W v. W (High Court judgment)

An intersex woman successfully defended an application to annul her marriage

October 2000

Judgment

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Case No. 4119 of 1996

W*v* W

JUDGMENT OF THE HON Mr JUSTICE CHARLES

This is the official judgment of the court and I direct that no further note or transcript be made

signed
THE HON Mr JUSTICE CHARLES

Dated 10/10/00

Introduction

The Applicant seeks a decree of nullity in respect of his marriage to the Respondent on the grounds that at the date of the marriage he and the Respondent were not male and female respectively. It is common ground that the Applicant is and was male. The issue before me is therefore whether the Respondent was, or was not, a female at the date of the marriage ceremony (see s. 11 (c) Matrimonial Causes Act 1973 and Corbett v Corbett [1970] 2 AER 33 at 48 f/g). In this judgment I refer to the report of the Corbett case (and others) in the All England Reports because these were the reports cited to me. So far as I am aware there is no material difference between these reports and others of the same cases.

I heard argument and evidence in private but I am delivering this judgment in public. In doing so I have identified the parties by letter. The letter I have used does not correspond to their names.

The Respondent maintains that at the time of the marriage ceremony she was female (I shall use the male or female pronoun as seems appropriate in the relevant context).

The Corbett case set a biological test for determining a person's sex for the purposes of marriage. The test is that the determining factors or criteria are biological and if the gonadal, chromosomal and genital tests are congruent that determines the person's sex. I deal with this case in far greater detail later in this judgment.

In broad outline and notwithstanding statements in later cases that the biological test set out in the Corbett case might now merit reconsideration in the light of medical and legal developments that have taken place since it was decided neither side invited me to take this approach on the facts of this case.

The approach of the Respondent through counsel was that this was not a case where the biological test set and applied in the Corbett case was satisfied or provided the answer and therefore there was no need for me to refuse to follow it. It was submitted that this case was within the category of case that Ormrod J (at [1970] 2 AER 48j to 49a) in the Corbett case said must be left until it comes for decision. It was therefore argued that it was open to me to apply by a different and extended test to the biological test set and applied in the Corbett case, which involved a person who satisfied that test.

The position of the Applicant was that the biological test set out in the Corbett case could and should be applied in this case and that when this was done it founded the conclusion that the Respondent was not a female at the time of the marriage.

Unless I explain that this is not the case when I refer to "marriage" in this judgment I do so in the sense explained by Potter LJ in his judgment in S-T v J [1998] 1 AER 431 at 470 c/e where he says:

By s 11(c) of the 1973 Act, a marriage is void if the parties are not respectively male and female. It is plain that the use of the word 'marriage' in such a case is no more than convenient shorthand for a purported ceremony of marriage.

Background

I shall set this out by way of a chronology which contains findings of fact (and many facts which were not in dispute)

1947	The Respondent was born in the North of England
1947	The Respondent was registered with a boy's name and as a boy. The Respondent says (and I accept) that she was told by her mother before her death that because she was born of indeterminate sex the doctor asked her parents whether they wanted the Respondent to be registered as a girl or a boy and as her father wanted a boy the Respondent was registered as a boy.
1948	A cousin of her mother and her husband adopted the Respondent. The Respondent's adoptive parents treated the Respondent as a boy.

1947/62	From an early age the Respondent played with dolls and chose to wear girl's clothes. At secondary school the Respondent refused to shower with the boys and to wear the boys' uniform. From about the age of 11 the school allowed the Respondent to wear girl's tops. By 1962 the Respondent had noticeable breasts and female body shape and had developed a romantic interest in boys.
1962/3	At the age of 15 the Respondent's adoptive father convinced their GP to administer a course of testosterone injections to the Respondent with a view to making the Respondent's body more masculine and to stop the Respondent's breasts from growing. The Respondent resisted and was held down by the Respondent's adoptive father when the injections were given. These injections had no real effect and when the Respondent's adoptive father threatened to increase the dosage and frequency of the injections and that the Respondent should have surgery to reduce the size of the Respondent's breasts - the Respondent ran away from home and lived as girl. The Respondent was found and forcibly resumed home.
1964/5	At the age of 17 the Respondent ran away from home again and never resumed. Since then the Respondent has used a girl's name.
Mid to late 1960s	The Respondent lived with a man in Manchester. As time went by he complained that the Respondent was too feminine and that he wanted a man not a woman and the Respondent ended the relationship. The detail of this relationship which from the Respondent's evidence was at least in part of a homosexual nature was not investigated in evidence before me.
Late 1960s onwards	From the end of that relationship the Respondent has never again dressed or lived as anything but a woman.
1970 approx	At the age of 23 the Respondent was due to have surgery to construct a vagina but this was postponed indefinitely because the Respondent was thought to have suffered a small cerebrovascular accident.
1970 to 1980	The Respondent received no treatment but did experience occasional cyclical symptoms as might be experienced in a menstrual cycle.
1980	From about 1980 the Respondent started treatment with oral oestrogen.
May 1987	The Respondent had gender reassignment surgery.
May 1990	The Respondent married a man for the first time (Mr X).

1991	The Respondent's female appearance was re-inforced with thyroid chondroplasty.
1992	The Respondent acting on the advice of her then solicitor obtained a decree of nullity on the grounds that the Respondent and Mr X were not respectively female and male at the time of the marriage. The Respondent did not wish to do this but was persuaded by her then solicitor that it was the appropriate and cheapest way of ending the marriage.
1993	The Respondent married the Applicant (Mr W). As a result of the marriage Mr W gained a right to remain in the UK.
1996	The parties separated.
1996	The Respondent issued a petition for divorce from the Applicant.
1996/7	Proceedings took place between the parties under the Domestic Violence and Matrimonial Proceedings Act 1976 in which the parties made serious and hostile allegations about each other. In those proceedings the Applicant raised the point that he maintains that the Respondent is not a female and therefore not within the provisions of that Act.
1997	The Applicant did not contest the divorce and a decree nisi and absolute were granted, and the Respondent commenced ancillary relief proceedings and gave notice of intention to proceed with them before the decree absolute.
1998	The Applicant issued the present application.
1998	The Applicant re-married.

I have based this chronology and the facts stated therein primarily on the Respondent's statement, her oral evidence and the account of her medical history set out in the report of the medical expert (Dr. Conway). As I understand it he based this report on what the Respondent told him and the Respondent's scant medical records.

The Applicant was not in a position to challenge the evidence of the Respondent in respect of the period before he and the Respondent met. His counsel put some cross examination on a photograph of the Respondent dressed as a man when in her teens or early twenties. The Respondent said that this was taken at a cross dressing party. I accept that evidence. Further and in any event if this was not the case and that time (and thus around the time of her relationship with a man in Manchester) the Respondent did dress (or sometimes dressed) as a man this would make no material difference to the result of this case. Also there were other photographs of the Respondent, which show that from her teens (and thus well before she started to take oestrogen and any surgery) the Respondent looked and dressed like a girl and then a young woman.

In my judgment correctly in submission the Applicant's counsel accepted that the Respondent

has lived day to day life as a female since the time that the Respondent has been able to choose the gender in which she lives her day to day life and thus that socially the Respondent was female at the time of the marriage to the Applicant.

In my judgment the facts set out in the chronology (including the truth of the statement made to the Respondent by the Respondent's mother) are true on the balance of probabilities.

Miscellaneous

When I read the papers in this case it was unclear to me why the Applicant was pursuing this application. Through his counsel I was told that the Applicant was doing so on legal advice and because the result would affect his status and if he was successful he would be able to marry in a church. He, and the Respondent, accepted (as is the case) that if the Applicant is granted a decree of nullity the court has power to entertain proceedings for ancillary relief (see for example S-T v J [1998] 1 AER 431 at 443 g/j).

The Respondent has not brought any proceedings for declaratory relief but it was made clear through counsel that the Respondent was defending these proceedings because they related to the Respondent's status and the result thereof may assist the Respondent to obtain an alteration of the Respondent's birth certificate and would affect the Respondent's ability to marry again.

Before the hearing the parties had recorded their agreement that neither of them would raise any issue of estoppel or laches based on the decree absolute made on the Respondent's petition for divorce, the decree of nullity made in respect of the Respondent's earlier marriage to Mr X or the Respondent's allegation that the Applicant entered into the marriage with the Respondent with full knowledge of the Respondent's medical history. I agree (a) that this agreement accords with the decisions in Hayward v Hayward [1961] P 152 at 158/9, and Vervaeke v Smith [1982] 2 AER 144 at 152 d/e and (b) that those decisions show that having regard to the inquisitorial nature of the jurisdiction relating to nullity of a marriage and the fact that it relates to status the parties could not have advanced arguments based on estoppel or laches successfully.

Further the cases referred to in the last paragraph and the Corbett case ([1970] 2 AER 33 at 51) and S-T v J [1998] 1 AER 431 at 443 g/j found the conclusion that if the Applicant can establish that the Respondent was not a female at the date of the marriage he is entitled to a decree of nullity and the court should not in its discretion refuse to make such a decree as it might a declaration on the basis that it is hypothetical or otherwise. I add that it is now provided by s. 58(5) Family Law Act 1986 that a declaration that the marriage was at its inception void cannot be made.

Although it was raised in the skeleton argument of counsel for the Applicant the issue of whether the Respondent had committed perjury under s. 3 Perjury Act 1911 was not pursued before me. I therefore did not hear any evidence from the Respondent relating to the mens rea of that offence. Having regard to the decision (by a majority) of the Court of Appeal in S-T v J [1998] 1 AER 431 as to the effect of perjury in respect of a marriage in my judgment it was not necessary or appropriate for the parties, or the court, to pursue this issue.

I comment that others in a similar position to the Respondent could be well advised to seek declaratory relief from the court as to their capacity to marry before entering into a marriage and making statements relating thereto that are required by law and which can found a charge of perjury if they are false. As to this it would be for the court at the relevant time to determine whether or not it should entertain such an application. Although I recognise that there is authority to the effect that generally a court will not in the exercise of its discretion entertain an application for a declaration whether a particular course of conduct would amount to a criminal offence (see Imperial Tobacco Ltd v A-G [1981] AC 718) it seems to me that as any such declaration would relate to status and the legislation does not require that the relevant issue to be decided by the relevant criminal courts, or after a marriage has taken place, there is a good chance that such an application would be entertained by the court (see the discussion in Zamir and Woolf on Declaratory Judgment paragraphs 4.162/6 & 186/192 and Airedale NHS Trust v Bland [1993] AC 789.

Neither party sought relief under s. 12 (a) Matrimonial Causes Act on the basis that the marriage was voidable on the grounds of the alleged incapacity of the Respondent to consummate it. This alternative was considered by Ormrod J in the Corbett case (see [1970] 2 AER at 47g to 48f) where he refers to S v S (otherwise W) (No 2) [1962] 3 AER 53. Naturally I accept that it was open to the parties to take this course. However as a matter of law in my judgment the interrelationship between sections 11 (c) and 12 (a) should be remembered.

