is clinically appropriate.

[205] In relation to material disadvantage, PATHA says the most obvious one is denial of access to clinically appropriate healthcare. Further, PATHA says it has adduced extensive and uncontested evidence about the impact of the Regulations on the targeted cohort. This includes:

- (a) The evidence of Associate Professor Fenaughty and Professor Green,¹⁰⁹ that the cohort of transgender young people is already suffering under significant disadvantage compared to their cisgender peers (including their other rainbow cisgender peers). They say that this is a vulnerable

¹⁰⁹ Associate Professor Fenaughty is based at the University of Auckland in the School of Education and Social Practice. He has conducted surveys and projects involving issues faced by takatāpui and rainbow young people. Professor Green's expertise is in Māori and indigenous development, and has conducted research on takatāpui identities.

group, with already higher rates of social exclusion, suicide and self-harm. Those vulnerabilities will both reduce their resilience to deal with this ban and amplify its impacts on their mental health.

- (b) The extensive evidence in the affidavits filed by the families and young people subject to the Regulations of the impact on them. The evidence highlights that the Regulations will result in a radical and extremely adverse change in the direction of a young person's life. Ms Casey KC highlighted, as an example, evidence from a family where the young person has identified as transgender from a very young age. Since early childhood it has been clear to this child and their family that the child's identity did not align with their sex assigned at birth. The person's family and community have treated them in accordance with their identified gender for the entirety of their life. Ms Casey emphasised that this demonstrates a clear example where the Regulations would cause significant harm. A child would be required to experience permanent changes to their body from puberty despite being misaligned with their gender identity.
- (c) The evidence before the Minister and Cabinet of the impact of the ban in the RIS and through the November 2024 consultation process. The RIS considered the status quo best met the policy objectives and that a prohibition on new prescriptions carries a high risk of adverse health outcomes, and a significant loss of trust and confidence in the health sector. This is further confirmed by a letter dated 5 December 2025 from Te Whatu Ora's Clinical Director of Child Health in the Capital Coast and Hutt Valley District. The letter records a formal notification of an "urgent new clinical risk" being loaded on the District Risk Register following the announcement of the Regulations. The "Draft Risk Document" records that: "[s]ignificant increase in mental health distress, self-harm and suicide attempts are anticipated in transgender youth following the government's announcement."

- (d) Professional organisations speaking out against the ban following its announcement. These organisations have raised strong concerns with the impact the Regulations would have on trans and gender diverse young people, including that lives are at risk. This includes Te ORA Māori Medical Practitioners; Te Kāhui Mātai Arotamariki o Aotearoa The Paediatric Society of New Zealand; the Royal Australasian College of Physicians; the Royal Australian and New Zealand College of Psychiatrists; New Zealand Society of Endocrinology; NZNO College of Child and Youth Nurses; and the Royal New Zealand College of General Practitioners.
- (e) PATHA’s expert evidence about the impact of the Regulations. This includes evidence about the increased risk of self-harm and suicide:
 - (i) Associate Professor Fenaughty describes New Zealand data on transgender youth suicidality associated with access and non-access to gender-affirming healthcare, including puberty blockers. The data shows that there were lower rates of thoughts and plans of suicide in the last 12 months for those accessing puberty blockers compared to those without access. The data also showed improved reports of wellbeing and lower rates of self-harm (non-suicidal).
 - (ii) Dr Natacha Kennedy provides evidence of her findings in her study: “Harming Children: The effects of the UK puberty blocker ban”.¹¹⁰ This study compared those who could not access the medicine due to the ban (pending the clinical trial) and those who could still access it because they had been prescribed it prior to the ban. She reported an increase in suicidality and constant severe distress for those unable to access puberty blockers. She also gives evidence of a United

¹¹⁰ Natacha Kennedy “Harming Children: The effects of the UK puberty blocker ban” (2025) *Journal of Gender Studies*. Dr Kennedy is a researcher in the Department of Educational Studies at Goldsmiths College University of London, focusing on the experiences of young trans and non-binary people.

States study containing similar findings of statistically significant increases in suicide attempts in states that had implemented puberty blocker bans and other anti-trans measures.

- (iii) Dr Aidan Kelly provides firsthand experience of the impact of the UK ban following the Cass Review including a marked increase in suicidal ideation and suicide attempts.¹¹¹ This has also included “young people that have attempted self-castration or engaged in other types of physical self-harming. Some have developed an eating-disorder. Others are attempting or succeeding to access medication via unregulated online sources, all in an attempt to delay or minimise the effects of their unwanted pubertal hormones.”
- (iv) Dr Julia Moore says a substantial number of young people forced to go through an incongruent puberty are likely to experience an acute deterioration in their mental health.¹¹² They are also quite likely to experience increasing depressive and anxiety symptoms associated with worsening gender dysphoria. She says it is quite likely that some young people will commit suicide as a direct result of this ban due to a combination of increased stress, loss of hope, sense of injustice, invalidation, rejection, marginalisation and unbearable increasing gender dysphoria. Being in a life predicament which seems hopeless is a long-recognised risk factor for suicide. For some transgender young people, who are already at high risk of self-harm and suicide, progressive incongruent puberty is a predicament which seems hopeless. She says that withholding timely access to appropriate medical gender-affirming care that can relieve this distress is cruel and irresponsible.

