FAMILY COURT OF AUSTRALIA

RE: JAMIE ***[2015] FamCA 455***

FAMILY LAW – CHILDREN – MEDICAL PROCEDURES – Where the applicants are the parents of a child diagnosed with gender dysphoria – where the applicants seek a declaration or finding that the child is competent to authorise her own stage two treatment – where the child's treating medical experts and parents support the child commencing stage two treatment – assessment of whether 15 year old child is *Gillick* competent to consent to medical treatment – finding that the child is competent to consent and authorised to make her own decision about stage two treatment for gender dysphoria.

Application on a point of law – for declaration that competence to consent to medical treatment by a child is not required by law in the absence of any controversy on the issue – not argued having regard to the Full Court decision in *Re: Jamie* – application dismissed.

Evidence Act 1995 (Cth) s 140
Family Law Act 1975 (Cth) ss 43, 60CA, 60CB, 60CC, 60CE, 60CG, 67ZC, 68L, 69H, 100B
Family Law Rules 2004 (Cth) rr 4.08, 4.09, 4.10

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Re: Jamie [2013] FamCAFC 110; 50 Fam LR 369
Re K (1994) FLC 92-461
Secretary Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218

FIRST APPLICANT: The Mother

SECOND APPLICANT: The Father

FILE NUMBER: By Court Order File Number is suppressed

DATE JUDGMENT DELIVERED: 16 June 2015

DATE ORDERS MADE: 5 June 2015

JUDGMENT OF: Thornton J

HEARING DATE: 5 June 2015

REPRESENTATION

By Court Order the names of counsel and solicitors have been suppressed

ORDERS MADE 5 JUNE 2015

IT IS ORDERED THAT

(1) These proceedings be known by and referred to as "Re: Jamie".

(2) Leave be granted for the proceedings to be heard "in camera".

(3) Subject to paragraph 4, the full name of the Child born … 2000 – now known and referred to as "Jamie" – Jamie's family members and their occupations, any medical practitioner and hospitals, Jamie's school and any staff at the school, the court file number, the State of Australia in which the proceedings were initiated, the names of the applicants' legal representatives, any witnesses, and any other fact or matter that may identify Jamie shall not be published in any way and only anonymised reasons for judgment and orders (with cover sheets excluding the Registry, file number, lawyers' names and details, as well as the parties' real names) shall be released by the Court to non-parties without further contrary order of a Judge.

(4) Jamie be at liberty to identify herself as the subject of this application and as the child the subject of the decision of the Full Court in *Re Jamie* [2013] FamCAFC 110 as she may choose.

(5) Until further order pursuant to s 100B(2) of the *Family Law Act 1975* (Cth), Jamie and her brother R both born … 2000, be permitted to be present and remain in court during the hearing of the application filed 28 May 2015.

(6) No person shall be permitted to search the court file in this matter without first obtaining the leave of a Judge of the Court.

(7) Leave granted to an employee of this Court as an observer and a relative of Jamie's family to be present in court this day.

(8) Paragraph 1 of the Initiating Application filed 28 May 2015 is dismissed.

(9) Upon the Court being satisfied that the child … born … 2000 ("Jamie") is competent to consent to the medical treatment described in the Initiating

Application filed 28 May 2015, the Court authorises Jamie to make her own decision in relation to that treatment.

(10) The treatment described in the Initiating Application filed 28 May 2015 is the administration of oestrogen by oestradiol valerate and the administration of endogenous testosterone blocker by spironolactone for the treatment of Gender Dysphoria ("Stage Two Treatment" and the "special medical procedure") in such doses, in such a manner and with such frequency as recommended by Jamie's treating medical practitioners including but not limited to Dr T and Associate Professor P, together with any associated, additional, consequential or necessary procedure connected with the special medical procedure.

(11) Notwithstanding paragraph 3 of these orders, the applicants to these proceedings shall be at liberty to collect by hand, a full copy of the orders and any reasons for judgment published thereunder with all of the identifying details which are otherwise excluded by paragraph 3 of these orders and such documents may be provided to the treating medical practitioners.

(12) The applicants be at liberty to provide a copy of the unanonymised orders and the unanonymised reasons for judgment to all persons involved with Jamie's treatment.

(13) The applicants' Initiating Application filed 28 May 2015 be otherwise dismissed and the matter be removed from the list of cases awaiting hearing.

IT IS NOTED that publication of this judgment by this Court under the pseudonym *Re: Jamie* has been approved by the Chief Justice pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order file number is dismissed

The Mother
First Applicant

And

The Father
Second Applicant

REASONS FOR JUDGMENT

Introduction

1. These are my reasons for making orders finding that a child, Jamie, aged 15, is competent to consent to medical treatment, being stage two treatment for gender dysphoria. Jamie is in Year 10 and the application was made by Jamie's parents.