Presumptions - Onus of Proof

I was referred to two presumptions which conflicted in this case, namely:

a. the entry on a person's birth certificate is prima facie evidence of that person's sex (see for example The Rees Case [1987] 2 FLR 111 at 496 para 27 and The Cossey Case [1991] 2 FLR 492 at 499 para 24), and

b. The presumption that a marriage is valid where the parties enter into an ostensibly valid marriage and live together as man and wife (see Mahadervan v Mahadervan [1962] 3 AER 1108 at 1116D).

In my judgment correctly neither side placed any real weight on either of these presumptions or the prima facie position arising from them.

Also and again in my judgment correctly neither side sought to place weight on the onus of proof (as to which in the context of the capacity to marry see Wicken v Wicken [1999] 1 FLR 293 at 297F to 298E).

The medical evidence

The parties jointly instructed Dr Conway who is a consultant endocrinologist. I am very grateful to him for his considerable help and patience. He clearly had considerable knowledge and experience in his field of expertise and he gave his evidence as an expert witness should.

After setting out the account given to him by the Respondent (which appears in my chronology) Dr Conway said this in his report under the heading "review of available notes":

There is very little information available prior to the gender reassignment surgery in 1987, so little further information is available regarding her original appearance. A letter on 11 December 1969 by Dr B reviews the psychiatric background but no physical examination took place at this stage. A letter dated 5 November 1984 from Dr S highlights the fact that unwanted hair growth was a minor problem. The letter from Dr M dated 19 February 1987 reviews the case for gender reassignment surgery but does not shed any light on an underlying diagnosis. Lastly, the operation note from Mr D states only that a routine operation took place but provides no detail as to the original anatomy. The only other point of note in the remaining correspondence is that the female appearance was reinforced with a thyroid chondroplasty in 1991 and breast augmentation in 1996.

At my instigation further information was sought and received from Mr D during the hearing in respect of (a) the nature of the Respondent's external genitalia before the operation, and (b) the nature and extent of the operation.

In the Respondent's written and oral evidence the Respondent had described that genitalia as a flap of skin of less than 2.5 centimetres where a normal penis would be and no vaginal opening. The Respondent also said that she had no testicles and a vestigial scrotal sac.

In the Respondent's oral evidence she was reticent and unclear in answering questions as to where the urethral opening was in that flap of skin and how she urinated as a child and later before the operation. She simply failed to answer whether the urethral opening was at the tip of the flap of skin or elsewhere. I accept that giving this evidence must have been both upsetting and embarrassing for the Respondent but in my judgment in this part (and only in this part) of her evidence the Respondent was not being completely open. In my judgment the inference is and I so find on the balance of probabilities that the urethral opening was at, or near, the end or tip of the flap of skin.

The Respondent also said, and I accept that (a) the unwanted hair growth referred to by Dr Conway in the part of his report cited above was on her lip, and (b) the date of the operation performed by Mr D was brought forward because the flap of skin had atrophied.

During the hearing Mr D told the solicitors to the parties, the following:

a. the external genitalia were extremely small,

b. he could not remember where the urethral opening was other than it was amongst the penile skin flaps,

c. the Respondent did not have a normal penis and that "it was definitely abnormal", and

d. in performing the operation he opened the skin flap, then opened the normal site of the vagina in the pelvis which he lined with the skin flap. He then placed the urethral opening in the normal female position.

When he first gave his oral evidence Dr Conway said that it was "a close call" on the information he had whether the whether the flap of skin should be described as a micro penis or a mini clitoris. His view was that if one had to classify the Respondent's external genitalia as male or female it would fall on the male side of the line and thus the flap of skin should be classified as a mini penis. Helpfully Dr Conway resumed (as he had said he would if asked) to answer questions that had arisen during the course of submissions and further consideration of the case after he had first given oral evidence. On his return he was made aware of the additional information from Mr D and the evidence of the Respondent. This additional information did not cause him to change his view.

In his report under the heading "case analysis" Dr Conway said this:

It is extremely difficult to be conclusive about an original diagnosis of an intersex state after surgery has been completed. It is clear that her genetic sex is male, it is likely that her gonadal sex was male, and it seems clear that her gender orientation is female. Sex as determined by genital appearance, appears to have been ambiguous at birth and body habitus is predominantly female.

The most likely medical diagnosis that would fit everything described above, would be of partial androgen insensitivity. Particularly in favour of this diagnosis is the history of a failure to masculinize in response to treatment with testosterone. Further, she has developed scant body hair and underwent spontaneous breast development. Partial androgen insensitivity represents a spectrum of appearances from a fully male appearance with a low sperm count, to a predominantly female appearance with a slightly enlarged clitoris. In this spectrum, Ms W appears to be towards the female end of a midpoint. Gender identity in partial androgen insensitivity is just as variable as the physical appearance and it would not be unusual for her to have a fully female gender identity. The alternative diagnoses of "vanishing testis syndrome" or a disorder of testosterone synthesis are unlikely because of her failure to masculinize when given testosterone. In addition, the disorders of androgen synthesis, such as 5-a-reductase deficiency, or 17-hydroxysteroid-dehydrogenase deficiency, share a tendency for sufferers to become more masculine at puberty, and the converse appears to have been the case here.

Partial androgen insensitivity is caused by mutations of the androgen receptors so that the male body is unable to "see" testosterone. While it may be possible to finally clinch this diagnosis by DNA sequencing the androgen receptor gene, it is at present only possible to identify the mutation in 50% of individuals with this phenotype. The only part of this history which does not fit with the diagnosis of partial androgen insensitivity is the unsubstantiated reference to a vestigial uterus. In the spectrum of disorders, it would be very unusual for such an organ to have existed and the nature of occasional abdominal pain and cyclical symptoms is obscure.

Partial androgen insensitivity is distinct from complete androgen insensitivity where the external appearance is unambiguously female and in particular; the external genitalia appear quite normally female at birth. The complete androgen insensitivity syndrome occurs when the failure of androgen receptors to respond to testosterone approaches 100%. If testosterone is able to transmit any signal to the androgen receptor, then the genitalia appear ambiguous and the diagnosis is of partial androgen insensitivity.

In summary the intersex state which underlies the background to Ms W is most likely due to the partial androgen insensitivity syndrome. Her genetic sex and gonadal sex are male. Her genitalia were ambiguous and her body habitus and gender orientation appear female.

In his oral evidence Dr Conway confirmed that this remained his view. He also:

(a) Read the following passage from the judgment of Ward LJ in S-T v J at [1998] 1 AER 450g to 451b, namely:

> At the XXIIIrd Colloquy on European Law in April 1993, the European Committee on Legal Cooperation at the Council of Europe approved a paper by Professor Dr Gooren on the biological aspects of transsexualism and their relevance to its legal aspects. He explained:
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> 'It has become clear that the differentiation process of becoming a man or a woman is a multistep process with for each step a window of time, a critical phase. Once this phase has passed there is no backtracking. With the fusion of an ovum and a sperm, the chromosomal pattern becomes established … The differentiation of the gonads takes place in the human foetus between 57 weeks of pregnancy … When the gonads have become either testes or ovaries … the next step of the differentiation process is the formation of the internal genitalia. The foetal testis becomes endocrinologically active and secretes testosterone … The following step is the formation of the external genitalia, obeying to the same paradigm: male external genitalia in the presence of testosterone … and female external genitalia in the absence of testosterone … The decision on sex assignment is in modern medicine primarily guided by the nature of the external genitalia … The demonstrable sex differences in the brain become only manifest by the age of 3-4 years postnatally … Upon examination of a very limited number of male-to-female transsexuals post mortem, their brains showed morphological differences in comparison with non-transsexual controls … The implication of the above scientific insight that the sexual differentiation of the brain occurs after birth is that assignment of a child to the male or female sex by the criterion of the external genitalia is an act of faith.'
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> and confirmed that he agreed with that part of Professor Dr Gooren's paper.

(b) Stated that the relevant, or potentially relevant, medical advances since the Corbett case had been psychological and in respect of studies and research relating to brain structure referred to by Ward LJ in the S-T v J case. He added that so far as he was aware the latter had been directed to homosexuals and transsexuals and not to persons with diagnoses of total or partial androgen insensitivity.

(c) In respect of biological advances he referred to the advances relating to DNA but confirmed that they and the DNA test he referred to in his report were unlikely to assist in this case.

(d) Stated that if the test was not confined to biological factors then, in general terms, there was no obvious stopping point in identifying factors to be taken into account and that psychological matters and the interaction of the developing brain and sex hormones were interesting and could provide points of discrimination. The factors

would therefore include the five factors set out in the Corbett case (see below).

(e) Confirmed the points made in the Corbett case as to doctors choosing the sex in which a person was to live and added that now a case such as this tests would be carried to determine whether testes were present and the reaction of the child to testosterone. He also stated that now in western countries in cases of real difficulty and uncertainty there is probably a bias towards assigning an inter-sex child to the female gender and lifestyle with appropriate surgical intervention.

(f) Stated that the continuing effect of testosterone altered a person's gender and not the person's sex. He did not expand on this statement and it seems to me that it must depend on the criteria used for determining a person's sex. In its context I understood this statement to be based on a purely biological test for determining sex (i.e. the Corbett test). As appears from point (e) the effect (or likely effect) of testosterone is a factor taken into account by doctors (and others) in choosing the sex (or gender) in which a person who was not on a purely biological test unambiguously male or female. I return to this point when commenting on passages in the Corbett case concerning the "assignment" of a person to the female sex.

(g) Stated that the further information from Mr D did not add much on the issue whether there were testicles. In cases of androgen insensitivity it would be normal to find testes in the abdomen but it did not seem from Mr D's description of the operation that testes had been removed.

Findings having regard to the Respondent's history and the medical evidence

I reach the following conclusions:

1. It is clear that the Respondent's chromosomal sex is male. Dr Conway reported that investigations undertaken in 1999 at his instigation showed that she had a normal male karyotype 46XY.

2. There is no clear evidence as to the Respondent's gonadal sex but (like the parties) I accept and find that it is likely that it was male (i.e. that she had testes and no ovaries). In this context I have had regard to the fact there is no evidence of any testes being removed from the abdomen at the time of the Respondent's operation which Dr Conway accepted during his oral evidence would have been normal in such an operation if they had been present. But the lack of this evidence did not cause him to change his view that the Respondent's gonadal sex was likely to be male. I accept that view. Also I accept his view that it would be very unusual for a uterus to have existed and on that basis conclude that the Respondent did not have a uterus.

3. The Respondent's external genital appearance was ambiguous.

4. The Respondent has never had a normal penis and without surgery could never have had sexual intercourse using the flap of skin. But if a choice had to be made her external genitalia would be categorised as a mini penis rather than an enlarged clitoris.

5. The Respondent did not have the internal sex organs or genitalia of a woman and had

no vaginal opening.

6. On a purely external genital test the Respondent was not, and was not close to being, a normal man or a normal woman. However if a choice had to be made based purely on the Respondent's internal and external genitalia the Respondent would be on the male side of the line and thus male.

7. The Respondent's body habitue and general appearance from her early teens was more female than male. For example, she had little body hair, small hands and feet and she had some spontaneous female breast development.

8. The Respondent chose to live life as a woman well before the time that she commenced taking oestrogen and well before her gender reassignment surgery. That choice was a final one and there was no realistic prospect that the Respondent would change it even if she had not starting taking oestrogen and had surgery. Her taking of oestrogen and surgery were therefore in accordance with and confirmed that choice. There is now no realistic prospect that the Respondent would ever choose to live as a man.