¹¹¹ Dr Kelly is a clinical psychologist in the United Kingdom, specialising in child and adolescent mental health as well as transgender healthcare.

¹¹² Dr Moore is a child and adolescent psychiatrist based at the Perth Children’s Hospital in the Gender Diversity Service section.

- (v) Dr Cate Rayner says she has witnessed the difference that puberty blockers make in the lives of transgender young people who require them.¹¹³ She expects the impact of the Regulations will be serious short and long-term harms, including an increased risk of suicide. She considers there is no clinical justification to warrant removing access to this medicine for this cohort, and to do so would be a gross mistreatment of an already vulnerable group.
- (vi) Dr Jamie Speeden says that the cohort is already at higher risk of suicide and long-term mental health challenges. Many of those denied access to puberty blockers will suffer severe distress for the rest of their lives, leading some to self-harm, and some to commit suicide.¹¹⁴ Others will suffer permanent long-term damage to their health and wellbeing. The trajectories of their future education, employment and social engagement will likely be radically changed from what they might have been had they been permitted to access appropriate care.

[206] PATHA emphasises that the “blanket” nature of the Regulations (prohibition on all prescriptions for new patients) means that clinically appropriate treatment will be denied to individuals who are at serious or imminent risk of self-harm and suicide.

[207] PATHA also points to the disadvantage on this cohort of denying the right to autonomy over their bodies and to make their own healthcare decisions, simply because they are transgender. PATHA notes that when granting an interim injunction in respect of a ban on access to puberty blockers and hormone therapy for gender diverse young people in *Egale Canada*,¹¹⁵ the Judge said:¹¹⁶

... singling out health care for gender diverse youth and making it subject to government control will cause irreparable harm to gender diverse youth by

¹¹³ Dr Rayner is a consultant paediatrician and adolescent physician. She is the Head of Department in Adolescent Medicine at the Royal Children’s Hospital in Melbourne.

¹¹⁴ Dr Speeden is a New Zealand-based psychiatrist specialising in child and adolescent health, and a paediatrician who has extensive experience working with trans and gender diverse youth.

¹¹⁵ *Egale Canada*, above n 25, at [205]–[206].

¹¹⁶ At [205].

reinforcing the discrimination and prejudice that they are already subjected to. Intentionally or not, the Ban will signal that there is something wrong with or suspect about having a gender identity that is different than the sex you were assigned at birth. Gender diverse youth will bear the entire burden of that speculation ...

[208] PATHA says that justification, in the context of prima facie discrimination in access to clinically appropriate (and potentially life-saving) healthcare by way of secondary legislation, against an already disadvantaged minority group and causing significant harm, will need to be substantive and affirmatively meet the *R v Oakes* test. It says the Crown's grounds of justification do not begin to approach that threshold.

[209] The Crown's justification includes that the ban applies to off-label use and there is an absence of good quality evidence about the risks and benefits of that use. PATHA notes that the Ministry was clear in its advice to the Minister that off-label prescribing is common in paediatric medicine in particular. PATHA says this is backed up by its uncontested expert evidence. This includes evidence of off-label prescribing of puberty blockers to young people for conditions other than gender dysphoria/incongruence, but also a wide range of other medicines.

[210] PATHA argues that off-label use and low certainty evidence about the risks and benefits cannot justify differential treatment, as these factors apply to both comparator groups and many other medicines used in paediatrics and mental health. PATHA says there is clear and uncontested expert evidence that prescribing on the basis of "low quality" (more properly "low certainty") evidence, and/or a complete absence of data on long-term harms and benefits is common. This includes medications that are Medsafe approved, such as ADHD medications where the evidence base is recorded as "low" and there are no studies into the harms and benefits beyond 12 weeks. Yet, the Minister chose to ban only one medication, and one use of that medication, purportedly because of uncertainty in the evidence, especially as to long term benefits. PATHA says the complete lack of logic demonstrates that the decision is capricious and arbitrary.

[211] PATHA says the Minister is imposing a different and far higher threshold of assured safety and certainty of evidence for a particular use of a medication for a targeted minority group. PATHA highlights Dr C's evidence on these points,

especially in relation to “low” certainty evidence for the use of ADHD medications. Drs Kelly, Rayner and Speeden also talk about the arbitrarily elevated evidence threshold for transgender care, and the absence of a clinical basis for it.

