FAMILY COURT OF AUSTRALIA

RE: KELVIN ***[2017] FamCAFC 258***

CASE STATED – CHILDREN – Gender Dysphoria – Where s 67ZC(1) and s 69ZH of the *Family Law Act 1975* (Cth) confer power on the Family Court of Australia to determine applications concerning the administration of stage 2 medical treatment for Gender Dysphoria for children – Where s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) and s 174 and s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) do not affect these proceedings – Whether the Court confirms its decision in *Re: Jamie* (2013) FLC 93-547 ("*Re Jamie*") to the effect that stage 2 treatment of a child for the condition of Gender Dysphoria in adolescents and adults in the DSM-V requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth), unless the child is *Gillick* competent to give informed consent (Question 1) – Where this question can and should be answered by considering whether it is appropriate to now depart from *Re Jamie* in order that the law is able to effectively reflect the current state of medical knowledge – Where it is unnecessary and inappropriate for the Court to find that *Re Jamie* is "plainly wrong" in order to answer the question posed – Where there are legally relevant factual differences between the two cases, namely advances in medical science regarding the purpose for which the treatment is provided, the nature of the treatment, and the risks involved in undergoing, withholding, or delaying treatment – Where the treatment can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the court – Where the answer to question 1 is "no" – Whether it is mandatory to apply to the Family Court of Australia for a determination whether the child is *Gillick* competent where stage 2 treatment is proposed, the child consents to the treatment and the parents and the medical practitioners are in agreement (Question 2) – Where the nature of the treatment no longer justifies court authorisation and the concerns identified in *Re Jamie* do not apply – Where the answer to question 2 is "no" – Where it is unnecessary to answer questions 3 to 6 of the stated case

Australian Constitution s 51(xxxvii)
Children and Young Persons (Care and Protection) Act 1998 (NSW) ss 174, 175
Commonwealth Powers (Family Law – Children) Act 1986 (NSW)
Family Law Act 1975 (Cth) ss 64B(2)(i), 65D(1), 67ZC, 69H, 69ZE, 69ZH, 91(1)(b)(ii), 94A
Minors (Property and Contracts) Act 1970 (NSW) s 49

Bass v Permanent Trustee Co Ltd (1999) 198 CLR 334
Conway v The Queen (2002) 209 CLR 203
De Simone v Bevnol Constructions & Developments Pty Ltd (No 2) (2010) 30 VR 211
Director of Public Prosecutions, South Australia v B (1998) 194 CLR 566
E. (Mrs) v Eve [1986] 2 S.C.R. 388
F Firm & Ruane and Ors (2014) FLC 93-611
Fowles v The Eastern and Australian Steamship Co Ltd (1913) 17 CLR 149

Gett v Tabet (2009) 254 ALR 504
Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Minister for Immigration and Multicultural and Indigenous Affairs v B (2004) 219 CLR 365
Nguyen v Nguyen (1990) 169 CLR 245
P v P (1994) 181 CLR 583
PMT Partners Pty Ltd (In Liq) v Australian National Parks and Wildlife Service (1995) 184 CLR 301
Re Alex: Hormonal Treatment for Gender Identity Dysphoria (2004) FLC 93-175
Re GWW and CMW (1997) FLC 92-748
Re Inaya (Special Medical Procedure) (2007) 38 Fam LR 546
Re: Jamie (2013) FLC 93-547
Re: Jaden [2017] FamCA 269
Re Lucy (Gender Dysphoria) (2013) 49 Fam LR 540
Re Sam and Terry (Gender Dysphoria) (2013) 49 Fam LR 417
Re: Sarah [2014] FamCA 208
Re Sean and Russell (Special Medical Procedures) (2010) 44 Fam LR 210
Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218
R v Ross-Jones; Ex Parte Beaumont (1979) 141 CLR 504
State of Queensland v B [2008] 2 Qd R 562
Telstra Corporation Ltd v Treloar (2000) 102 FCR 595

Explanatory Memorandum to the Family Law Reform Bill 1994 (Cth)
Felicity Bell, "Children with Gender Dysphoria and the Jurisdiction of the Family Court" (2015) 38(2) *University of New South Wales Law Journal* 426
J D Heydon, "How Far Can Trial Courts and Intermediate Appellate Courts Develop the Law?" (2009) 9 *Oxford University Commonwealth Law Journal* 1