2. Jamie was born a male but has identified as a female from a very young age. She was diagnosed with gender dysphoria by Associate Professor P of the Hospital in 2007 and wishes to undergo stage two treatment for gender dysphoria. There was some urgency to the application, for reasons which will become apparent.

3. There is no controversy about Jamie's diagnosis, her wishes or her competence to provide informed consent for medical treatment. Jamie's parents and her treating professionals, Associate Professor P and Dr T, are supportive of the application.

4. Significantly, Jamie is the child who was the subject of the decision of the Full Court in *Re: Jamie* [2013] FamCAFC 110; 50 Fam LR 369 ("*Re: Jamie*"). Given the decision in that case, Jamie's parents brought an urgent application for a declaration (or finding) that Jamie is "*Gillick* competent" pursuant to the decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 to consent to stage two treatment for gender dysphoria. As Jamie's parents, the applicants have standing to make this application.[1]

5. Regarding a point of law, the parents also sought, in paragraph 1 of the Initiating Application, that a declaration of competence to consent to medical

[1] Family Law Rules 2004 (Cth), r 4.08(a).

treatment by a child is not required by law in the absence of any controversy on that issue. Counsel for the parents did not press this aspect of the application as he accepted at the outset that this part of the application would be dismissed because I am bound by the decision of the Full Court in *Re: Jamie*. I agreed with that submission and therefore dismissed that part of the application.

6. The application before me was then essentially an application for determination by the Court as to whether Jamie is competent to consent to her own stage two medical treatment for gender dysphoria.

Background and Previous Court Proceedings

7. Jamie was originally the subject of court proceedings and judgment regarding stage one treatment for gender dysphoria as noted above. Her Honour Dessau J made orders on 28 March 2011 permitting the parents to consent to Jamie undergoing stage one treatment for gender dysphoria, which involved Jamie receiving puberty suppression hormones.

8. A point of law was raised on appeal by the parents to the Full Court in *Re: Jamie*. The parents' case was that the Court does not have jurisdiction to authorise the parents to consent to treatment for "childhood gender identity disorder" because it is not a special medical procedure which displaces their parental responsibility. This argument was predicated on being limited to circumstances where there is unanimous agreement between the relevant people involved with the welfare of the child including, if appropriate, the child.

9. As an adjunct and further, the parents argued on appeal that once the diagnosis was established and treatment approved, the trial judge erred in law and the exercise of discretion in concluding that the treatment for the disorder should be the subject of a further application to the Court when the stage two treatment is about to commence.

10. The parents on appeal sought to distinguish the circumstances of Jamie's case from the circumstances which applied in the decision of the High Court in *Secretary Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 ("*Marion's case*").

11. The Independent Children's Lawyer appointed by the trial judge was a party to the appeal and, in a separate judgment by the same Full Court bench, the public authority was permitted to intervene on a limited basis, such that the authority was confined to making written and oral submissions about ground one of the appeal. The Australian Human Rights Commission also intervened in the appeal without objection.

12. The Full Court of the Family Court undertook a comprehensive analysis of the earlier authorities in the context of the appeal. Separate judgments were delivered by each member of the bench.

13. Distilled into very simple relevant terms for the purposes of the present application, the Full Court in *Re: Jamie* determined that court authorisation was unnecessary for stage one treatment. However, the Full Court considered it was bound by what the High Court said in *Marion's case* and found that "the nature of the treatment at stage two requires that the Court determine *Gillick* competence".[2]

The Application

14. The parents sought the following orders (inter alia):

    1. That the Court find that a declaration of competence to consent to medical treatment by a child is not required by law in the absence of any controversy on that issue and order accordingly.
    2. That [Jamie] be declared competent to give informed consent to stage two treatment for gender dysphoria (specifically - the administration of oestrogen by oestradiol valerate and the administration of endogenous testosterone blocker by spironolactone for the treatment of gender dysphoria in such doses, in such a manner and with such frequency as recommended by the child's treating medical practitioners including but not limited to Dr [T] and Associate Professor [P], together with any associated, additional, consequential or necessary procedure connected with the special medical procedure).

15. For the reasons outlined previously, the parents' application in paragraph 1 was not argued before me. Accordingly, these reasons for judgment do not deal with this point of law.

16. The parents sought other orders in the alternative to paragraph 2 which are not relevant.

17. Jamie's age, psychological state and her circumstances are the reasons for the urgency of the application.

18. Numerous procedural orders were also sought, which will be discussed below.

Service of the Application

19. The relevant Department, the relevant public authority and the Australian Human Rights Commission ("the AHRC") have been served with the application in accordance with Rule 4.10 of the Family Law Rules 2004 (Cth). Affidavits of service in respect of each of those organisations were relied upon by the parents in support of their application. Letters from the AHRC and the public authority were tendered by counsel for the parents (Exhibits A and B respectively).