9. The Respondent has always been sterile and has never had the potential for developing into a male or a female who was not sterile.

10. Without surgery the Respondent would never have been capable of having sexual intercourse as a man or a woman.

I accept that on the balance of probabilities Dr Conway's diagnosis of partial androgen insensitivity is correct and my understanding is that his reference in his report to the intersex state of the Respondent is based on that diagnosis and thus its cause (namely mutations of the androgen receptors so that the male body is unable to "see" testosterone), taken together with the Respondent's ambiguous external genitalia, body habitus and gender identity all of which Dr Conway points can vary widely in people diagnosed with partial androgen insensitivity.

As the judgment in the Corbett case shows there can be debate and differences as to who should be included within the description "inter-sex" or "physical inter-sex". In my judgment those labels or descriptions can be misleading and it is more important to consider the factors which lead to them being applied, or to the possibility of them being applied, than the labels or descriptions themselves.

However I accept that such labels or descriptions are a useful shorthand and as appears later under the heading "My conclusions and reasoning" in my view the label or description "physical inter-sex" can be applied to the Respondent.

Recent Authority relating to Transsexuals

I was not referred to any authority that concerned a person with a diagnosis of partial androgen insensitivity. In the Corbett case and in a lecture given by Ormrod J to the Royal Society of Medicine in 1972 (which I refer to later) androgen insensitivity and hormonal disorder are referred to but in the Corbett case Ormrod J found that the factual basis of any

hormonal disorder had not been established and that it had not been established that the respondent in that case should be classified as a case of intersex on the basis of hormonal abnormality.

The Corbett case concerned a transsexual.

In his minority judgment in S-T v J [1998] 1 AER 431 (in particular at pages 443 to 454 under the headings "*Transsexuals and matrimonial law*" and "*The medical condition of transsexualism and its effect on the defendant's state of mind*") Ward LJ gives a very helpful review of the United Kingdom authorities and cases before the European Court of Human Rights concerning transsexuals. I adopt it with gratitude and I shall not attempt to summarise it. However I make the following points in respect of it, and that case, namely:

(A) As the headings I have referred to show Ward LJ was concerned with a transsexual. Care needs to be taken with definitions or descriptions but it is clear from the facts of that case that it involved a person who at birth unambiguously had the chromosomal, gonadal and genital features of the female sex. This was not disputed (see 434f) and therefore that case did not involve, and the discussion of the authorities therein was thus not directed to, a case such as this where the evidence is that the genital features of the relevant person were not unambiguously male or female at birth.

(B) Ward LJ (at 449j) and Sir Brian Neill (at 476j) recognise that the use of the words "male and female" in s. 11 Matrimonial Causes Act might found an argument that the test or approach in the Corbett case should be revisited and not followed on the basis that a test related to gender and not sex should now be applied.

(C) All the judgments recognise the possibility that the Corbett case might merit or require reconsideration in the light of modern medical advances and the approach in other jurisdictions (see 450b, 470e and 476j). However they also make it clear that at present the test under the Matrimonial Causes Act is as set out in the Corbett case. In this context Potter LJ says this at 470 e/g

> For the purpose of determining whether a particular human being is of a particular sex, the criteria are biological: see *Corbett v Corbett (otherwise Ashley)*[1970] 2 All ER 33 at 48[1971] P 83 at 106 and *Rees v UK* (1985) 7 EHRR 429 (App 9532/81) (1986) 9 EHRR 56 and *Cossey v UK* (1990) 13 EHRR 622. While it may be that the advance of medical science may lead to a shift in the criteria applied by the English courts, it is plain that at present, the position is that laid down in *Corbett v Corbett* and that, even in jurisdictions which have extended the criteria in the case of transsexuals, a 'female to male' transsexual is not generally regarded as having satisfied the criteria of masculinity unless endowed (by surgery or otherwise) with apparent male genitalia. In those circumstances it is also plain that the defendant was well advised not to defend the suit for nullity brought against him by the plaintiff.

> This accords with what Ward LJ says and he points out at 444b/c that although the approach in the Corbett case has not been followed in some jurisdictions it has

escaped censure in the European Court of Human Rights. This remains the case after the case of Sheffield and Horsham v UK [1998] 2 FLR 928 albeit that it can still be said thereafter having regard, for example, to the size of the majority in that case that the winds of change, or potential change, are still blowing in Europe.

(D) Advances in medical science since the decision in the Corbett case are identified by Ward LJ (at 451) where he says:

> Professor Gooren was one of the authors of further recent research, a resume of which was published in (1995) 378 Nature 68 (November). These studies show a female brain structure in genetically male transsexuals which supports the hypothesis that gender identity develops as a result of an interaction of the developing brain and sex hormones. The tiny region of the brain that is under scrutiny is the central sub-division of the bed nucleus of the stria terminalis. It is part of the, hypothalamus which helps to keep the different systems of the body working in harmony and which is essential for sexual behaviour. This brain area is ordinarily larger in men than in women, and in transsexuals the size corresponds with the gender assumed. Medical science has, therefore, made very considerable advances since 1970 when *Corbett v Corbett* was decided.
>
> In argument before me in this case the Respondent did not advance, or seek to rely on, such advances in medical science as the basis of an argument that the biological test in the Corbett case should not be applied and, for example, the Respondent did not advance, or rely on, evidence or research relating to brain structure. Further the Respondent did not advance any medical evidence as to her state or mind.

(E) Accordingly in this case, as was the position in S-T v J, it is not for me to decide whether English law can or should change to match the advances in medical knowledge referred to in that case and other cases relating to transsexuals.

(F) However in considering the arguments in this case and thus whether or not biological test set out in the Corbett case should be applied to provide the answer to the issue whether or not the Respondent was a female at the date of the marriage, in my judgment I should bear in mind the points made in S-J v T in respect of the medical advances that have been made and the approach in Europe and other jurisdictions concerning transsexuals.

The Corbett case - Corbett v Corbett [1970] 2 AER 33

I cite from this case at length. My main reasons for doing so are:

a. it sets out the reasoning behind the biological test decided upon and applied therein by Ormrod J,

b. the reasoning contains descriptions of medical terms and other medical matters, which are relevant to this case and, in my view, extremely helpful to people (like myself) who (unlike Ormrod J) do not have any medical training. (Dr Conway confirmed that these descriptions remain accurate),

c. the case therefore provides informative and helpful background, and

d. a close study of the case is necessary for the purpose of deciding which of the rival arguments in this case is correct.

Although I cite from this case at some length my citations are selective and it is important to read all of the judgment of Ormrod J. In citing from the case I have (a) emphasised passages which in my judgment are of particular importance in this case, and (b) paused to make comments which form part of my reasoning.

Ormrod J defined the issues in the Corbett case as follows:

The case, therefore, resolves itself into the primary issue of the validity of the marriage, which depends on the true sex of the respondent; and the secondary issue of the incapacity of the parties, or their respective willingness or unwillingness, to consummate the marriage, if there was a marriage to consummate. On the primary issue, the basic facts are not in dispute; the problem has been to discover them. On the secondary issue, there is a direct conflict of evidence between the petitioner and the respondent, but it lies within a narrow compass. (35 d/e)

Later Ormrod J says this in respect of the facts:

The relevant facts must now be stated as concisely as possible. The respondent was born on 29 April 1935 in Liverpool and registered at birth as a boy in the name of George Jamieson, and brought up as a boy. It has not been suggested at any time in this case that there was any mistake over the sex of the child. ——— After some six months' treatment, the doctor who had been treating the respondent under Dr Vaillant's supervision reported his conclusions to the general practitioner in a letter dated 5 June 1953, which reads in part as follows:

'This boy is a constitutional homosexual who says he wants to become a woman. He has had numerous homosexual experiences and his homosexuality is at the root of his depression. On examination, apart from his womanish appearance, there was no abnormal finding.'

Unfortunately, it has proved impossible to trace this doctor whose evidence would have been of great value in resolving some of the questions raised by the experts called on behalf of the respondent. ———

—— he was introduced to a certain Dr Burou who practised at Casablanca, and, on 11 May 1960, he underwent, at Dr Burou's hands, a so called 'sex-change operation', which consisted in the amputation of the testicles and most of the scrotum, and the construction of a so-called 'artificial vagina', by making an opening in front of the anus, and turning in the skin of the penis after removing the muscle and other tissues from it, to form a pouch or cavity occupying approximately the position of the vagina in a female, that is between the bladder and the rectum. Parts of the scrotum were used to produce an approximation in appearance to female external. I have been at some pains to avoid the use of emotive expressions such as 'castration' and 'artificial vagina' without the qualification 'so-called', because the association of ideas connected with these words or phrases are so powerful that they tend to cloud clear thinking. It is, I think, preferable to use the terminology of Miss Josephine

Barnes, who examined the respondent as one of the medical inspectors in this case. She described the respondent as having a 'cavity which opened on to the perineum'. There is no direct evidence of the condition of the respondent's genitalia immediately before their removal at this operation. I was informed by counsel that Dr Burou had refused to supply any information, or even to answer letters addressed to him by the respondent's solicitors. The respondent, herself, was almost as unhelpful. In evidence-in-chief, she said that she 'thought' that she had a penis at the time when she was in the Merchant Navy. She had testicles at that time. She said 'I haven't the foggiest idea of the size of my penis' and had no idea of the size of the testicles. In cross-examination, she was asked whether she had ever had an erection, and whether she had had ejaculations. She simply refused to answer either question and wept a little. It is a curious fact that, in the further and better particulars under para 5 of the answer, the operation is said to have been for the removal of a 'vestigial' penis, and the construction of an artificial vagina. No explanation was forthcoming as to the source of the word vestigial', and there is no evidence that the respondent's penis or testicles were abnormal. Insofar as credibility is concerned, I do not think that it would be right to hold that these particular answers reflect adversely on the respondent's credit generally, because the evidence of the psychiatrists is that persons who suffer from these intense desires to belong to the opposite sex, often exhibit a profound emotional reaction when asked about the genitalia which they so much dislike. Nevertheless, such unhelpful evidence does nothing to support the suggestion that there was anything unusual about the respondent's sexual anatomy.