[212] PATHA says the Crown’s other ground of justification, namely the access to other treatment in the form of psychiatric support, relies on the incorrect assertion that such treatment is available and clinically appropriate. PATHA refers the evidence of Drs Kelly, C and Speeden that psychiatric support on its own is not a clinically appropriate “other treatment” for gender diverse young people who would otherwise be prescribed puberty blockers. In fact, this approach is known to cause direct harms and carries significant risks for these young people. PATHA also submits that there is irony in the fact that, as Dr Speeden confirms, the other medicines that could be used to support psychiatric care, such as anti-depressants (SSRIs), are also mostly used off-label for this cohort and usually come with greater and established side effects.

[213] Further, PATHA notes that Dr Speeden confirms that New Zealand has a Child Mental and Adolescent Mental Health Service (CAMHS) that is one of the least populated with specialists in the OECD. The Minister advised promulgation of the Regulations after he and Cabinet made a deliberate decision to reject the Ministry’s proposal to put additional resources into services to accommodate the known increase in need. Instead, the Minister decided to direct Te Whatu Ora to set up an “online hub” (that is, a page on its website) with links to existing (already overstretched) services. Dr Speeden’s evidence is that “[m]erely providing another ‘directory’ or ‘hub’ to existing services, while at the same time increasing the level demand on these services will not help these young people in the slightest.”

[214] Moreover, PATHA emphasises that the Minister knew the Regulations would result in an increased need for acute and intensive sustained care for young people whose experience of puberty is leading them to self-harm, develop eating disorders, and/or become suicidal. As Dr C says, not only will there be increasing numbers of transgender youth presenting to mental health services, but their conditions are likely to be of greater severity and more challenging to treat. PATHA emphasises that this suffering is real and avoidable.

[215] Therefore, PATHA submits, this “other treatment” is ineffective and, even if it were effective, it has not been put in place.

The Crown

[216] The Crown submits that there is no differential treatment. The availability of any medicine is not dependent on the psychological impairment (disability) of the patient but on the properties of the medicine and the safety in using the medicine to treat that psychological impairment.

[217] In any case, any differential treatment on the basis of disability is justified under s 5 of the Bill of Rights. The Crown argues that Medsafe has already approved the use of puberty blockers for precocious puberty, endometriosis and some hormone sensitive cancers, but it has not for gender dysphoria/incongruence. The use of puberty blockers for those conditions is supported by a greater evidence base compared to treatment for gender dysphoria/incongruence in young people. The legitimate off-label use of one treatment for a specific disorder does not equate to the legitimate off-label use of another treatment for another disorder.

[218] The Crown denies that other off-label medicines are subject to different standards or thresholds for evidence. Every medication should be assessed against its risk profile and medical condition for which it is prescribed.

[219] The Crown highlights Dr Clayton’s evidence that it is not particularly useful to compare other off-label prescribing in paediatrics, such as ADHD medication or SSRIs, to puberty blockers. Professor Paul further explains that comparisons with off-label paediatric prescribing of medicines such as antidepressants are misplaced. In those cases, the medicines are prescribed to children for the same condition for which they are approved. By contrast, the off-label use of puberty blockers for gender dysphoria involves prescribing for a condition materially different from their approved use in treating precocious puberty.

Assessment of discrimination on the disability ground

Differential treatment or effects

[220] I bear in mind that establishing a prima facie case of discrimination does not involve value judgments about the nature of the discrimination, or the purpose or justification for a policy irrelevant to the prima facie case assessment. These considerations are best left to the justification stage of the *Atkinson* test to avoid prematurely justifying discrimination without subjecting it to thorough scrutiny.¹¹⁷

[221] The first step in the *Atkinson* test is to consider if there is differential treatment or effects as between persons or groups in analogous or comparable situations. I bear in mind that the use of comparator groups is a tool and not a formula, it is not necessary to fix a single conclusive comparator, the exercise must not become circular (producing an inevitable answer favourable to the Crown), and it must not effectively “cut out” the inquiry into potentially discriminatory action too soon.¹¹⁸

[222] I consider that the appropriate comparator group is young people in the same age range who can still access puberty blockers but for different health conditions (such as short stature, endometriosis, catamenial epilepsy, certain cancers). I consider it is appropriate to exclude from the comparator group those receiving puberty blockers for precocious puberty given their use for that condition generally occurs before the age of 12. This reflects the evidence that there is potential for different risks to arise when puberty blockers are used to delay normal puberty (particularly in relation to psychosocial development), compared to blocking early commencement of puberty in the case of precocious puberty. I note the exclusion does not significantly impact on the chosen comparator group given it includes a population of young people over 12 who remain able to access the medicine for a number of conditions.

[223] Having identified the appropriate comparator group, I turn to consider whether there is differential treatment or effects between the comparator group and young people with gender incongruence/dysphoria.

¹¹⁷ *New Zealand College of Midwives*, above n 103, at [477].

¹¹⁸ At [485].