[2] *Re: Jamie* [2013] FamCAFC 110; 50 Fam LR 369, [137] (Bryant CJ).

20. The AHRC indicated that it did not intend to seek leave to intervene in this application but did however state that the Commission would consider intervening in any appeal dealing with the legal issues raised in the previous Full Court decision in *Re: Jamie*.

21. The public authority confirmed that the public authority is not able to intervene in the proceeding but reserved the position of the public authority if the matter were to proceed on appeal. The second letter from the public authority referred to a conversation with Associate Professor P about Jamie. The letter provides that:

> A/P [P] discussed with me issues about the ability to make a free and voluntary decision when one has strong desires that take one in a particular direction; about the ability to weigh up information, not just understand it; and that consent is not just about particular medical procedures, but to a choice of identity with concomitant lifestyle implications.
>
> A/P [P] was able to address these matters in relation to [[Jamie]] and I was reassured by the conversation that these matters are addressed in [[Jamie's]] case.

22. The Department did not seek to be heard on the application.

The Law: *'Gillick'* Competence

23. The term "*Gillick*" refers to the English case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

24. In *Marion's case* the High Court said that the view of the House of Lords in the *Gillick* case represented the common law in Australia.

25. In *Gillick*, Lord Scarman recognised the underlying principle in the case law that parental right yields to the child's right to make his/her own decisions when he/she reaches a sufficient understanding and intelligence to be capable of making up his/her own mind on the matter requiring decision. Lord Scarman referred to the spirit and principle of the law captured by Lord Denning MR when he said that:

> The common law can, and should, keep pace with the times. It should declare … that the legal right of a parent to the custody of a child ends at the 18th birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice.[3]

26. In *Gillick*, Lord Scarman said at 188-189:

[3] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 129 (Lord Scarman), quoting *Hewer v Bryant* [1969] 3 All ER 578, 582 (Lord Denning MR).

> … I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law.

27. In *Marion's case*, Mason CJ, Dawson, Toohey and Gaudron JJ, in discussing the *Gillick* principle enunciated by Lord Scarman, said as follows at 237-238:

> A minor is, according to [the *Gillick*] principle, capable of giving informed consent when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".
>
> This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.
>
> (References omitted).

28. In *Re: Jamie* the Full Court held that stage two treatment of gender dysphoria (administration of testosterone or oestrogen) was a medical procedure that required court authorisation, unless the Court found that the child was *Gillick* competent and thus able to fully understand and give informed consent to stage two treatment at the time it was to commence. The Full Court found that it was the Court's responsibility to assess whether or not a particular child was *Gillick* competent.

29. In summarising her conclusion in *Re: Jamie* Bryant CJ relevantly said (inter alia) at [140]:

> …
>
> c) In relation to stage two treatment, as it is presently described, court authorisation for parental consent will remain appropriate unless the child concerned is *Gillick* competent.
>
> d) If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy.
>
> e) The question of whether a child is *Gillick* competent, even where the treating doctors and the parents agree, is a matter to be determined by the court.
>
> (Original emphasis).

30. In that same case Finn J, whilst expressing reluctance to impose upon the child and her parents the costs and stress of further court proceedings, particularly

when the Court may ultimately reach the same decision which the child and her parents had already reached with the child's doctors, stated at [186]:

> Nevertheless, I have concluded that at least the question of the child's capacity to consent to treatment which has the irreversible effects of stage two treatment must remain a question for the court. I have reached this conclusion because of the requirement by the High Court majority in *Marion's case* for court authorisation for irreversible medical treatment in circumstances where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment and where the consequences of such a wrong decision are particularly grave, as they would be in this case.

31. Her Honour, in reaching that conclusion, took into account "the persuasive submissions" made on behalf of the Australian Human Rights Commission and the public authority "which support continued court involvement in decisions concerning stage two treatment".[4]

32. In the same case Strickland J agreed with the outcomes proposed by both the Chief Justice and Finn J and generally for the reasons set out by each of them. He stated at [196] :

> Whether the child is able to fully understand and give informed consent to stage two treatment… is a threshold issue that the court must decide. This is because of the requirement by the High Court majority in *Marion's case* that it is for the court to authorise medical treatment that is irreversible where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment, and where the consequences of such a wrong decision are particularly grave.

Jurisdiction

33. This application is brought under Part VII of the *Family Law Act 1975* (Cth) ("the Act").

34. Section 69H(1) of the Act provides that jurisdiction is conferred on the Family Court in relation to matters arising under this part.

35. Section 67ZC of the Act provides additional jurisdiction under Part VII of the Act to make orders relating to the welfare of children. It was inserted by an amendment to the Act in 1995 and reads:

> (1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.