APPLICANT:	The Father
FIRST INTERVENOR:	A Gender Agenda Inc.
SECOND INTERVENOR:	Australian Human Rights Commission
THIRD INTERVENOR:	Secretary for the Department of Family and Community Services
FOURTH INTERVENOR:	Attorney-General of the Commonwealth
FIFTH INTERVENOR:	The Royal Children's

	Hospital
INDEPENDENT CHILDREN'S LAWYER:	Legal Aid NSW
FILE NUMBER:	SYC 456 of 2017
APPEAL NUMBER:	EA 30 of 2017
DATE DELIVERED:	30 November 2017
PLACE DELIVERED:	Perth
PLACE HEARD:	Sydney
JUDGMENT OF:	Thackray, Strickland, Ainslie-Wallace, Ryan & Murphy JJ
HEARING DATE:	21 September 2017
LOWER COURT JURISDICTION:	Family Court of Australia
LOWER COURT JUDGMENT DATE:	16 February 2017 (case stated amended on 25 August 2017)
LOWER COURT MNC:	[2017] FamCA 78

REPRESENTATION

COUNSEL FOR THE APPLICANT:	Ms Painter SC with Ms Palaniappan
SOLICITOR FOR THE APPLICANT:	Inner City Legal Centre
COUNSEL FOR THE FIRST INTERVENOR:	Ms Walker QC with Ms Bennett
SOLICITOR FOR THE FIRST INTERVENOR:	Human Rights Law Centre
COUNSEL FOR THE SECOND INTERVENOR:	Ms Younan

SOLICITOR FOR THE SECOND INTERVENOR:	Australian Human Rights Commission
COUNSEL FOR THE THIRD INTERVENOR:	Mr Anderson with Mr Hume
SOLICITOR FOR THE THIRD INTERVENOR:	Crown Solicitor’s Office
COUNSEL FOR THE FOURTH INTERVENOR:	Ms Richardson SC with Mr Herzfeld
SOLICITOR FOR THE FOURTH INTERVENOR:	Australian Government Solicitor
COUNSEL FOR THE FIFTH INTERVENOR:	Mr Glass
SOLICITOR FOR THE FIFTH INTERVENOR:	The Royal Children’s Hospital Medico-Legal Office
COUNSEL FOR THE INDEPENDENT CHILDREN’S LAWYER:	Ms Ward
SOLICITOR FOR THE INDEPENDENT CHILDREN’S LAWYER:	Legal Aid NSW

ORDERS

(1) The questions stated for the opinion of the Full Court be answered as follows:

Question 1: Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) DSM-5 (the treatment), requires the court’s authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) (“the Act”), unless the child was *Gillick* competent to give informed consent?

Answer: No

Question 2: Where:

2.1 Stage 2 treatment of a child for Gender Dysphoria is proposed;

2.2. The child consents to the treatment;

2.3. The treating medical practitioners agree that the child is *Gillick* competent to give that consent; and

2.4. The parents of the child do not object to the treatment

is it mandatory to apply to the Family Court for a determination whether the child is *Gillick* competent (Bryant CJ at [136-137, 140(e)]; Finn J at [186] and Strickland J at [196] *Re Jamie*)?

Answer: No

Question 3: If the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for a declaration that the child is *Gillick* competent, be dismissed?

Answer: Unnecessary to answer

Question 4: In the alternative, if the answer to question 2 is yes, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for an order authorising the administration of the treatment, be dismissed?

Answer: Unnecessary to answer

Question 5: If the answer to question 3 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make a declaration that the child was *Gillick* competent to give informed consent to the treatment?

Answer: Unnecessary to answer

Question 6: If the answer to question 4 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and

power of the court enlivened, pursuant to s 67ZC of the Act, to make an order authorising the administration of the treatment?

Answer: Unnecessary to answer

Note: The form of the order is subject to the entry of the order in the Court's records.