[224] I do not accept the Crown submissions that there is no differential treatment on a prohibited ground because the difference arises not from the condition (gender dysphoria/incongruence), but because of the difference in clinical effectiveness of the use of the medicine to treat this condition.¹¹⁹ The Crown says the risk of harm outweighs the benefits for this condition, which is not the case for the comparator group. However, there is overwhelming clinical support in New Zealand for the use of puberty blockers to treat gender dysphoria/incongruence in this cohort; clinical use that has occurred for approximately 15 years (since 2011). While the long-term benefits are uncertain, there can be no doubt that it has the short-term benefit of preventing the distress caused to gender dysphoric/incongruent youth experiencing permanent changes to their body that do not align with their gender identity.

[225] I accept that the purpose of the measure is to address the risk of harm from the use of the medicine, but it is the effect not the purpose that is the focus of the differential treatment inquiry. The effect of the measure is that youth requiring treatment for gender dysphoria/incongruence are being denied access to clinically appropriate medicine to which their peers have access for different conditions. I consider the Crown's reliance on the difference in clinical effectiveness is properly considered at the justification stage. There is a circularity to the Crown's submission that there is no differential treatment because any difference is due to a difference in clinical effectiveness. In these circumstances, accepting the Crown argument would effectively "cut out" the justification inquiry too soon, prematurely justifying discrimination without subjecting it to thorough scrutiny.

[226] I therefore accept that there is a *prima facie* case of differential treatment.

Disadvantage

[227] The second step of *Atkinson* involves an assessment of whether there has been a material disadvantage to young people with gender dysphoria/incongruence.

¹¹⁹ The Crown initially suggested that off-label use was another reason why the comparison was inapt. However, Mr Powell responsibly accepted in oral argument that off-label use could not by itself make the comparison inapt given the off-label use of puberty blockers and other medicines in the comparator group.

[228] I consider the test of “real” or “more than trivial disadvantage” cannot be seriously contested, and I did not understand the Crown to do so.¹²⁰ The evidence relied on by PATHA and summarised at [205] above clearly establishes material disadvantage.

Justification

Margin of appreciation

[229] I turn first to consider the “margin of appreciation” that should be afforded to the Minister when considering whether the measure was demonstrably justified under s 5 of the Bill of Rights (the *Four Members* approach).¹²¹

[230] Taking the approach to outlined by the Court in *Four Members*, I consider the following factors favour affording the Minister a generous margin appreciation (or wide discretion):

- (a) Parliament has entrusted the Minister to make decisions about access to medicines based on their safety and effectiveness.
- (b) The Minister is required to make a complex and multi-factored predictive assessment that appropriately balances the potential benefits against the risk of harm.
- (c) The Minister was required to weigh clinical evidence but there was no objective clinical standard he was required to meet, and there will not be a single correct answer about allowing access to medicines where the clinical evidence is uncertain.

¹²⁰ *New Zealand College of Midwives*, above n 103, at [557] citing *Atkinson*, above n 103, at [109].

¹²¹ See above discussion at [185]–[188].

[231] The factors that weigh against a generous margin of appreciation (or narrow discretion) include:

- (a) The right to be free from discrimination is an important human right, especially for an already disadvantaged minority group.
- (b) The decision involved access to clinically appropriate and potentially life-changing/life-saving physical and mental healthcare for a group already at high risk of very poor health outcomes including suicide and self-harm.

[232] As was the case in *Four Members*, the balance is not easy to strike.¹²² The Court can be expected to allow the Minister a margin of appreciation in respect of the difficult task of weighing complex clinical evidence to balance the risks and benefits of access to puberty blockers. On the other hand, the Court can be expected to carefully scrutinise justifications for a measure that deprives a disadvantaged cohort of access to a medicine that is considered a clinically appropriate treatment for those at high risk of serious poor health outcomes.

Assessment of justification

[233] Against that background, I turn to consider the matters advanced by the Crown as establishing justification in this case.

[234] I accept PATHA's submissions that the off-label nature of the prescribing or the low certainty evidence about long-term harms and benefits is not a justification for the differential treatment. The evidence is that off-label prescribing and low-certainty evidence about long term harms and benefits is common in paediatrics and mental health. The off-label nature of the prescribing cannot be a justification when most of the prescribing of puberty blockers for the comparator group is also off-label (especially when use for precocious puberty is excluded from the comparator group).¹²³ In fairness to the Crown, it did not press the off-label point in oral argument.

¹²² *Four Members of the Armed Forces*, above n 63, at [109].

¹²³ See [38] above.

[235] The uncontested evidence is that the risk of harm from puberty blockers is the same for both the cohort affected by the measure and the comparator group. This does not change because the off-label use of the medicine in the comparator group is well-established for other conditions. In any event, the clinical evidence is that the use of puberty blockers for gender dysphoria/incongruence has been accepted as clinically appropriate since at least 2011.