[4] *Re: Jamie* [2013] FamCAFC 110; 50 Fam LR 369, [187].

(2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

36. Sections 60CB to 60CG of the Act deal with how the Court determines a child's best interests.

37. The Court has power to make an order under s 67ZC of the Act to authorise medical treatment. In the circumstances of this case it is not necessary to do so because, for reasons set out below, I am satisfied that Jamie is *Gillick* competent.

Procedure

38. Bryant CJ in *Re: Jamie* made the following observations in reference to an application with respect to *Gillick* competence:

> That application however would only need to address the question of *Gillick* competence and once established the court would have no further role. The material in support of such an application, whilst needing to address the proposed treatment and its effects, and the child's capacity to make an informed decision, would not need to be as extensive as an application for the court to authorise treatment and I can see no reason why any other party need be involved, absent some controversy. It would be an issue of fact to be determined by the court on the material presented.[5]

39. Counsel for the parents relied upon this aspect of the judgment in *Re: Jamie* in support of his submission that it was unnecessary to serve the Independent Children's Lawyer, who had been involved in the previous proceedings before Dessau J and the Full Court (referred to above) and whose appointment was discharged following the conclusion of those proceedings. He also relied upon the fact that the other members of the Court either did not express a contrary view or expressed implicit agreement with the Chief Justice on this point.

40. Section 68L of the Act allows for the appointment of an Independent Children's Lawyer in proceedings under the Act in which a child's best interests are, or a child's welfare is the paramount, or a relevant consideration. It is a discretionary matter for the Court as to whether a child's interests in the proceedings ought to be independently represented by a lawyer.

41. Having regard to all the circumstances of this case, including Jamie's age, the urgency of the proceedings, and the absence of any controversy regarding the proposed treatment, I accept the submissions of counsel for the applicants. I am satisfied that the appointment of an Independent Children's Lawyer is unnecessary. In *Re K* (1994) FLC 92-461 at 80,773, the Full Court issued guidelines as to the circumstances in which an Independent Children's Lawyer

[5] *Re: Jamie* [2013] FamCAFC 110; 50 Fam LR 369, [139].

should usually be appointed. One of the categories referred to in those guidelines were applications in the Court's welfare jurisdiction relating in particular to the medical treatment of children where the child's interests are not adequately represented by one of the parties. In the circumstances of this case, I am satisfied that Jamie's interests are adequately represented by her parents. I am fortified in that view by the evidence of the expert witnesses.

42. Under s 60CE of the Act, there is nothing in Part VII of the Act that permits the Court or any person to require the child to express his or her views in relation to any matter. However, in this case, Jamie's views have been clearly expressed through her parents and her treating professionals. Jamie has also written a letter by email to the Court through her parents' solicitors in which she expresses her clear desire for stage two treatment. That email was copied in its entirety in the summary of argument filed by the parents on 4 June 2015 and was tendered as Exhibit C. That same email is also extracted later in this judgment.

43. An application was made by counsel for the parents at the beginning of the hearing that pursuant to s 100B(2) of the Act, Jamie and her brother R be permitted to be present and remain in court during the hearing of the substantive application. The default position under s 100B(2) is that a child must not be present during Family Court proceedings unless the Court makes an order allowing the child to be present. In support of the submission that I should make such an order allowing Jamie and her brother to be present, counsel relied upon the factors listed at paragraph 4 of the summary of argument filed by the applicants. The factors set out in paragraph 4 are as follows:

a) The application is uncontested and unopposed.

b) The hearing is non-adversarial. No witnesses are to be cross-examined and no attack on credit will be made.

c) All the relevant parties and witnesses are in agreement about the outcome.

d) Jamie is entitled to be heard and to know what is happening in relation to a very significant aspect of her life.

e) The evidence establishes that Jamie and her brother share a close relationship. R is Jamie's major support and has accepted her gender identity at an early stage (see affidavit of the mother at [29] and [60]).

f) Jamie wishes R to be present.

g) Although s 60CC does not apply to this part of the application (under s 100B) as it is not a parenting order (see s 60CA) the best interests principles permeate all proceedings under the Act which relate to children; See *Northern Territory of Australia v GPAO* (1999) FLC 92-838. Reference is also made to *Re: Jordan* [2015] FamCA 175 where Kent J

made a similar order to that sought in this case in circumstances where the evidence did not establish that the child was *Gillick* competent.

44. In making an order allowing Jamie and her brother to be present during the proceedings, I considered all of those factors relied upon by counsel. In addition, I considered s 43(1)(c) of the Act which provides that in exercising its jurisdiction under the Act, the Family Court shall have regard to the need to protect the rights of children and to promote their welfare.