Following the operation, the respondent returned to London, now calling herself April Ashley, and dressing and living as a female. In evidence she stated that, after the operation, she had had sexual relations with at least one man, using the artificial cavity quite successfully. (35h to 37d)

Later (from 40d) Ormrod J turns to discuss the medical evidence and beginning at 42c he says:

There was general agreement among all the doctors on the basic principles and the fundamental scientific facts. Anomalies of sex may be divided into two broad divisions, <u>those cases which are primarily psychological in character, and those in which there are developmental abnormalities in the anatomy of the reproductive system (including the external genitalia).</u> (42c)

I pause to add that in my judgment that it is important to remember this distinction, and that in the next passage Ormrod J is dealing with it. He continues as follows:

<u>Two kinds of psychological abnormality are recognised, the transvestite and the transsexual</u>. The transvestite is an individual (nearly, if not always a man) who has an intense desire to dress up in the clothes of the opposite sex. This is intermittent in character and is not accompanied by a corresponding urge to live as or pass as a member of the opposite sex at all times. Transvestite males are usually heterosexual, often married, and have no wish to cease to play the male role in sexual activity. <u>The transsexual, on the other hand, has an extremely powerful urge to become a member of the opposite sex to the fullest extent which is possible.</u> They give a history, dating back to early childhood, of seeing themselves as members of the opposite sex which persists in spite of their being brought up normally in their own sex. This goes on until they come to think of themselves as females imprisoned in male bodies, or vice

versa, and leads to intense resentment of, and dislike for, their own sexual organs which constantly remind them of their biological sex. They are said to be 'selective historians', tending to stress events which fit in with their ideas and to suppress those which do not. Some transsexual men live, dress and work regularly as females and pass more or less unnoticed. They become adept at make-up and knowledgeable about using oestrogen, the female sex hormone, to promote the development of female-like breasts, and at dealing with such masculine attributes as facial and pubic hair. As a result of the publicity which has been given from time to time to so-called 'sex-change operations', many of them go to extreme lengths to importune doctors to perform such operations on them. The difficulties under which these people inevitably live result in various psychological conditions such as extreme anxiety and obsessional states. They do not appear to respond favourably to any known form of psychological treatment and, consequently, some serious-minded and responsible doctors are inclining to the view that such operations may provide the only way of relieving the psychological distress. Dr Randell has recommended surgical treatment in about 35 cases, mostly restricted to castration and amputation of the penis, but in a few carefully selected cases he and Professor Dewhurst and the plastic surgeon who is working with them have undertaken vagino-plasty as well, that is the construction of a so-called vagina. The purpose of these operations is, of course, to help to relieve the patient's symptoms and to assist in the management of their disorder; it is not to change their patient's sex, and, in fact, they require their patients before operation to sign a form of consent which is in these terms:

'I … of … do consent to undergo the removal of the male genital organs and fashioning of an artificial vagina as explained to me by … (surgeon). I understand it will not alter my male sex and that it is being done to prevent deterioration in my mental health.

(Signature of Patient)'

Professor Roth is doubtful about the therapeutic efficacy of these procedures and has only recommended one of his patients for operation.

There is, obviously, room for differences of opinion on the ethical aspects of such operations but, if they are undertaken for genuine therapeutic purposes, it is a matter for the decision of the patient and the doctors concerned in his case. ——— This phenomenon of transsexualism must, however, be seen in its true perspective. It occurs in men and women of all ages, some of whom are married in their true sex and are fathers or mothers of children. In a paper published on the British Medical Journal in December 1959, Dr Randell refers to 13 transsexual men who were or had been married. Some of his male patients, on whom operations have been performed, have been men of mature age; one was a naval petty officer aged 42 years. All his male transsexual patients, which now number 190, have been biologically, that is anatomically and physiologically, normal males. Female transsexuals present corresponding problems but they are not relevant to the present case.

It is clear from the account which I have given of the respondent's history that it accords very closely with this description of a male transsexual. Dr Randell considered that the respondent is properly classified as a male homosexual transsexualist. Professor Dewhurst agreed with this diagnosis and said the description 'a castrated male' would be correct. Dr Armstrong agreed that the evidence contained in the Walton Hospital records was typical of a male transsexual, but he considered that there was also evidence that the respondent was not a

physically normal male. He said that the respondent was an example of the condition called inter-sex, a medical concept meaning something between intermediate and indeterminate sex, and should be 'assigned' to the female sex, mainly on account of the psychological abnormality of transsexualism. Professor Roth thought that the respondent was a case of transsexualism with some physical contributory factor. He was prepared to regard the case as one of inter-sex, and thought that the respondent might be classified as a woman 'socially'. He would not recommend that the respondent should attempt to live in society as a male. Both he and Dr Randell had been successful in asking the Ministry of Labour to register some of their male transsexual patients as female for national insurance purposes. Insofar as there are any material differences in the evidence of Dr Randell, Dr Armstrong and Professor Roth, I was less impressed by Dr Armstrong's evidence than by that of the other two doctors, both of whom were exceptionally good witnesses. Of the latter two. I am inclined to prefer the evidence of Dr Randell because I do not think that the facts of this case when critically examined, support the assumptions which Professor Roth had been asked to make as the basis of his evidence.

There was a considerable amount of discussion in the course of the expert evidence about the aetiology or causation of transsexualism. Dr Randell and Professor Roth regard it at present as a psychological disorder arising after birth. probably as a result of some, as yet unspecified, experiences in early childhood. The alternative view is that there may be an organic basis for the condition. This hypothesis is based on experimental work by Professor Harris and others on immature rats and other animals, including rhesus monkeys, which suggests that the copulatory behaviour of the adult animals may be affected by the influence of certain sex hormones on particular cells in the hypothalamus, a part of the brain closely related to the pituitary gland, in early infancy. At present the application of this work to the human being is purely hypothetical and speculative. Moreover, the extrapolation of these observations on the instinctual or reflex behaviour of animals to the conscious motives and desires of the human being seems to be, at best, hazardous. The use of such phrases as 'male or female brain' in this connection is apt to mislead owing to the ambiguity of the word 'brain'. In the present context it refers to a particular group of nerve cells, but not to the seat of consciousness or of the thinking process. In my judgment, these theories have nothing to contribute to the solution of the present case. On this part of the evidence my conclusion is that the respondent is correctly described as a male transsexual, possibly with some comparatively minor physical abnormality. (42c to 44a)

I pause to comment that this is an important finding in the context of (i) the Corbett case itself, (ii) the cases in this country and before the ECHR concerning transsexuals and (iii) this case and the manner in which it was argued. This is because (a) it demonstrates that in the Corbett case Ormrod J decided that he was not concerned with a transsexual or the aetiology or causation of transsexualism to which he refers and as to which unsurprisingly there has been research, development and advances since 1970 which are referred to in later cases concerning transsexuals, and (b) as I have said in this case the Respondent did not seek to rely on any such research development or advances.

Rather the argument was that the Respondent was not a transsexual and did not fall within the test formulated by Ormrod J and therefore (a) the Corbett case did not require me to decide this case solely on the biological factors referred and relied on by Ormrod J in deciding the Corbett case, and (b) it was open to me to take other factors into account.

Accordingly the Respondent's argument was that the Respondent could not be properly described as a *"male transsexual, possibly with some comparatively minor physical abnormality"* and that the Respondent did not fall within, and this case should not be decided solely by, an application of the biological test or formulation set out by Ormrod J later in his judgment. This entails assertions that (i) the Respondent is not a male with some comparatively minor physical abnormality, and (ii) in deciding this case the court should not limit itself to a consideration of which side of the line the combination of the Respondent's chromosomal, gonadal and genital characteristics fall or each of those factors fall.

As to point (i) it should be remembered that as appears from the above citation Ormrod J was less impressed with the evidence of Dr Armstrong than with that of the other doctors and Ormrod did not accept Dr Armstrong's view that there was evidence that the respondent in the Corbett case was not a physically normal male.

Ormrod J continued as follows (at 44a):

I must now deal with the anatomical and physiological anomalies of the sex organs, although I think that this part of the evidence is of marginal significance only in the present case. In other cases, it may be of cardinal importance. All the medical witnesses accept that there are, at least, four criteria for assessing the sexual condition of an individual. These are —

i. Chromosomal factors.

ii. Gonadal factors (i.e. presence or absence of testes or ovaries).

iii. Genital factors (including internal sex organs).

iv. Psychological factors.

Some of the witnesses would add-

v. Hormonal factors or secondary sexual characteristics (such as distribution of hair, breast development, physique etc which are thought to reflect the balance between the male and female sex hormones in the body).

It is important to note that these criteria have been evolved by doctors for the purpose of systematising medical knowledge, and assisting in the difficult task of deciding the best way of managing the unfortunate patients who suffer, either physically or psychologically, from sexual abnormalities. As Professor Dewhurst observed 'We do not determine sex — in medicine we determine the sex in which it is best for the individual to live'. These criteria are, of course, relevant to, but do not necessarily decide, the legal basis of sex determination. (44a to 44e)

I pause to repeat that (a) Dr Conway agreed with the passage quoted from the evidence of Professor Dewhurst which is also in line with the comments in the judgment of Ormrod J as to "assigning" a sex to a person, and (b) in my judgment it follows that when Dr Conway said that the continuing effect of testosterone altered a person's gender and not the person's sex he did so on the basis that a person's sex was to be determined on the biological criteria

identified by Ormrod J.

Ormrod J continued as follows (at 44e):

The hermaphrodite has been known since earliest times as an individual who has some of the sexual characteristics of both sexes. In more recent times the true hermaphrodite has been distinguished from the pseudo-hermaphrodite. The true hermaphrodite has both a testis and an ovary and some of the other physical characteristics of both sexes. The pseudo-hermaphrodite has either testes or ovaries, and other sexual organs, which do not correspond with the gonads which, are present. Still more recently, much more knowledge has been obtained about these cases by the development of techniques, which enable the structure of the nucleus of the individual cells of the body to be observed under the microscope. Using these techniques, it is possible to see the individual chromosomes in the nucleus. These are the structures on which the genes are carried which, in turn, are the mechanism by which hereditary characteristics are transmitted from parents to off-spring. The normal individual has 23 pairs of chromosomes in his ordinary body cells, one of each pair being derived from each parent. One pair is known to determine the sex of normal individuals. The normal female has a pair which is described as XX; the normal male a pair which is described as XY. The Y chromosomes can be distinguished quite clearly from the X. In the male, the X chromosome is derived from the mother and the Y from the father. In the female one X chromosome is derived from the father and one from the mother. All the ova of a female carry an X chromosome but the male produces two populations of spermatozoa, one of which carries the Y, and the other the X chromosome. Fusion of a Y spermatozoon with an ovum produces an embryo with XY chromosomes which, under normal conditions, develops into a male child; fusion of an ovum with an X spermatozoon produces an XX embryo, which becomes a female child. Various errors can occur at this stage which led to the production of individuals with abnormal chromosome constitutions, such as XXY and XO (meaning a single X only). In these two cases, the individuals will show marked abnormalities in the development of their reproductive organs. The XXY patient will become an under-masculinised male with small, underdeveloped testes and some breast enlargement. The abnormality will become apparent at puberty when the male secondary sex characteristics, such as facial hair and male physique, will not develop in the normal way. The XO individual has the external appearance of a female, a vagina and uterus but no active ovarian tissue. Without treatment the vagina and uterus remain infantile in type and none of the normal changes of puberty occur. Administration of oestrogen, however, produces many of these changes. The individual of course remains sterile.