[236] I have not overlooked the Crown evidence from Dr Clayton that includes a list of what she says are established “likely” side effects and harms of puberty blockers including disruption to reproductive development, impaired cardiovascular health, and sexual dysfunction. As PATHA points out, the Ministry’s Evidence Brief clearly stated, in line with the Cass Review, that there is no evidence of long-term harms of this kind. This was one of the grounds on which PATHA objected to the admissibility of Dr Clayton’s evidence, namely it is inadmissible post-decision evidence attempting to justify the decision. Rather than explicitly ruling on the objections to the evidence of Dr Clayton, and the other Crown expert Professor Paul, I have decided to treat the objections as a matter of weight, given the artificiality in having to consider the evidence in order to rule on its admissibility. However, in this instance I consider I should not give any weight to Dr Clayton’s evidence about these “likely” harms from puberty blockers when it is contrary to the material provided to the decision-maker, as well as the other clinical information and evidence provided in this case. In any event, even if these harms were established, they would apply equally to the comparator group.

[237] Turning next to the Crown’s reliance on the uncertain evidence of the benefits of using the medicine for the targeted cohort compared to the comparator group. The evidence is that there is overwhelming clinical support for the continued use of puberty blockers to treat gender dysphoria/incongruence in appropriate cases. As the Judge noted in *Egale Canada*, the harm to the cohort includes “causing gender diverse youth to experience permanent changes to their body that do not align with their gender identity.”¹²⁴ While the long term benefits are uncertain, there can be no doubt about the short-term benefits of preventing young people with gender

¹²⁴ *Egale Canada*, above n 25, at [205].

dysphoria/incongruence from experiencing distress arising from permanent changes to their body that do not align with their gender identity. Moreover, there is extensive evidence from highly qualified clinicians about an increased risk of serious and life-threatening health outcomes from blanket denial of access. That evidence weighs heavily against the Crown's argument that discrimination is justified based on low certainty evidence of the benefits for this cohort.

[238] I also accept PATHA's submissions that the availability of alternative treatments (such as psychiatric intervention) cannot be a justification for differential treatment in this case. There is clear evidence about the limitations on the effectiveness and availability of that treatment as set out at [212]–[215] above. Further, there are obvious limitations on psychiatric intervention to address the distress caused to gender dysphoric/incongruent youth experiencing permanent *physical* changes to their body that do not align with their gender identity. Moreover, I share Dr Speeden's concerns about the Minister and Cabinet's decision to reject the Ministry's advice to provide additional resources to help cope with the predicted increase in need for such services following promulgation of the Regulations.

[239] The Ministry had recognised that removing the ability to prescribe puberty blockers for new patients would cause potential harm. The final version of the November 2024 Cabinet paper, following input from ACT and NZ First, removed the option of preserving access for those at high risk of significant poor health outcomes, but still referred to preserving access as part of an approved clinical trial (presumably to align with the UK position). Obviously, the option of preserving access in the context of a clinical trial was also later removed.

[240] I consider the blanket nature of the prohibition on access to puberty blockers for all new patients in this vulnerable cohort cannot be justified under s 5. The Minister placed heavy reliance on the United Kingdom position following the Cass Review, but in the United Kingdom there will remain access for those in high need through the clinical trial process (once established). As emphasised by PATHA's experts, Drs Kennedy and Moore, the Cass Review did not recommend a complete ban on puberty blockers. The Ministry also considered the Cass Review in its Evidence Brief and concluded it did not warrant a prohibition on new prescriptions.

This appears to be reflected in Dr Cass’s comments following the United Kingdom Secretary of State for Health pausing the United Kingdom trial based on advice raising concerns about it, including the risk of sterility and indicating increasing the entry age to 14. Dr Cass is reported in the media as criticising this intervention, saying the agency who advised the Secretary had made “completely bizarre” claims, had not produced any new evidence and seemed to be responding to “political pressure, not science”. Dr Cass said the trial was necessary because “we genuinely don’t know if some children will benefit or have no benefit”. The article quotes her as saying that an age limit of 14 “would cut out children who might benefit”, which “will make the results invalid”.¹²⁵

[241] I also note the Crown’s expert, Professor Paul, while clearly supportive of restrictions on the use of puberty blockers for similar reasons to those outlined in the Cass Review, does not go as far as saying that she supports a prohibition on prescriptions for new patients. Professor Paul concludes that:

If any use of GnRHa for gender dysphoria is allowed to continue in New Zealand, this should only be done under research conditions and with medical professional standards adhered to.

[242] There was some discussion at the hearing about whether the United Kingdom clinical trial’s limit on the number of participants has been calibrated to those likely to be in high need, or if the numbers could be increased if it transpires that calibration is incorrect. I am not in a position to resolve that issue, but the practical reality is that there remains a cohort of United Kingdom children and young people experiencing gender dysphoria/incongruence that will be able to access puberty blockers through a clinical trial. The Crown also highlighted that the entry criteria to the United Kingdom trial precludes anyone suffering from acute mental health issues, which suggests the trial will not be catering to those at high risk of self-harm or suicide. However, this entry criterion appears to be aimed at ensuring capacity to consent to the trial, and the Crown’s submission misses the wider point that the trial will still enable treatment for those at high risk who can be identified as needing treatment before becoming acutely unwell.