45. The usual procedural orders that the proceedings be conducted in camera and that only an anonymised version of these reasons be published were made having regard to the sensitivity of the proceedings. It was appropriate to make the usual orders preserving Jamie's anonymity which include the treating professionals, lawyers and others involved in the case.

46. However, the order suppressing the publication of all information identifying Jamie as the child the subject of these proceedings was made subject to an order that Jamie be at liberty to identify herself as the subject of this application and as the child the subject of the decision of the Full Court in *Re: Jamie* as she may choose. Counsel for the parents submitted that it is not in Jamie's best interests to compel her to maintain secrecy should she wish to reveal her circumstances to people of her choosing. Having regard to the fact that there is no controversy between the parents and the expert witnesses in this case as to *Gillick* competence, I accepted counsel's submissions and made an order allowing Jamie to be at liberty to reveal herself as the child of these proceedings to whomever she chooses.

Evidence and Standard of Proof

47. The rules provide that evidence may be given in the form of an affidavit or orally with the Court's permission.[6] The documentary evidence relied upon for this hearing is listed in Annexure A to these reasons. No witnesses were cross-examined and the case proceeded by way of submissions only.

48. The standard of proof applicable is on the balance of probabilities under s 140 of the *Evidence Act 1995* (Cth).

The Nature of the Proposed Medical Treatment

49. It is proposed that Jamie will commence treatment with the administration of oestrogen by oestradiol valerate and the administration of endogenous testosterone blocker by spironolactone. The use of oestrogen will induce feminising changes to Jamie's body including the induction of breast growth, decreased facial and body hair, softening of skin, decreased libido and changes to fat distribution.

[6] Family Law Rules 2004 (Cth), r 4.09(3)

50. In her report, Dr T details the longer term risks from taking oestrogen and spironolactone which include:[7]

> Specific risks of oestrogen:
>
> - chronic problems with veins in the legs;
> - heart disease;
> - pulmonary embolism (blood clot to the lungs);
> - stroke;
> - type 2 diabetes;
> - liver disease;
> - high cholesterol and high blood pressure;
> - gallstones;
> - headaches or migraines;
> - prolactinoma (non-cancerous tumour of the pituitary gland);
> - long term infertility.
>
> Specific risks of Spironolactone:
>
> - gastrointestinal symptoms (cramping, diarrhoea, nausea, vomiting, ulceration and gastritis);
> - drowsiness;
> - lethargy;
> - headache;
> - skin reactions.

Gillick Competence

51. The evidence of the parents and Jamie's treating doctors supports a finding that she is *Gillick* competent. The evidence is summarised below.

Evidence in support of the application

52. I accept the unchallenged evidence of the parents, and particularly the mother, who depose to a number of matters regarding Jamie's circumstances.

53. According to the mother, Jamie first began identifying with the female gender when she was about two and a half to three and a half years of age. Jamie's insistence that she was female increased significantly when she commenced primary school in 2006.

[7] Report of Dr T dated 25 May 2015 (Annexure MT3 to her affidavit filed 28 May 2015).

54. In or about July 2007, the parents contacted an adult Gender Dysphoria Clinic who gave them the name of Associate Professor P. Jamie's first appointment with him took place in or about October 2007 when Jamie was seven years old.

55. Towards the end of 2008, Jamie's brother R insisted that the parents call Jamie a girl. From that time, the parents and R started using the female pronoun for Jamie. At the commencement of the 2009 school year, when Jamie was in Grade 3, the parents notified Jamie's teacher that her family was using the female pronoun for her at home and requested that she do the same. By this time, the mother had informed the school of Jamie's diagnosis of gender dysphoria. Following incidences of bullying, Jamie and her brother commenced at a new primary school in Term 3 of 2009. Jamie was known exclusively as a girl at school from that point onwards.

56. Jamie's name was formally changed in August 2012. An Australian Passport has also been obtained for Jamie and she is identified as female on that passport. Jamie commenced secondary school in 2013 and is currently in Year 9. The mother states that Jamie is progressing well at school and deposes extensively as to her extracurricular involvement. Jamie has confided in several of her friends her diagnosis of gender dysphoria. By all accounts, her friends have been supportive of her.

57. In 2010, Professor W at the Endocrinology Department of the Hospital performed a test for the onset of puberty on Jamie which indicated that she had entered puberty in or about April 2010. The small physical changes experienced by Jamie at this time, such as the development of some pubic hair and the broadening of her chest, were distressing for Jamie. By February 2011, tests undertaken by Professor W indicated that Jamie was undergoing rapid pubertal development at a rate normally seen in 14 year old boys. At this stage, Janme was not yet 11 years of age. Stage one treatment was recommended as being urgently required to prevent the irreversible deepening of Jamie's voice.