The Y chromosome is, therefore, nominally associated with the development of testicular tissue in the embryo, the second X chromosome with the development of ovarian tissue. This is, however, by no means the whole story. Whether or not a normal male or female child develops depends on what may be loosely called the maintenance of the correct chemical balance in the embryo. The process may be illustrated by two examples. The first is called the 'adreno-genital syndrome', in which the chromosomal constitution is XX but the external genitalia appear to be male. Gross enlargement of the clitoris produces a phallus which may be mistaken for a penis, and fusion of the labia produces the appearance of a scrotum, but no testicles are present in it. This may lead to a diagnosis of undescended testicles in a male' but further investigation reveals that then individual has normal ovaries, a normal uterus and vagina and no actual male organs. This condition is caused by the exposure of the embryo at a critical phase of its development to the effect of masculinising or androgenising substances

either from the mother or from some abnormality in the foetus itself. The individual is, in fact, a fertile female and surgical removal of the abnormal external genitalia will enable her to live and function as a normal woman. In the second example, the external genitalia appear to be female but the chromosomal constitution is XY. Testes are present, usually in the abdomen. In the extreme case called the testicular, feminisation syndrome, the individual appears to be more or less normal female with well-formed breasts and female external genitalia but with an abnormally short vagina, ending blindly, no cervix and no uterus. In another type, the testicular failure syndrome, the appearance of the external genitalia may be more doubtful, with a phallic organ which could be either a small penis or an enlarged clitoris and a short vagina. It seems that in these cases the embryonic sexual organs fail to respond normally to the male hormone, testosterone, which is produced by the foetal testis.

All the medical witnesses accept that these examples are properly described as cases of intersex. In each there are discrepancies between the first three criteria for sex assessment, ie the chromosomal sex and the gonadal sex do not correspond with the genital condition of the patient. But there is a difference of opinion whether cases in which the chromosomal, the gonadal and the genital sex are congruent, but psychological or hormonal factors are abnormal, should be classified as cases of intersex. Dr Randell said that, in terms of sex determination, he would not give much weight to such psychological factors as transsexualism if the chromosomes, the gonads and the genitalia were all of one sex. Professor Dewhurst's views are similar. Dr Armstrong and Professor Roth, on the other hand, would classify transsexuals as cases of inter-sex. Professor Mills, as an endocrinologist, takes a rather different view. In his opinion, patients in whom the balance between male and female hormones is abnormal should be regarded as cases of inter-sex, and he considers that there is sufficient evidence to justify the view that the respondent is an example of this condition.

Professor Mills's conclusion is, of necessity, based largely on inference because the removal of the testicles at the operation in 1960 would, to a considerable extent, affect the hormonal balance at the present time. He thinks that the respondent was probably a case of partial testicular failure, in the sense that, though born a male, the process of androgenisation at and after puberty did not proceed in the normal way. It is suggested that she may be a case of what is called Klinefelter's syndrome, a disorder in which a degree of feminisation takes place about the time of puberty in hitherto, apparently, normal males. The diagnostic signs of this condition are atrophied or very small testicles, some spontaneous development of the breast, a female pattern of pubic hair and very little facial hair. Many, but not all, of these cases are of the XXY chromosome type. To make this diagnosis with any degree of confidence it is necessary to know whether the respondent's testicles were abnormally small or not, and it is desirable to examine a biopsy specimen of them under the microscope. There is, however, no evidence on this point at all. There is evidence from the respondent that spontaneous development of the breasts occurred at about the age of 18 years, but I am unable to accept her statement that this was spontaneous. It is admitted that she had taken oestrogen over a long period to promote the growth of the breasts. In evidence she said that she began to take it in Paris at the age of 20 years, but she told Professor Roth that she had started taking it at the age of 18 years. The Walton Hospital notes record that, on 22 May 1953, she was suggesting that she should take female hormones to help her change her sex. Oestrogen can be obtained quite easily and without prescription. It was suggested that the absence of pigmentation round the nipples indicated that she could not have taken large quantities of oestrogen but, on her own admission, she was taking it regularly in Paris over a

period of four years. In the circumstances I am not prepared to accept her evidence that the development of the breasts was spontaneous.

Professor Mills attached much significance to the note in the Walton Hospital records, 'little bodily or facial hair', and to his examination of the face which showed no sign of what he called 'androgenised hair'. In his opinion, this condition could not have been produced by taking oestrogen, nor could he find any sign of the removal of the hair by electrolysis or any other type of depilation. Professor Dent, however, said that he had seen cases in which puberty in boys had been delayed for several years but had then come on, in which there was no sign of male-type facial hair at the age of 18. In such cases he thought that oestrogen followed by castration could account for its absence as in this case. Dr Randell said that he had seen male transsexuals with no sign of facial hair. Professor Mills, I think, was relying largely on his experience of attempting, unsuccessfully, to treat hirsute women with oestrogens. In my judgment, it would not be safe to draw any inferences from the absence of facial hair in an individual who had been closely associated with experienced female impersonators for a number of years.

Professor Mills also referred to two chemical tests carried out on the respondent's urine, both, of course, after the removal of the testicles, the results of which indicated that the hormonal balance in the respondent was strongly female, in character. One of these tests, the estimation of the 17 ketosteroids in the urine, was repeated during the trial in the laboratory at University College Hospital, and gave a distinctly different result. Professor Dewhurst pointed out that this test requires the collection of a 24-hour specimen of urine, and that in both cases the volume of urine supplied by the respondent was much smaller than was to be expected. As neither sample was collected under supervised conditions — the respondent being merely asked to supply the specimen — little significance can be attached to the results, particularly in a forensic as opposed to clinical situation. A similar comment is to be made about a psychological test called the Tumer-Miles test which was used on the respondent. This is a questionnaire which is completed by the patient, but in this case the psychologist was not present and, indeed, has never seen the respondent. There is no evidence as to how the questionnaire was completed.

In my judgment, therefore, the factual basis for the Klinefelter syndrome or any other hormonal disorder has not been established, although the respondent may have been a partially under-developed male at the time of the operation. It follows that it has not been established that the respondent should be classified as a case of intersex on the basis of hormonal abnormality. (44e to 46j)

I pause to comment that this rejection of the evidence of Professor Mills (an endocrinologist) is important point of distinction between this case and the Corbett case because here Dr Conway (a consultant endocrinologist) has given evidence and a diagnosis of partial androgen insensitivity which I accept.

It follows that unlike the position in the Corbett there is evidence in this case which I accept and which supports a conclusion that the Respondent should, or could, be classified as a case of intersex, or physical inter-sex, on the basis of an hormonal abnormality or that combined with ambiguity of one of the first three of the doctors' criteria set out in the Corbett case.

As appears below under the heading "My conclusions and reasoning" in my view the label or description "physical inter-sex" can be applied to the Respondent.

Ormrod J continued as follows (at 46j):

My conclusions of fact on this part of the case can be summarised, therefore, as follows. The respondent been shown to have XY chromosomes and, therefore, to be of male chromosomal sex; to have had testicles prior to the operation and, therefore, to be of male gonadal sex; to have had male external genitalia without any evidence of internal or external female sex organs and, therefore, to be of male genital sex; and psychologically to be a transsexual. The evidence does not establish that she is a case of Klinefelter's syndrome or some similar condition of partial testicular failure, although the possibility of some abnormality in androgenisation at puberty cannot be excluded. Socially, by which I mean the manner in which the respondent is living in the community, she is living as, and passing as, a woman more or less successfully. Her outward appearance, at first sight, was convincingly feminine, but on closer and longer examination in the witness box it was much less so. The voice, manner, gestures and attitude became increasingly reminiscent of the accomplished female impersonator. The evidence of the medical inspectors, and of the other doctors who had an opportunity during the trial of examining the respondent clinically, is that the body, in its postoperative condition, looks more like a female than a male as a result of very skilful surgery. Professor Dewhurst, after this examination, put his opinion in these words — 'the pastiche of femininity was convincing'. That, in my judgment, is an accurate description of the respondent. It is common ground between all the medical witnesses that the biological sexual constitution of an individual is fixed at birth (at the latest), and cannot be changed, either by the natural development of organs of the opposite sex, or by medical or surgical means. The respondent's operation, therefore, cannot affect her true sex. The only cases where the term 'change of sex' is appropriate are those in which a mistake as to sex is made at birth and subsequently revealed by further medical investigation. (44j to 47d)

I pause to comment that Dr Conway agreed with this common ground that the biological sexual constitution of an individual is fixed at birth. In my view this means that if a person's sex is to be determined solely by reference to biological factors it is fixed at birth. However if other factors are introduced into the test different considerations may apply. They may simply be factors, which show (with the benefit of hindsight or of development) that the person was always of a particular sex or they might be said to be factors that establish a change in a person's sex.

Ormrod J continued as follows (at 47d):

On that state of facts, counsel for the petitioner submitted that it had been established that the respondent was a male and that, accordingly, the so-called marriage must be void and of no effect. Counsel for the respondent, however, contended that the respondent should be classified, medically, as a case of inter-sex, and that, since the law knew only two sexes, male and female, she must be 'assigned' to one or the other, which, in her case, must be female, and that she should be regarded for all purposes as a woman. He submitted further that 'assignment' was a matter for the individual and his doctor, and that the law ought to accept it as determining his sex. The word 'assign', although it is used by doctors in this context, is apt to mislead since, in fact, it means no more than that the doctors decide the gender, rather

than the sex, in which such patients can best be managed and advise accordingly. It was also suggested that it was illogical to treat the respondent as a woman for many social purposes, such as nursing her in a female ward in hospital, or national insurance, and not to regard her as a woman for the purpose of marriage. These submissions are very far-reaching and would lead to some surprising results in practice but, before examining them in detail, I must consider the problems of law which arise in this case on a broader basis.

It appears to be the first occasion on which a court in England has been called on to decide the sex of an individual and, consequently, there is no authority which is directly in point. This absence of authority is, at first sight, surprising, but is explained, I think, by two fairly recent events, the development of the technique of the operation for vagino-plasty, and its application to the treatment of male transsexuals; and the decision of the Court of Appeal in *S v S (otherwise W)*(No 2), in which it was held that a woman, suffering from a congenital defect of the vagina, was not incapable of consummating her marriage because the length of the vagina could be increased surgically so as to permit full penetration. There are passages in the judgments which seem to go so far as holding that an individual, born without a vagina at all, could be rendered capable of consummating a marriage by the construction of an entirely artificial one. But for this decision, the respondent would have had no defence to the prayer for a decree of nullity on the ground of incapacity. Until this decision, all matrimonial cases arising out of developmental abnormalities of the reproductive system could be dealt with as case of incapacity, and, therefore, it has not been necessary to call in question the true sex of the respondents, assuming that it had occurred to any pleader to raise this issue. Now that it has been raised, this case is unlikely to be the last in which the courts will be called on to investigate and decide it. I must, therefore, approach the matter as one of principle. (47d to 48b).

I pause to comment that Ormrod J returns to the case of *S v S (otherwise W) (No 2)* when dealing with the secondary issue of incapacity to consummate and I shall comment further on it then. As will then appear there are indeed passages in the judgments which support the view that an individual born without a vagina at all could be rendered capable of consummating a marriage by the construction of an entirely artificial one.

Ormrod J continued as follows (at 48b):

The fundamental purpose of law is the regulation of the relations between persons, and between persons and the State or community. For the limited purposes of this case, legal relations can be classified into those in which the sex of the individuals concerned is either irrelevant, relevant or an essential determinant of the nature of the relationship.