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

Note: This copy of the Court's Reasons for Judgment may be subject to review to remedy minor typographical or grammatical errors (r 17.02A(b) of the Family Law Rules 2004 (Cth)), or to record a variation to the order pursuant to r 17.02 Family Law Rules 2004 (Cth).

THE FULL COURT OF THE FAMILY COURT OF AUSTRALIA AT SYDNEY

Appeal Number: EA 30 of 2017
File Number: SYC 456 of 2017

The Father
Applicant

And

A Gender Agenda Inc.
First Intervenor

And

Australian Human Rights Commission
Second Intervenor

And

Secretary for the Department of Family and Community Services
Third Intervenor

And

Attorney-General of the Commonwealth
Fourth Intervenor

And

The Royal Children's Hospital
Fifth Intervenor

And

Independent Children's Lawyer

REASONS FOR JUDGMENT

THACKRAY, STRICKLAND & MURPHY JJ

INTRODUCTION

1. This matter comes before the Court by way of an amended case stated by Watts J on 25 August 2017, pursuant to s 94A(1) of the *Family Law Act 1975* (Cth) ("the Act").

2. The case stated arises from an application by the applicant father concerning the administration of stage 2 medical treatment for Gender Dysphoria for his then 16 year old child, "Kelvin".

3. In essence, the questions stated for the opinion of this Court concern the effect of the Full Court's decision in *Re: Jamie* (2013) FLC 93-547 ("*Re Jamie*") and the role of the Family Court more generally in relation to stage 2 medical treatment for Gender Dysphoria and the determination of *Gillick* competence (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; see *Re Jamie* at [115] and *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 ("*Marion's case*") per Mason CJ, Dawson, Toohey and Gaudron JJ at pages 237 – 238).

4. A Gender Agenda Inc., the Australian Human Rights Commission, the Secretary for the Department of Family and Community Services, and the Royal Children's Hospital were granted leave to intervene. The Attorney-General of the Commonwealth intervened as of right pursuant to s 91(1)(b)(ii) of the Act.

THE FACTS AS SET OUT IN THE CASE STATED

5. We set out in full below the facts set out in the case stated (as amended in circumstances described later in these reasons).

Gender Dysphoria

6. Gender Dysphoria is a term that describes the distress experienced by a person due to incongruence between their gender identity and their sex assigned at birth.

7. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (302.85 (F64.1) ICD-10-CM F64.1) defines Gender Dysphoria as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical intervention by means of hormones and/or surgery are not available". A diagnosis of Gender Dysphoria can be made when specific criteria are met, the distress has been present for at least six months' duration,

and when the condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Treatments

8. Treatment guidelines for the care of trans and gender diverse children and adolescents are in place, with the World Professional Association for Transgender Health Standards of Care version 7 (2011) and the Endocrine Society Treatment Guidelines (2009) being the basis of treatment protocols internationally, including throughout Australia.

9. Australia's specific guidelines for the standards of care and treatment for transgender and gender diverse children and adolescents are expected to be available in September 2017 (in the form annexed to the affidavit of Associate Professor Telfer sworn 7 August 2017).

10. Best practice medical treatment for Gender Dysphoria is offered following a comprehensive multidisciplinary assessment. The multidisciplinary treating team may include clinicians with experience in the disciplines of child and adolescent psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychology, gynaecology, andrology, fertility counselling and services, speech therapy, general practice and nursing. These treating professionals need to agree on the proposed treatment plan before it can be implemented. Medical treatment is only commenced after physical examination and blood tests confirm that the adolescent has entered into puberty. Best medical practice is that the adolescent and their parents/guardians must provide informed consent.

11. The existing medico-legal structure for stage 1, stage 2 and stage 3 treatment in Australia requires at least one psychiatrist or clinical psychologist to confirm a diagnosis of Gender Dysphoria in Adolescents prior to medical intervention.

12. Stage 1 treatment is "puberty blocking treatment" and the effects of this treatment are reversible when used for a limited time for approximately three to four years. Gonadotrophin releasing hormone analogue (GnRHa) are used for stage 1 treatment and are administered via injection with the aim of reducing the psychological distress associated with development and progression of the unwanted, irreversible changes of the adolescent's endogenous (biological) puberty. It also allows the adolescent time to mature emotionally and cognitively such that they can achieve maturity sufficient to provide informed consent for stage 2 treatment. Stage 1 treatment is ideally commenced in the early stages of puberty (known as Tanner Stage 2) which can occur from the age of approximately nine to 12 years of age.