58. Jamie has experienced continued difficulties in finding the correct type and dosage of stage one treatment sufficient to adequately suppress male puberty. The ongoing inadequacies of the stage one treatment have caused Jamie considerable distress and anxiety. Jamie has recently insisted upon monthly blood tests (as opposed to half yearly) to monitor her testosterone levels on a more regular basis.

59. Due to the puberty blocking treatment Jamie has received since the age of 10, she has the appearance of a pre-pubescent girl. She is concerned that she does not resemble her female peers, particularly in terms of the development of breasts.

60. The mother further deposes that Jamie's family have been discussing the advantages, disadvantages and risks of stage two treatment with Jamie's treating doctors for many years. When advised by Dr T that Jamie was ready

for stage two treatment, Dr T provided Jamie and her family with a detailed information sheet in relation to that treatment. Jamie annotated her own copy of the sheet, marking aspects of it that she wanted to discuss further with her doctors.

61. Both parents depose that they support Jamie seeking treatment for her gender dysphoria. The parents and Jamie have signed the Hospital form "Informed Consent for Feminizing Hormone Treatment with Oestrogen". A copy of that form is Annexure RSR5 to the mother's affidavit.

62. The mother specifically addresses the issue of *Gillick* competence in her affidavit. At paragraphs 75 to 77 of her affidavit she says:

> [Jamie] is an intelligent, mature and confident person. She has approached the diagnosis of [gender dysphoria], the treatment options and the risks and benefits of that treatment with patience and clarity. She has asked many questions about the diagnosis and treatment, and listens carefully to advice. She expresses her own ideas and opinions. She is certain, confident and relaxed about her female identity and has been for a long time.
>
> Professor P[], Dr [T], [the father] and I have explained to [Jamie] what the proposed medical treatment involves and have discussed her options with her over many years. I believe [Jamie] has a full understanding of what the treatment entails, its risks and benefits and how it will affect her physically, socially and emotionally.
>
> [Jamie] has demonstrated significant resilience and resourcefulness in dealing with the diagnosis of [gender dysphoria] and the effect on her. I believe that she would apply the same attitude and skills to dealing with the impacts of stage two treatment in the future.

63. Although the mother is not a medical expert, she has had the advantage of observing, and interacting with, Jamie since her birth.

64. As referred to above, Exhibit C is the parents' summary of argument which included a letter to the Judge written by Jamie. Although it is not evidence, because there was no application for Jamie to give evidence and I considered it unnecessary for Jamie to adopt the letter in oral evidence before me, it is important because it articulates Jamie's views.

65. Jamie wrote:

> To Her Honour,
>
> I am a normal, cheerful, confident girl and I know who I am. It's just that my exterior, doesn't mirror my interior. I want my body to develop alongside my peers, and I want my body to match who I really am; a girl. It is simple, however it frustrates me deeply that I have to go to court to be who I am. It frustrates me that anyone has to endure this. It shouldn't be

the court's decision. It is my body, and only I have the right to decide what goes into it. It is acceptable for my family or the experienced doctors to advise me, but in the end, it should all be up to me. However, this right has been taken completely out of my hands. Not only have I experienced much anxiety about almost going into male puberty 4 years after I started puberty blockers, but I have absolutely no control over my body. It is you that has control, so I implore you to let me start stage 2 treatment. Then, I can be who I am, without this worry hanging over me.

Thank you.

The Evidence of Associate Professor P

66. Associate Professor P is a consultant child and adolescent psychiatrist with 34 years of practice at the Hospital. Associate Professor P has considerable experience working with children and adolescents with a range of gender identity developmental problems having seen approximately 80 children and adolescents experiencing gender dysphoria. Associate Professor P has known Jamie and her family since July 2007 in his capacity as a consultant psychiatrist; he has met with Jamie and her parents at regular and generally three month intervals since that time.

67. I accept the evidence of Associate Professor P in the following terms. It is his opinion that Jamie meets the criteria for a diagnosis of Gender Dysphoria (DSM-V 302.85) specified: Post-transition and gender dysphoria of childhood and adolescence under DSM-V (previously Gender Identity Disorder under DSM-IV). Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender (natal gender). The diagnosis of Gender Identity of Childhood was confirmed by Professor N, professor of child and adolescent psychiatry, in May 2009. Associate Professor P also states that he believes that Jamie definitely meets the criteria for the diagnosis of Gender Dysphoria in Adolescents and Adults (DSM V) and sets out the criteria for that diagnosis. He also believes that Jamie meets the criteria for a diagnosis of "Gender Identity Disorder of Adolescence" under the World Health Organisation ICD 10 health classification system. He further states that the minor symptoms of anxiety experienced by Jamie are not, in his opinion, the primary causative reason for her gender dysphoria.