¹²⁵ James Tapper “Pausing puberty blockers trial seems political, not scientific, says Cass” (22 February 2026) The Observer < <https://observer.co.uk/>>.

[243] Applying the *R v Oakes* criteria set out at [186] above, I consider the Regulations served a sufficiently important purpose to justify curtailment of the right to be free from discrimination. The purpose was to ensure that puberty blockers are prescribed safely and effectively to young people with gender dysphoria/incongruence. I also consider the Regulations were rationally connected to this purpose. However, I do not consider a blanket prohibition on prescriptions for new patients impaired the right no more than was reasonably necessary, nor was it in due proportion to the importance of its objective.

[244] I consider there was a rational basis for the Minister to impose restrictions on access to puberty blockers for this cohort given the material provided to him in the Evidence Review and the approach being taken overseas, particularly in the United Kingdom following the Cass Review. However, I consider it was a discriminatory and disproportionate response to impose a blanket prohibition on prescriptions for new patients pending completion of the United Kingdom clinical trial that is likely to take many years to complete. Indefinitely prohibiting access to this medicine for those at high risk of seriously poor health outcomes, particularly self-harm and suicide, was not a justifiable limit on the right to freedom from discrimination.

[245] I therefore conclude that the Minister's decision to promulgate the Regulations unjustifiably discriminated against young people with gender dysphoria/incongruence on the basis of disability.

Grounds five to seven: ss 8, 9 and 10 of the Bill of Rights

[246] I do not consider it appropriate to conclusively determine the remaining Bill of Rights grounds of review. They raise novel and difficult issues about the scope of the rights that are said to be limited by the Regulations. I consider conclusive determination should be left to a case where it will be determinative of the outcome.

[247] However, I will make some brief comments about each of these grounds.

Ground five: s 8 (right to life)

[248] Section 8 provides:

No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

[249] The words “established by law and are consistent with the principles of fundamental justice” provide an internal calibration on the right. However, the issue is whether the Regulations *engage* the right such that a proportionality assessment is required. PATHA says this issue is determined by a straightforward application of two decisions.

[250] The first is the Supreme Court in *Attorney-General v Zaoui*, where it was held that s 8 is engaged by a decision to deport a person where substantial grounds have been shown to believe that the person faces a real risk of being killed upon return to their homeland.¹²⁶

[251] The second is the High Court decision in *Seales v Attorney-General*, which held that legislative settings preventing assisting suicide through medicinal interventions, where that denial increases the risk of suicide, can engage the right to life.¹²⁷

[252] PATHA submits that the Regulations fail to meet the requirements of fundamental justice as they have the effect of increasing the risk of suicide in an already vulnerable cohort and are arbitrary or grossly disproportionate. PATHA says that an immediate risk to a particular individual is not required provided there is a clear risk to the lives of an identifiable cohort of individuals subject to, or in this case targeted by, the measure.

[253] The Crown says that the cases to date have stopped well short of widening the positive obligation in s 8 to prevent every significant increase in risk to life. The obligation has so far been confined to circumstances where there is an immediate and

¹²⁶ *Attorney-General v Zaoui* [2005] NZSC 38, [2006] 1 NZLR 289 at [79].

¹²⁷ *Seales*, above n 101, at [164]–[166].

conspicuous risk to the life of a known person.¹²⁸ The Crown says increased risk to a young person denied access to puberty blockers falls well short of even identifying a particular person who is at risk let alone any immediate risk to their life.¹²⁹

[254] If I were required to determine this issue, I would be inclined to the view that the clear and foreseeable increased risk of suicide to an identifiable and vulnerable cohort targeted by state action is capable of engaging s 8. I do not accept that the risk to life must be imminent. The risk to life was not imminent in either *Seales* or *Zaoui*.

[255] I consider the Crown raises valid policy concerns about imposing unreasonable obligations on the state to protect against every increased risk to life. However, at a policy level, I struggle to see a distinction between a clear and foreseeable risk to the life of a particular person (as in *Seales* and *Zaoui*), and the same level of risk to a clearly identifiable cohort of people deliberately targeted by the state action. The Court would not be imposing a general obligation on the state to protect its citizens from every increased risk to life. Rather, the obligation would be to ensure that a measure aimed at a particular cohort does not expose that cohort to a clear and foreseeable increased risk of suicide unless it is consistent with the principles of fundamental justice. I do not think it matters that a particular person cannot be identified in advance as being exposed to the increased risk of suicide provided there is evidence (as there is here) that individuals within the cohort will be exposed to the risk.