Over a very large area the law is indifferent to sex. It is irrelevant to most of the relationships which give rise to contractual or tortious rights and obligations, and to the greater part of the criminal law. In some contractual relationships, eg life assurance and pensions schemes, sex is a relevant factor in determining the rate of premium or contributions. It is relevant also to some aspects of the law regulating conditions of employment, and to various State-run schemes such as national insurance, or to such fiscal matters as selective employment tax. It is not an essential determinant of the relationship, in these cases because there is nothing to prevent the parties to a contract of insurance or a pension scheme from agreeing that the person concerned should be treated as a man or as a woman, as the case may be. Similarly,

the authorities, if they think fit, can agree with the individual that he shall be treated as a woman for national insurance purposes, as in this case. *On the other hand sex is clearly an essential determinant of the relationship called marriage because it is and always has been recognised as the union of man and woman. It is the institution on which the family is built and in which the capacity for natural heterosexual intercourse is an essential element.* It has, of course, many other characteristics, of which companionship and mutual support is an important one, *but the characteristics which distinguish it from all other relationships can only be met by two persons of opposite sex.* There are some other relationships such as adultery, rape and gross indecency in which, by definition, the sex of the participants is an essential determinant: see Rayden on Divorce, *Dennis v Dennis* and the Sexual Offences Act 1956, ss 1 and 13.

Since marriage is essentially a relationship between man and woman, the validity of the marriage in this case depends, in my judgment, on whether the respondent is or is not a woman. I think, with respect, that this is a more precise way of formulating the question than that adopted in para 2 of the petition, in which it is alleged that the respondent is a male. The greater, of course, includes the less, but the distinction may not be without importance, at any rate in some cases. *The question then becomes what is meant by the word 'woman' in the context of a marriage* for I am not concerned to determine the 'legal sex' of the respondent at large. *Having regard to the essentially heterosexual character of the relationship which is called marriage,* the criteria must, in my judgment, be biological, for even the most extreme degree of transsexualism in a male *or the most severe hormonal imbalance which can exist in a person with male chromosomes, male gonads and male genitalia cannot reproduce a person who is naturally capable of performing the essential role of a woman in marriage.* In other words, the law should adopt, in the first place, the first three of the doctors' criteria, ie the chromosomal, gonadal and genital tests, and, if all three are congruent, determine the sex for the purpose of marriage accordingly, and ignore any operative intervention. The real difficulties of course, will occur if these three criteria are not congruent. This question does not arise in the present case and I must not anticipate, but it would seem to me to follow from what I have said that greater weight would probably be given to the genital criteria than to the other two. This problem and, in particular, the question of the effect of surgical operations in such cases of physical inter-sex, must be left until it comes for decision. My conclusion, therefore, is that the respondent is not a woman for the purposes of marriage but is a biological male and has been so since birth. It follows that the so-called marriage of 10 September 1963 is void. (48b to 49a)

I pause to comment that this is clearly an important passage in the judgment.

It opens with a reference to the fundamental purpose of the law and in my judgment it sets out Ormrod J's essential reasoning for choosing the test that he did.

The passage also makes the point relied on by the Respondent in this case that the real difficulties occur if the three identified criteria are not congruent. In this context it should also be remembered that Ormrod J introduces the biological test he applies with the words "in the first place".

The passages I have put in italics as well as underlined seem to me to be of particular importance in respect of Ormrod J's conclusion that the criteria must be biological. I shall

return to these points but at this stage I add that in my judgment they are also important in determining how this case should be approached and decided.

Ormrod J continued as follows (at 49a):

I must now return briefly to counsel for the respondent's submissions. If the law were to recognise the 'assignment' of the respondent to the female sex, the question which would have to be answered is, what was the respondent's sex immediately before the operation? If the answer is that it depends on 'assignment' then, if the decision at that time was female, the respondent would be a female with male sex organs and no female ones. If the assignment to the female sex is made after the operation, then the operation has changed the sex. From this it would follow that if a 50 year old male transsexual, married and the father of children, underwent the operation, he would then have to be regarded in law as a female, and capable of 'marrying' a man! The results would be nothing if not bizarre. I have dealt, by implication, with the submission that, because the respondent is treated by society for many purposes as a woman, it is illogical to refuse to treat her as a woman for the purpose of marriage. The illogicality would only arise if marriage were substantially similar in character to national insurance and other social situations, but the differences are obviously fundamental. These submissions, in effect, confuse sex with gender. Marriage is a relationship which depends on sex and not on gender. (49a to 49d)

I pause to comment that having regard to the difficulties that arise in cases of this sort by reason of the requirement that a marriage is to be between parties who are respectively male and female it seems to me that what some may regard as bizarre results can arise whatever course is taken to decide whether the parties to a marriage are respectively male and female. The difficulties and the potential for bizarre results are not confined to the statutory requirement that the parties be respectively male and female but extend to the question whether they have the capacity to consummate the marriage. For example, the test and result in the Corbett case leads to the result that the respondent therein could have married a woman on the basis that they were respectively male and female (see also the citation from a New Zealand case in S-T v J [1998] 1 AER at 447 b/c).

Ormrod J continued as follows (at 49d):

I now turn to the secondary issue of incapacity or wilful refusal to consummate the marriage, assuming for this purpose that the marriage is valid and that the respondent is to be treated as, or deemed to be, a woman. I must deal with this quite shortly because this judgment is long enough already. Of the two versions of the events which took place after the ceremony I prefer, and accept, the petitioner's. Although in some ways the respondent's account seems more plausible, and the lack of any contemporary complaints by the petitioner in the correspondence seems surprising, the evidence of the respondent on the question of the alleged abscesses in the so-called artificial vagina was so unsatisfactory and unconvincing that I had little doubt but that on this part of the case she was not telling the truth. The failure on her part to call the doctor, Dr Rosedale, who, she said, had been treating her for this condition at the relevant time, and the absence of any explanation for not calling him, casts further doubt on her reliability. I was, moreover, impressed by the petitioner's frankness in dealing with his letter written on 26 October 1964. This letter is typical of the kind of letter which one often finds in nullity cases and which throws light on the sexual situation between

the parties. To my surprise, the petitioner immediately made it clear that he was not referring to the sexual failure. A dishonest witness would have seized on this letter as most helpful to his case. I accordingly, accept his evidence that the respondent evaded the issue of sexual relations, and that he did not press it believing that this aspect of the marriage would come right in the end. I find it extraordinarily difficult, in the peculiar circumstances of this case, to judge whether the respondent's attitude should be regarded as a wilful refusal or a psychological repugnance. I regard both as essentially unreal in this particular case, but the evidence supports refusal better than repugnance. In any event, however, I would, if necessary, be prepared to hold that the respondent was physically incapable of consummating a marriage because I do not think that sexual intercourse, using the completely artificial cavity constructed by Dr Burou, can possibly be described in the words of Dr Lushington in *D-E v A-G (falsely calling herself D-E)* (1845) 1 Rob Eccl 279 at 298, 299 as 'ordinary and complete intercourse' or as 'vera copula - of the natural sort of coitus'. In my judgment, it is the reverse of ordinary, and in no sense natural. When such a cavity has been constructed in a male, the difference between sexual intercourse using it, and anal or intra-crural intercourse is, in my judgment, to be measured in centimetres.

I am aware that this view is not in accordance with some of the observations of the Court of Appeal in *S v S (otherwise W)*(No 2) [1962] 3 AER 55, but, in my respectful opinion, those parts of the judgments which refer to a wholly artificial vagina, go beyond what was necessary for the decision in that case and should be regarded as obiter. The respondent in that case was assumed to be a woman, with functioning ovaries, but with a congenital abnormality of the vagina, which was only about two inches long and small in diameter, according to the report of the medical inspectors. This is a very different situation from the one which confronts me. There are, I think, certain dangers in attempting to analyse too meticulously the essentials of normal sexual intercourse, and much wisdom in another of Dr Lushington's observations in the same case where he said ((1845) 1 Rob Eccl at 297):

'It is no easy matter to discover and define a safe principle to act upon: perhaps it is impossible affirmatively to lay down any principle which, if carried to either extreme, might not be mischievous.'

The mischief is that, by over-refining and over-defining the limits of 'normal', one may, in the end, produce a situation in which consummation may come to mean something altogether different from normal sexual intercourse. In this connection, I respectfully agree with the judgment of Brandon J in *W (otherwise K) v W* [1967] 3 AER 178 The possibility mentioned by Willmer LJ in his judgment in *S v S (otherwise W)*(No 2) [1962] 3 All ER at 63, [1963] P at 61, that a married man might have sexual relations with a person, using a so-called artificial vagina, and yet not commit adultery, does not seem to me to be very important, since neither oral intercourse with a woman, nor mutual masturbation will afford the wife the remedy of adultery: *Sapsford v Sapsford and Furtado* [1954] 2 AER 373. (49d to 50e).

I pause to comment that this part of the judgment is not necessary for the decision of Ormrod J.

I would agree that this conclusion of Ormrod J is not in accordance with some of the observations in S v S (otherwise W) (No 2) [1962] 3 AER 55 and that the parts of that case which refer to a wholly artificial vagina can be said to be obiter because the Court of Appeal

concluded that the true description of the woman in question was not that there was no vagina but that there was an abnormal vagina (see Willmer LJ at 60). However Willmer LJ goes on to express views on the basis that his view of the facts was incorrect and the correct position was that the wife had no natural vagina at all, and in this context it should be remembered that as he records (at 59) the judge's judgment proceeded on the basis that that there was a complete absence of a vagina. Willmer LJ expressed himself in strong terms as follows (at 61) with my emphasis:

In case, however, I am wrong in the view which I have taken as to the facts actually proved, let it be assumed that this is a case in which the wife had no natural vagina at all. Would the creation out of nothing of an artificial vagina, sufficient in size to enable full penetration to be achieved, enable the marriage to be consummated, so as to preclude the husband from saying that the wife's incapacity is incurable? It certainly does not seem to have occurred to Miss Bottomley that coition by means of such an artificial vagina would not amount to consummation. Otherwise she could never have given the answer which she gave when she said:

"I told her [the wife] that she would never menstruate, and that it was impossible to have any children, but that it was possible to do an operation to construct an artificial vagina, if and when at some future date she was going to get married."

I recognise, however, that the question is one of law, and that the medical opinion of a doctor, however eminent, is by no means conclusive. For myself, I find it difficult to see why the enlargement of a vestigial vagina should be regarded as producing something different in kind from a vagina artificially created from nothing. The operation involved in either case is substantially the same. It consists in the removal of the soft tissue in the place where the vagina would normally be, so as to form a passage in the tissue, which is then lined by means of a skin graft. In either case the resulting passage has substantially the same characteristics, at any rate for so much of its length as is artificially created. In either case there is no more than a cul-de-sac and there can be no possibility of a child being conceived. It is admitted, however, that inability to conceive a child is no ground for saying that the marriage cannot be consummated. It is also admitted that the degree of sexual satisfaction that may be obtained by either or both of the parties makes no difference. As to this point, however, it seemed to me that some inconsistency was to be detected in the argument for the husband. For we were pressed to consider certain physiological differences between the natural and the artificial vagina; for instance, the absence in the latter of the natural membrane, of the normal secretions and of the special sensory quality of the former. It may be that the absence of these would affect the degree of sexual satisfaction that could be obtained by a wife with an artificial vagina. But, once it is admitted that sexual satisfaction is not a determining factor, it appears to me that these distinctions are largely irrelevant. In any case much the same could be said of a natural vagina artificially enlarged by a surgical operation of the same type. Moreover, it is to be remembered that in the present case it is not the wife, but the husband, who is the complaining party, and according to the evidence of Miss Bottomley the degree of sexual satisfaction to be obtained by the husband would not be very materially affected.