68. Associate Professor P records Jamie's medical history in treating her gender dysphoria. He reports that Jamie experienced a relatively early onset of puberty and that following approval from this Court (as referred to above), Professor W commenced Jamie on treatment with Zoladex, a puberty blocking medication. Dr O took over Jamie's medical care upon Professor W's retirement at the end of 2011. Subsequently, Jamie has been cared for by Dr T after Dr O commenced maternity leave. The evidence of Dr T is referred to below.

69. Although Associate Professor P notes that Dr T is in a better position to detail the precise nature of the proposed stage two treatment, he observes that it is clear that it has been a difficult process to suppress Jamie's intrinsic testosterone production and that this has led to continued real distress for Jamie. He also confirms that there is no alternative or less invasive treatment available than the stage two treatment proposed.

70. In terms of his opinion as to whether Jamie is capable of making an informed decision about the stage two treatment, Associate Professor P deposes that Jamie is *Gillick* competent and has been able to give thorough, thoughtful and mature consideration to the risks and benefits of the proposed oestrogen treatment. He reports that she has consistently demonstrated a clear understanding of the impact of oestrogen upon her body, including both short and long-term side effects and risks. Associate Professor P notes that Jamie has asked very appropriate and pertinent questions, and has demonstrated a clear understanding of the content of the Hospital hormone treatment information brochure. Jamie has further given sound consideration to the various options available in terms of fertility and has already undergone a biopsy of testicular material which has been placed in storage and has the potential to be used in later years.

71. Associate Professor P outlines the likely long-term physical, social and psychological effects on Jamie if treatment is carried out and, in the alternative, if treatment is not carried out. Notably, he deposes that the treatment would minimise the possibility of Jamie developing major depressive and anxiety symptoms. Associate Professor P is of the opinion that it is "extremely important that [Jamie] is able to feel comfortable within her body consistent with her female gender identity. This necessarily involves allowing for feminisation of her body…".[8] It is his opinion that the treatment will substantially improve Jamie's social, emotional and physical health and there will be a reduced risk of depression, anxiety and self- harm.

72. Associate Professor P notes that Jamie has undertaken independent research about fertility and hormone treatment for gender dysphoria. She has expressed her wish to commence stage two treatment very clearly and consistently on the occasions she has met with Associate Professor P. It is his opinion that Jamie has come to the decision to proceed to stage two treatment as an independent agent without pressure from her parents or others. Associate Professor P warns if Jamie is not able to commence treatment with oestrogen soon, her overall emotional, social and physical health will be put at severe jeopardy.

Urgency of the application

73. Associate Professor P's evidence, which I accept, is that there is a real urgency to commence treatment and that this should occur immediately in order to

[8] Report of Associate Professor P dated 20 May 2015 (Annexure CP3 to his affidavit filed 29 May 2015).

minimise psychological trauma. He notes that Jamie has become increasingly distressed about the physical difference she experiences between her own non-feminised, pre-pubertal body and that of her age peers.

74. Significantly, he concludes that "[Jamie] may feel that her life is not worth living without being able to become the more feminine person she expects to become". He deposes that the treatment is "necessary for her further physiological development, and will minimise the experience of her gender dysphoria and minimise otherwise major risk to psychological and emotional development".

The Evidence of Dr T

75. Dr T is the current head of the Gender Dysphoria Service at the Hospital. She has seen Jamie on five occasions from 21 February 2014 to 7 May 2015 in her capacity as a subspecialist Adolescent Physician and Jamie's paediatrician. She is a current member of the Hospital's Vulnerable Children's Committee. Dr T has worked in paediatrics since 2003.

76. In her affidavit, Dr T reports that her colleagues in the multidisciplinary team practising in Adolescent Medicine confirm that Jamie meets diagnostic criteria for gender dysphoria. Dr T also reports that during the five occasions she has met with Jamie, she has given responses to ongoing psychosocial assessment that are entirely consistent with that diagnosis. I accept this evidence.

77. Dr T proposes treatment with oestradiol at a dosage of 1 mg orally daily. During the first six months of this treatment, the puberty blocker diphereline will be continued to prevent a rise in endogenous (naturally produced) testosterone levels while the dose of oestradiol valerate is low. On cessation of the diphereline, spironolactone will be commenced at 100 mg twice daily to block the endogenous testosterone effect on Jamie's body. After a period of 6-12 months, the dose of oestradiol valerate will be reassessed and possibly increased to 2 mg daily. The final adult dose of oestradiol valerate is 2-4mg daily, which will be reached following two years of treatment. Dr T reports that the combined treatment of oestradiol valerate and spironolactone is appropriate for the long-term management of Jamie's gender dysphoria. Dr T reports that alternative ways of delivering oestrogen to the body (for example, via dermal patches or implants) are not appropriate for the initiation of hormone treatment in adolescents and that there is no alternative treatment for gender dysphoria for biological males who, like Jamie, have a female gender identity.