[256] However, if I were to find that s 8 is engaged in this case, I would then need to apply the framework for determining whether the risk to life is consistent with the principles of fundamental justice set out in *Seales*.¹³⁰ In *Seales*, Collins J adopted the Canadian approach to the principles of fundamental justice, which requires consideration of three components: arbitrariness (no rational connection between the objective and the law); whether the law is overly broad (namely, denying the right in a way that has no bearing on the objective of the law); and gross disproportionality

¹²⁸ *Smith v Attorney-General* [2024] NZCA 692, [2025] 2 NZLR 1 (CA).

¹²⁹ Compare *S v Midcentral District Health Board* [2004] NZAR 342 (HC); and *Wallace v Attorney-General* [2022] NZCA 375, [2022] 3 NZLR 398 (CA).

¹³⁰ *Seales*, above n 101.

(the impact is grossly disproportionate to the purpose of the law).¹³¹ Although this analysis appears similar to the proportionality assessment required under s 5 of the Bill of Rights, the Canadian authority adopted in *Seales* and the language of the three components suggest a higher threshold for inconsistency with the principles of fundamental justice.¹³² If I were required to determine this issue, I doubt that this higher standard could be met in circumstances where there was a rational basis to impose restrictions on the prescribing of puberty blockers but a blanket prohibition on prescriptions for new patients was disproportionate.

Ground six: s 9 (torture or cruel treatment)

[257] Section 9 provides:

Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

[258] The first issue is whether the promulgation of the Regulations can be considered “treatment.” In *R (on the application of Limbuela) v Secretary of State for the Home Department*, the House of Lords held that the effect of a statutory regime governing asylum seekers was inhuman or degrading treatment, in breach of art 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms.¹³³ Lord Scott explained that the statutory regime amounted to “treatment” because:

[66] ... Just as there is no [Convention] right to be provided by the state with a home, so too there is no [Convention] right to be provided by the state with a minimum standard of living: “treatment” requires something more than mere failure.

[67] The situation seems to me, however, to be quite different if a statutory regime is imposed on an individual, or on a class to which the individual belongs, barring that individual from basic social security and other state benefits to which he or she would, were it not for that statutory regime, be entitled.

...

¹³¹ At [170]–[175].

¹³² I also note that Collins J adopted the Canadian approach that the wider societal perspective required by a s 5 analysis does not form part of the individual rights focus required by s 8 (at [175]).

¹³³ *R (on the application of Limbuela) v Secretary of State for the Home Department* [2006] 1 AC 396 (HL) at [6] per Lord Bingham, [57] and [62]–[63] per Lord Hope, [64] per Lord Scott, [75] per Baroness Hale, and [103] per Lord Brown.

[69] An analogy would, I think, be a bar from medical treatment under the [National Health Service]. The [Convention] does not require signatory states to have a national health scheme free at the point of need. In this country we have such a scheme. Asylum seekers are entitled to make use of it whether or not they have applied for asylum as soon as practicable after arrival here. The s 55(1) bar on provision of support does not extend to a ban on medical treatment under the NHS. But suppose that it did. It could not, in my opinion, sensibly be argued that a statutory bar preventing asylum seekers, or a particular class of asylum seekers, from obtaining NHS treatment would not be treatment of them for article 3 purposes.

[259] Here, the Regulations have imposed a prohibition on a class of people (young people with gender incongruence/dysphoria) accessing medical treatment (puberty blockers) that they would otherwise be entitled to access. I therefore accept it is arguable that this regulatory measure targeted at a particular cohort could amount to “treatment”.

[260] The next issue is whether the treatment reaches the high threshold required by s 9. Although PATHA says the treatment is cruel and degrading, it seems to me it could not come within the test articulated by Blanchard J in *Taunoa*. Treatment will be “cruel” if:¹³⁴

... the suffering that results is severe or is deliberately inflicted. In the s 9 context, treatment or punishment is degrading if it gravely humiliates and debases the person subjected to it, whether or not that is its purpose.

[261] There is a better argument that it may come within the concept of “disproportionately severe treatment”. In *Taunoa*, Blanchard J said this requires treatment that does not reach the level of cruel or degrading but “which New Zealanders would nevertheless regard as so out of proportion to the particular circumstances as to cause shock and revulsion.”¹³⁵ If I were required to determine the issue, I doubt that this case could reach this high standard. There was a rational basis to impose restrictions, but the Minister has gone too far by imposing a blanket prohibition on prescriptions for new patients. This would weigh against a finding that the treatment is so out of proportion to the particular circumstances as to cause shock and revulsion.

¹³⁴ *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 at [171].

¹³⁵ At [172].

Ground seven: s 10 (medical experimentation)

[262] Finally, I turn to the right to freedom from medical experimentation under s 10 of the Bill of Rights. I accept the Crown’s submission that the meaning of “experimentation” should not be taken beyond its orthodox meaning of a process undertaken to make a discovery, test a hypothesis or demonstrate a known fact.¹³⁶ As the Crown submits, s 10 reflects an important right, a prohibition on the gravest abuse of medical and scientific power, which has its genesis in some of the most depraved conduct in human history. PATHA says that the Regulations can be properly classified as experimental because the hypothesis being tested is whether the withholding of clinically appropriate treatment will improve health outcomes. However, I do not think this argument could succeed in light of my conclusion that there was a rational basis for the Minister to impose restrictions, but the blanket prohibition for new patients was discriminatory and disproportionate.