If neither the ability to conceive nor the degree of sexual satisfaction to be obtained is a determining factor, what else, it may be asked, remains to differentiate between intercourse by means of an artificial vagina and intercourse by means of a natural vagina artificially

enlarged? In either case full penetration can be achieved, and there is thus complete union between the two bodies. Counsel for the wife conceded (no doubt rightly) that an artificial cavity created in some other part of the wife's body, into which the husband's organ could be inserted, would not be appropriate. But there is no question of that in relation to the operation suggested by Miss Bottomley. What would be created would be a vagina, albeit an artificial one, and it would be located precisely in the position where a natural vagina would be. In such circumstances I do not see why intercourse by means of such a vagina should not be regarded as amounting to "vera copula", so as to satisfy the test laid down by Dr Lushington.

He added at (62) that:

I would only add one further observation on this part of the case. If it is to be held that a wife with an artificial vagina is incapable in all circumstances of consummating her marriage, it can only be on the basis that such a woman is incapable of taking part in true sexual intercourse. If that were right, the strangest results would follow. It would involve, for instance, that such a woman might be to a considerable extent beyond the protection of the criminal law, for it would seem to follow that she would be incapable in law of being the victim of a rape. What is perhaps even more startling would be that a woman with an artificial vagina would be incapable in law of committing adultery. Consequently, the wife of a man engaging in intercourse with such a woman would be left wholly without remedy. I should regard such a result as bordering on the fantastic; yet it is accepted as being the logical conclusion of the argument presented on behalf of the husband.

Davies LJ agreed with these parts of the judgment of Willmer LJ.

In that case it was accepted that the wife was a woman although she had no uterus and either no vagina or an abnormal vagina.

It was also accepted that neither the ability to conceive nor the degree of sexual satisfaction is a determining factor in deciding the question whether a party has the ability to consummate a marriage.

Returning to the Corbett case Ormrod J continued as follows (at 50e):

In the result therefore, I hold that it has been established that the respondent is not, and was not, a woman at the date of the ceremony of marriage, but was, at all times, a male. (50e)

The address given by Ormrod J to the Medico-Legal Society on the Medico-Legal Aspects of Sex Determination (1972) Medico-Legal Journal 78

Ormrod J gave this address not long after he had delivered judgment in the Corbett case and in my judgment it gives an insight into, and a further explanation of, his thinking as to the test he applied therein, the people to whom it would be appropriate to apply that test and thus its extent.

It was submitted on behalf of the Respondent by reference to the address that this is a case in which I am not concerned with a transsexual but rather it is one which gives rise to some of

the difficult problems referred to by Ormrod J by reference to the chart he produced at page 84 of the report of his talk. This chart includes a reference to "testicular feminisation syndrome" and the genital, gonadal, chromosomal and social sex criteria related thereto which show a mixture of male and female sex criteria. They are as follows:

Genital	*External:*	Female
	Internal:	Partly female
	Breasts:	Female
Gonadal		Male (Testes in the abdomen)
Chromosomal		XY (Male)
Social		Female

The chart also refers to "testicular failure syndrome". As to that the above characteristics are shown as being the same save that the breasts are described as male.

Ormrod J refers to both testicular feminisation syndrome and testicular failure syndrome at page 45 d/f of his judgment in the Corbett case.

As the chart in such cases the chromosomal, gonadal and genital sex are not congruent. It follows that in such a case the biological test set down in the Corbett case would not be satisfied.

I also note at this stage that in other descriptions of sex criteria to which I have been referred breasts are not included within the description of a persons genital characteristics and as I understand it strictly they should not be so included.

A diagnosis for the sexual criteria described above as testicular feminisation syndrome would also be total androgen insensitivity and Ormrod J's reference to testicular feminisation syndrome in his judgment and this address is the same as (and would now be replaced by) a diagnosis of total androgen insensitivity.

Dr Conway told me that 'testicular failure syndrome" would now also be described as "disappearing or vanishing testes syndrome". As appears earlier in this judgment he thought that this was an unlikely diagnosis in this case because of the Respondent's failure to masculinize when given testosterone.

In the chart I have referred to above the genital sex criteria of a "transsexual male (post operatively)" were shown as (a) normal male, (b) psuedo-female, *Breasts*: female on oestrogen.

In another chart headed "Sexual Anomalies" Ormrod J included transsexuals and transvestites under the heading "psychological", the other heading being "anatomical".

In his address Ormrod J said this (at page 86) as to the Corbett case, the chart and the difficulty of determining sex:

I was fortunate enough to find myself faced with a transsexual. The chart shows how difficult it might have been. ———— The difficulty would be acute in the cases of testicular feminization and testicular failure. In these cases the genital sex is unalterably female or approaching female in character yet the gonads and the chromosomes are male. The social sex is female. If the decision ever had to be made in a matrimonial situation I think that the genital sex would probably be decisive. It also provides the socially appropriate answer although it would be quite wrong to regard the social criterion as in any way decisive in the matrimonial context.

In my view this is an indication that notwithstanding his views on consummation set out in the judgment in the Corbett case he would probably have found that a person with the characteristics he sets out by reference to testicular feminisation syndrome (total androgen insensitivity) and testicular failure syndrome (disappearing or vanishing testes syndrome) was a woman.

This is not a case of total androgen insensitivity but on the balance of probabilities one of partial androgen insensitivity. By reference to the above chart the genital, gonadal, chromosomal and social characteristics of the Respondent which found such diagnosis are as follows:

Genital	*External:*	Ambiguous (A close call but if had to choose on the male side of the line)
	Internal:	Neither or Ambiguous
	(Breasts:	Some spontaneous female breast development)
Gonadal		Probably Male (Probably testes in the abdomen and no uterus)
Chromosomal		XY (Male)
Social		Female

As this table indicates in this case the genital sex of the Respondent was not unalterably female or approaching female as described by Ormrod J in his chart (and in his judgment in the Corbett case at 45 d/f) in the case of testicular feminisation syndrome (total androgen insensitivity) or testicular failure syndrome (disappearing or vanishing testes syndrome).

I am therefore not concerned a case that was recognised by Ormrod J in this address as one of acute difficulty. However in my judgment it follows from what he said in this address that I am faced with a case which to his mind would have involved considerably greater difficulty than the case of a transsexual.

Alternative ways of putting this is that if Ormrod J had accepted the evidence of Professor Mills (45j) or had considered that the Corbett case was one of physical inter-sex (48j) he would have been of the view that it was more difficult and would have given weight to the genital criteria.

My conclusions and reasoning

I shall set these out under sub-headings which I hope are self explanatory.

Is the biological test in the Corbett case satisfied ?

In my judgment it is not. Accordingly on this point I accept the argument of the Respondent and reject that of the Applicant.

In my judgment having regard to my findings set out above under the heading "Findings having regard to the Respondent's history and the medical evidence" the chromosomal, gonadal and genital characteristics of the Respondent are not congruent in the sense used by Ormrod J.

In my judgment he used the word "congruent" to describe a situation closely akin to that which existed in his case and it would be an incorrect application of his test:

a. to take each of the criteria and ask which side of the line between male and female they fell and if (however near the line) all of them fell on one side of it that determined a person's sex for the purposes of marriage, and thus in this case

b. to determine the sex of the Respondent for the purposes of marriage by reference to the fact that the Respondent's ambiguous genital sex prior to the operation fell on the male side of the line.

In my judgment that conclusions flows from:

a. the facts of the Corbett case,

b. Ormrod J's essential reasoning leading to his adoption "in the first place" of the first three of the doctors' criteria,

c. his recognition of the difficulties that exist in cases of physical inter-sex,

d. his recognition by his reference to the evidence of Professor Mills of the possibility that a person might be properly classified as inter-sex on the basis of hormonal abnormality (or that combined with ambiguity of one of the first three of the doctors' criteria) and thus it seems to me that cases of physical inter-sex may not be confined to the examples he gave in his judgment and his address to the Medico-Legal Society of testicular feminisation syndrome (total androgen insensitivity) and testicular failure syndrome, and

e. his statement of opinion that when the first three of the doctors' criteria are not congruent greater weight should be given to the genital criteria. In my view this supports a conclusion that when the genital criteria are ambiguous and it cannot be said that they are approaching male or female, sex should not be decided by a decision as to which side of the line the genital criteria (internal and external) fall even if they would fall on the same side of the line as other two criteria.

In my judgment this conclusion is also supported by Ormrod J's address to the Medico-Legal Society and my comments based thereon.

I add that I also reject the argument of the Applicant that in applying to this case the

biological test set in the Corbett case weight should be given to the chromosomal and gonadal criteria to support a conclusion that the overall weight of the three criteria leads to the result that the Respondent is male. In my judgment additional reasons to those set out above for rejecting this argument are that it runs counter to Ormrod J's view that weight should be given to the genital criteria, and to the view of Ormrod J as expressed to the Medico-Legal Society (and of Dr Conway) that there are people with total androgen insensitivity who have male chromosomes and gonads but who should be treated as (or in the view of Dr Conway, which I accept, are) women.

Ormrod J's essential reasoning and consummation

I identified what I consider for present purposes to be the most important points in Ormrod J's essential reasoning by underlining and italics in the citation leading up to his choice and exposition of the test he applied. The passages are:

On the other hand sex is clearly an essential determinant of the relationship called marriage, because it is and always has been recognised as the union of man and woman. It is the institution on which the family is built, and in which the capacity for natural heterosexual intercourse is an essential element. ——

but the characteristics which distinguish it from all other relationships can only be met by two persons of opposite sex. ——

The question then becomes what is meant by the word woman in the context of a marriage, –

Having regard to the essentially heterosexual character of the relationship which is called marriage the criteria must, in my judgment, be biological, for even the most extreme degree of transsexualism in a male *or the most severe hormonal imbalance which can exist in a person with male chromosomes male gonads and male genitalia cannot reproduce a person who is naturally capable of performing the essential role of a woman in marriage.*

Ormrod J does not define precisely what he means by the "essential role of a woman in marriage". However the passages I have highlighted show that he had in mind a person who can naturally perform her part in the constitution of a family and who has the capacity for natural sexual intercourse. This forms a link between sections 11(c) and 12(a) of the Matrimonial Causes Act 1973 and the way in which Ormrod J dealt with the primary and secondary issues before him. The secondary issue being one of incapacity to consummate the marriage.

Ormrod J does not say or indicate that to be a woman or female for the purposes of marriage a person must have the capacity to bear children. Indeed to my mind it is clear that his biological test does not require that a woman should be able to naturally bear children. This also flows from his views on a person with testicular feminisation syndrome (total androgen insensitivity) as expressed in his address to the Medico-Legal Society.

In my judgment the institution of marriage on which the family is built does not require the parties to the marriage to be capable of naturally bearing children and Ormrod J was not intending to indicate the contrary. In my view even if it was accepted that a primary purpose of marriage was the procreation of children one only has to pause for a moment to conclude

that it is not an essential ingredient of a marriage between a man and a woman that they are both naturally capable of having children because there are a number of men and women who are not.