78. Dr T lists a series of physical and physiological changes that would occur in Jamie's body as a result of the treatment. She also warns that if treatment is not permitted, Jamie's anxiety symptoms will increase and she will be at an increased risk of depression, self-harm behaviour and death via suicide. Currently Jamie experiences a high level of anxiety and distress relating to ongoing difficulty she experiences with the testosterone medication. Jamie has

been requesting monthly blood tests from Dr T to reassure herself that her testosterone level is minimised and that further masculinisation of her body will be prevented. Dr T also warns that, if denied treatment, Jamie may choose to access oestrogen illegally and will not be able to do so with medical advice and monitoring for complications, with potentially dangerous physical and mental consequences. I accept this evidence.

79. I also accept the evidence of Dr T where she deposes that Jamie is *Gillick* competent and possesses insight into her current situation and the difficulties she faces now and in the future. Dr T further deposes that she has discussed the benefits and risks of oestrogen treatment with Jamie at length and that Jamie is well informed of and understands these risks "as well as any other person could, including that of an informed adult".[9] With respect to the risks involved in prolonged oestrogen treatment, Dr T reports that she, Jamie and Jamie's parents have discussed infertility in general and the options available to Jamie. Jamie has requested to undergo a testicular biopsy for long-term storage of testicular tissue to maximise her ability to produce a biological child in the future, and is aware that this procedure is currently experimental. Dr T expresses the opinion that Jamie has made the right decision in doing so, given that the storage of testicular tissue is the only available option for Jamie to have a biological child in the future while still remaining on her current puberty blocking medication.

80. Dr T recommends that Jamie be commenced on oestrogen immediately. Dr T reports that Jamie has now been on puberty suppression for four years and two months (as at the date of her report) and is, in Dr T's opinion, psychologically, emotionally and physically ready for commencement of oestrogen. Dr T deposes that there is no benefit in delaying the treatment.

Findings and Conclusion

81. I accept the unchallenged evidence of the expert witnesses and the parents. Jamie has demonstrated the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences which include infertility. Her views are clear and have not changed. This has also been demonstrated in her letter to the Court and her scrutiny of the evidence in support of the application.

82. On the basis of all of the evidence, I am satisfied on the balance of probabilities that Jamie is competent to fully understand the nature and consequences of the treatment described in the application and to make her own decision in relation to that treatment. The evidence before me demonstrates that Jamie has carefully considered, understood and retained the information presented to her regarding the treatment for gender dysphoria over a number of years. She has asked thoughtful and pertinent questions of the medical professionals involved in her

[9] Report of Dr T dated 25 May 2015 (Annexure MT3 to her affidavit filed 28 May 2015).

care. Jamie is a young person in the transition phase from childhood to adulthood referred to in the *Gillick* case and is competent to consent to treatment.

83. I am satisfied that it is appropriate to make a finding that Jamie is competent to make her own decision regarding the proposed treatment.

The Nature of the Relief Sought and Form of the Order

84. The relief sought in the Initiating Application was framed in terms of declaratory relief. However, the summary of argument filed by the parents on 4 June 2015 indicated that a declaration or finding of *Gillick* competence was sought.

85. There would appear to be some controversy about whether the Court has the power, absent a statutory conferral of power, such as in s 78 of the Act, to make a declaration regarding these types of applications.

86. I adhere to my view, indicated to counsel for the parents in discussion, that following the authorities, it is unnecessary to make a declaration. Accordingly, the order is not framed in terms of a declaration but there is a finding that Jamie is competent to consent to the medical treatment described in the application and authorised her to make her own decision in relation to that treatment.

I certify that the preceding eight-six (86) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Thornton delivered on 16 June 2015.

Associate:

Date: 16 June 2015

ANNEXURE A

Documents relied upon by the applicant parents:

- Initiating Application filed 28 May 2015;
- Affidavit of the Mother filed 28 May 2015;
- Affidavit of the Father filed 28 May 2015;
- Affidavit of Dr T (paediatrician) filed 28 May 2015;
- Affidavit of Associate Professor P (Consultant Child and Adolescent Psychiatrist) filed 29 May 2015;
- Affidavit of service in respect of the public authority filed 3 June 2015;
- Affidavit of service in respect of the Department filed 3 June 2015;
- Affidavit of service in respect of the Australian Human Rights Commission filed 3 June 2015;
- Exhibit A, letter dated 4 June 2015 received by the applicants' instructing solicitors from the Australian Human Rights Commission;
- Exhibit B, two letters dated 5 June 2015 from the public authority to the applicants' instructing solicitors; and
- Exhibit C, applicant parents' summary of argument filed 4 June 2015 containing Jamie's letter to the Judge.