Grounds four and ground nine: mistake of fact, irrationality and failure to take into account mandatory relevant considerations

[263] As noted above, I have addressed the Bill of Rights grounds first as it would be artificial to determine whether the decision was unlawful on the remaining grounds without first considering whether protected rights are engaged. As PATHA accepts, these remaining grounds can be framed in various ways, but essentially come down to whether alleged errors in the Minister’s assessment of the evidence mean his decision was unreasonable in the traditional *Wednesbury* sense of being capricious or outside the range of reasonable responses,¹³⁷ or in the *Bryson* sense of being so clearly untenable as to amount to an error of law.¹³⁸ PATHA’s allegation under these grounds include that the decision was grossly disproportionate.

[264] I have already determined the Minister’s decision to promulgate the Regulations did not comply with s 19 of the Bill of Rights as it was discriminatory and disproportionate. In the process of determining that ground of review and the other

¹³⁶ Citing Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [11.7.11]; and *Taunua v Attorney General* [2005] NZLJ 355 (HC) at [302].

¹³⁷ *Associated Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 (CA).

¹³⁸ *Bryson*, above n 82.

grounds of review, I have addressed many of PATHA’s complaints about the Minister’s assessment of the evidence. This includes the absence of a clinical justification for the decision,¹³⁹ assessment of the harm on the affected cohort,¹⁴⁰ reliance on there being appropriate alternative treatment,¹⁴¹ reliance on the precautionary principle,¹⁴² and deferral to NZ First’s “anti-woke” agenda.¹⁴³

[265] It is inappropriate to attempt to reconsider these and other matters to determine whether the decision would have been unreasonable or grossly disproportionate if the Bill of Rights had not been engaged. Section 19 of the Bill of Rights was engaged, and the limits imposed are not justified under s 5.

Conclusion and relief

[266] It is for the Minister and Cabinet to decide what, if any, restrictions should be placed on access to puberty blockers for gender dysphoric/incongruent young people having regard to all relevant matters, including this judgment. My role is simply to decide whether the current Regulations were lawfully made.

[267] For the reasons set out above and summarised at the start of this decision, I have concluded that the Regulations were not lawfully made. They were made in breach of the consultation requirements of s 105 of the Medicines Act and s 19 of the Bill of Rights.

[268] There is no basis to withhold the relief sought of a declaration that the Regulations are unlawful and an order setting them aside, given the breach of a protected right and the impact of that breach. I also consider the breach of the consultation requirements in s 105 would, on its own, likely have required the setting aside of the Regulations, given my finding that, had there been consultation on the substance of the regulations, those consulted are likely to have made materially different submissions.

¹³⁹ At [163]–[173] above.

¹⁴⁰ At [205], [224], [234] and [236] above.

¹⁴¹ At [212]–[215] and [238] above.

¹⁴² At [161] above.

¹⁴³ At [162] above.

[269] I therefore make the following orders:

- (a) I declare that the Regulations are unlawful and invalid.
- (b) The Regulations are set aside.

Name suppression

[270] There are permanent orders suppressing the names and identifying details of the young persons and their families who have provided affidavits in support of PATHA's case.¹⁴⁴

[271] Three of PATHA's expert witnesses, Drs A, B and C have interim name suppression and apply for permanent name suppression. The Crown does not oppose the application.

[272] The orders are sought primarily due to concerns for the safety of the three witnesses and their families, with heightened risks of abuse and violence arising out of publicity in connection with the proceedings. The witnesses are also concerned that their clinics may be targeted, and their patients and colleagues harassed. The orders are only sought in relation to their identity, rather than the content of their evidence.

[273] I consider the risk to the safety and security of these witnesses and their families requires departure from the principle of open justice.¹⁴⁵ I am therefore satisfied that it is in the interests of justice to make permanent orders suppressing the names and identifying particulars of Drs, A, B and C.

[274] The current order that the Court file is not to be inspected without the permission of a Judge following consultation with the parties remains in place.

¹⁴⁴ *Professional Association for Transgender Health Aotearoa Inc v Minister of Health* HC Wellington CIV-2025-485-000869, 9 March 2026.

¹⁴⁵ *Erceg v Erceg* [2016] NZSC 135, [2017] 1 NZLR 310 at [21].

Costs

[275] If costs cannot be agreed, the parties should agree a timetable for the filing of brief costs submissions. The parties can revert to me if a timetable cannot be agreed.

La Hood J

Solicitors:

DLA Piper, Wellington for Applicant

Crown Law Office, Wellington for Respondent

Human Rights Commission | Te Kāhui Tika Tangata, Wellington for Interested Party