It is equally the case that sterility is not relevant to consummation (see for example S v S (otherwise W)(No 2) [1962] 3 AER 63).

Unsurprisingly on the facts of the Corbett case it is easy to see the logic for the conclusion of Ormrod J that if necessary he would have been prepared to hold that the respondent in that case was physically incapable of consummating a marriage.

Ormrod J was concerned with a person who before was a man on the basis of the biological test he adopted. Also before the operation to create an artificial vagina the respondent in the Corbett case had a normal penis and, as I understand the findings of Ormrod J, the ability to have had sexual intercourse as a man. As Ormrod J recognised:

a. in S v S (otherwise W)(No 2) the Court of Appeal was faced with a very different situation in that the person who could have had the operation to create an artificial vagina of sufficient size to make sexual intercourse possible was described as (and was assumed to be) a woman and it is probable that on an application of his biological test, or a small adaptation thereof, Ormrod J would have concluded that she was a woman for the purposes of marriage, and

b. there are certain dangers in attempting to analyse too meticulously the essentials of normal sexual intercourse, and much wisdom in Dr Lushington's observations, that: *"It is no easy matter to discover and define a safe principle to act upon: perhaps it is impossible affirmatively to lay down any principle which, if carried to either extreme, might not be mischievous."*

I am therefore faced with two competing observations on consummation neither of which was essential to the decision reached. Equally I accept that there are dangers in analysing too meticulously or theoretically the essential ingredients of normal sexual intercourse.

I have found that here the biological test in the Corbett case is not satisfied. One of the reasons for that conclusion is that (unlike the position in the Corbett case but like the position in S v S (otherwise W)(No 2)) the Respondent in this case would never have been able to have sexual intercourse as either a man or a woman without some surgical intervention. In this case (and therefore similar ones) I prefer the approach taken and conclusion reached by the Court of Appeal in S v S (otherwise W)(No 2).

It follows that, in my judgment, the parties in this case had the capacity to consummate their marriage.

An incapacity to consummate a marriage renders it voidable whereas if the parties to a marriage are not respectively male and female the marriage is void. It therefore seems to me that as a matter of statutory interpretation the parties to a marriage have a choice as to whether or not either of them wishes to seek relief under s. 12(a) on the basis of an incapacity to consummate the marriage and that it is possible for there to be a marriage that satisfies s

11(c), and which is therefore for the time being valid, but which is voidable by reason of an incapacity to consummate it. Indeed it is not difficult to think of situations where this would occur.

It follows that there is not a necessary connection between the issue whether a person is male or female and a capacity to consummate a marriage as a male or a female. Also I accept that there is room for an argument that having regard to modern surgical techniques and the approach and decision in S v S (otherwise W)(No 2) that anyone is capable of consummating a marriage with a person of the opposite sex. But in my view in many cases such an argument would fall foul of the pragmatic approach of Dr Lushington that was recognised by Ormrod J and the Court of Appeal. For example, in my judgment there would be something unreal in an argument that if the Respondent in this case was a male for the purposes of marriage he had the capacity to consummate a marriage to a woman because he could have further surgery. This would be contrary to what in my judgment is a final and irreversible choice of the gender in which this Respondent has chosen to live her life.

Accordingly in my view the capacity of a person to consummate a marriage as a male or a female is a factor (although not a decisive factor) in considering whether that person is male or female for the purposes of marriage.

It is also the case that in considering that factor the court has regard to the effect, or the potential effect of, surgery. Ormrod J recognised that the effect of surgical operations in the cases of physical inter-sex to which he referred in his judgment (and thus their effect on a person's genital characteristics) was a problem. This indicates to me that he considered that part of that problem concerned the capacity to consummate the marriage.

In my judgment it follows from:

a. Ormrod J's recognition of the problems that exist in cases of physical inter-sex in particular in respect of the effect of surgical operations,

b. his recognition for the need for pragmatism in deciding whether a person is capable of natural sexual intercourse, and

c. his views on persons with testicular feminisation syndrome (total androgen insensitivity) as expressed in his address to the Medico-Legal Society

that in the case of someone with the chromosomal, gonadal and genital characteristics of someone with testicular feminisation syndrome (total androgen insensitivity) Ormrod J would have held that that person was a woman who was capable (after surgical intervention) of consummating a marriage. In my judgment it follows that it is at least possible that Ormrod J would have agreed with the conclusion I have reached that the Respondent in this case (who without surgery was not, and never would have been, capable of sexual intercourse) had capacity to consummate the marriage.

Are people who do not satisfy the biological test in the Corbett case neither men or women or male or female for the purposes of marriage

This is a possible result but not one that I reach.

Article 12 of the European Convention on Human Rights provides that:

Men and women of marriageable age have the right to marry and found a family, according to the national laws.

Shortly our legislation will so far as is possible have to be construed and given effect to in a way that is compatible with that Article and it seems to me from the ECHJ cases referred to in S-T v J [1998] 1 AER 431 that the ECHJ would not be likely to favour a result that a person was neither a man nor a woman for the purposes of marriage.

Further in my judgment such a result would create as many problems as it solved in the difficulties that already exist in defining a woman or a man, or a male or a female, for the purposes of marriage by creating a third category the boundaries of which would not be clear.

Also in my judgment such a result would run counter to (i) the approach of Parliament in enacting what became s. 11(c) Matrimonial Causes Act which is commented on in S-T v J [1998] 1 AER at 449 d/j by reference to paragraph 32 of the Law Commission Report on *Family Law: Report on Nullity of Marriage*, (ii) the decision in the case of S-T v J, and (iii) s. 58(5) Family Law Act 1986. These have the consequence that a marriage between persons who are not respectively male and female falls to be dealt with under s. 11(c) Matrimonial Causes Act and therefore the court has the power, which it does not have to exercise, to grant the normal range of financial provision in respect of such a marriage. It seems to me that:

a. this is further confirmation that it was the view and intention of Parliament that everyone is either male or female for the purposes of marriage because it shows that the section was included in the knowledge of the fact that there are tragic cases in which there may be doubt as to whether a person is male or female and in part to deal with those cases. Further and in any event it seems to me that it would be odd if Parliament had not intended s. 11(c) to cover all cases,

b. this is a further pointer in addition to the use of the words “male and female” that on the true construction of the Matrimonial Causes Act greater emphasis can be placed on gender rather than sex (see again S-T v J at for example [1998] 1 AER 449j), and

c. this is also a pointer that on the true construction of the Matrimonial Causes Act greater emphasis can be placed on the financial, civil, contractual and general living arrangements of marriage rather than the point made by Ormrod J that it is a relationship based on sex.

Points (b) and (c), and the point that shortly so far as it is possible to do so the Matrimonial Causes Act will have to be construed and given effect to in a way which is compatible with Article 12, are also relevant to the approach I should adopt to determining whether a person such as the Respondent in this case, who does not satisfy the biological test applied in the Corbett case, is male or female. However these points were not argued before me and although my preliminary’ view is that they support my conclusions I have not placed any weight on them in reaching those conclusions.

My approach and conclusion

I start this section of this judgment by repeating that:

A. I am not concerned with a transsexual.

B. I have not heard any medical evidence on the advances in medical science referred to by Ward LJ in S-T v J [1998] 1 AER at 451 b/d relating to brain structure and my decision is therefore not based thereon.

C. In my judgment I am concerned with a case in which the biological test set and applied in the Corbett case is not satisfied and does not provide the answer to the question whether the Respondent is a female for the purposes of marriage. Thus it follows that in my judgment I am concerned with a case which Ormrod J stated in the Corbett case must be left until it comes for decision and in respect of which he accepted there were difficulties over and above those he had to deal with in the Corbett case.

At birth the Respondent was a child with ambiguous external genitalia and (as was recognised at the time) was a baby in respect of whom it was appropriate for a decision to be made as to the sex in which he or she should be brought up. Additionally in my judgment Dr Conway's diagnosis of partial androgen insensitivity in respect of the Respondent is correct. As Dr Conway explained this is caused by mutations of the androgen receptors and affects the reaction of the male body to testosterone. The Respondent therefore had physical abnormalities in her external genitalia at birth and developmental abnormalities which had a physical cause (i.e. partial androgen insensitivity) whether or not they also had a psychological cause or were related to her brain structure.

As I have said in my judgment care should be taken with the use of the labels or descriptions "inter-sex" or "physical inter-sex" and it is more important to have regard to the factors which lead to them being applied or possibly applied. However I accept that they are convenient shorthand. In my judgment having regard to the findings I have made in this case under the heading "Findings having regard to the Respondent's history and the medical evidence" the term "physical inter-sex" is a convenient shorthand to describe the Respondent although I accept that the Respondent does not have the same genital, gonadal and chromosomal criteria as the cases of physical inter-sex referred to by Ormrod J.

As Dr Conway explained, and I accept, people with partial androgen insensitivity can develop physically and socially in a range of ways. Their assignment to a sex or gender in which they are to be brought up and live is a difficult one and it seems to me that in such cases (and in other cases where a decision as to the sex or gender in which a child should be brought up falls to be made by doctors and others) there is considerable force in the argument that it would be best to "wait and see". How long it would be appropriate to wait, and what tests would be appropriate, would vary from case to case.

In my judgment in the Respondent's case, and in other cases which can conveniently be described as cases of physical inter-sex for equivalent reasons, the decision as to whether the individuals involved are female (or male) for the purposes of marriage should be made having regard to their development and all of the factors listed in the Corbett case, namely (in a slightly different form extending them to six factors):

a. Chromosomal factors.

b. Gonadal factors (i.e. presence or absence of testes or ovaries).

c. Genital factors (including internal sex organs).

d. Psychological factors,

e. Hormonal factors, and

f. Secondary sexual characteristics (such as distribution of hair, breast development, physique etc.)

Dr Conway had regard to all these factors. Another way of putting this is that the decision as to whether the person is male or female for the purposes of marriage can be made with the benefit of hindsight looking back from the date of the marriage or if earlier the date when the decision is made.

In my judgment having regard to Dr Conway's evidence if the Respondent had been born today the medical decision taken would have been that she should be brought up as a girl. If that decision had been made at the time of the Respondent's birth it would have been vindicated by the Respondent's physical development as a result of her partial androgen insensitivity, her desire from an early age to live as a girl and her final choice to live as a woman before she starting taking oestrogen and had her surgery. In my judgment having regard to (i) those factors, and (ii) the fact that I have concluded that the Respondent's registration as a boy was not warranted by an application of the biological test set and applied many years after her birth in the Corbett case, with hindsight it can be seen that such registration was an error.

On the above approach and thus having regard to (i) the six factors I have listed, (ii) all my findings under the heading "Findings having regard to the Respondent's history and the medical evidence" and (iii) my conclusion that the Respondent had the capacity to consummate her marriage to the Applicant, but having regard in particular to:

a. my acceptance of the diagnosis of partial androgen insensitivity, its cause and effect,

b. the Respondent's ambiguous external genitalia, and

c. the Respondent's development which led to her making a final choice to live as a woman well before she starting taking oestrogen and before she had surgery

in my judgment the Respondent was a female for the purposes of her marriage to the Applicant.

Accordingly I refuse and dismiss the Applicant's application for a decree of nullity in respect of his marriage to the Respondent.