13. Stage 2 Treatment or "gender affirming hormone treatment" involves the use of either oestrogen to feminise the body in those who have a female gender identity or use of testosterone to masculinise the body in those who have a male

gender identity. This treatment is ideally commenced at an age where the adolescent is sufficiently mature to be able to provide informed consent given the irreversible nature of some of the effects of oestrogen and testosterone.

14. The irreversible physiological effects of oestrogen are breast growth and decreased sperm production and partially irreversible effects are decreased testicular volume and decreased terminal hair growth. The irreversible physiological effects of testosterone are facial and body hair growth, scalp hair loss, clitoral enlargement, vaginal atrophy and deepening of voice.

15. Stage 2 treatment for Gender Dysphoria may, but does not necessarily, cause long term infertility. For individuals who were assigned male at birth, oestrogen treatment may render the adolescent infertile over time. However, options are explored with the adolescent regarding their future ability to have biological children prior to the commencement of oestrogen use including preserving their fertility using sperm preservation procedures prior to the commencement of oestrogen use.

16. So that it is clear, stage 2 treatment does not include stage 3 treatment which treatment involves surgical interventions. Those interventions include:

    a) Chest reconstructive surgery (also known as top surgery) (*Re: Quinn* [2016] FamCA 617; *Re: Tony* [2016] FamCA 936; *Re: Leo* [2015] FamCA 50; *Re Lincoln (No. 2)* [2016] FamCA 1071)

    b) Phalloplasty

    c) Hysterectomy

    d) Bilateral salpingectomy

    e) Creation of the neovagina

    f) Vaginoplasty

Risks of not Providing Treatment

17. Failure to provide gender affirming hormones results in the development of irreversible physical changes of one's biological sex during puberty or the development of changes that lead to the need for otherwise avoidable surgical intervention such as chest reconstruction in transgender males or facial feminisation surgery in transgender females.

18. The prolonged use of puberty blockers (stage 1 treatment) has long term complications for bone density (osteopenia) namely osteoporosis and bone fractures in adulthood. Best practice is to limit the time an adolescent is on puberty blockers and then commence oestrogen or testosterone. Delaying stage 2 treatment for those on puberty blockers also results in psychological and social complications of going through secondary school in a pre-pubertal state which is inconsistent with the child's peers.

19. The distress caused by Gender Dysphoria can lead to anxiety, depression, self-harm and attempted suicide.

20. Individuals with Gender Dysphoria who commence cross sex hormone therapy generally report improvements in psychological wellbeing. An affirmation of their gender identity coupled with improvements in mood and anxiety levels typically results in improved social outcomes in both personal and work lives.

21. For a transgender male, manifestations of increased body hair and deepening of the voice are generally considered by them as positive.

22. For transgender females if stage 2 treatment is not administered another risk is linear growth beyond their expected final height.

23. Some patients receiving treatment for Gender Dysphoria have reported purchasing hormones over the internet or illegally obtaining hormones through prescriptions written for other people. They have also reported that oestrogen and testosterone are cheap and freely available over the internet or through friends or acquaintances. Accessing hormones in this way is dangerous for several reasons including the risks of complications from blood borne viruses such as Hepatitis B, Hepatitis C and HIV contractible with shared use of needles and syringes and the taking of inappropriate dosages of hormones which can be life threatening.

Kelvin

24. Kelvin was assigned female at birth in 2000.

25. Kelvin's parents were never married.

26. Kelvin's parents separated in 2003.

27. In April 2014, when he was in year 8, Kelvin transitioned socially as a transgender person.

28. Throughout 2015 Kelvin attended upon doctors for referrals for his general health and wellbeing.

29. In April 2015 Kelvin commenced being known by his preferred name at school.

30. In April 2015 Kelvin attended upon a psychologist and continued to do so for 10 sessions.

31. In June 2015 Kelvin attended upon an endocrinologist. He attended a further appointment with this doctor in August 2016.

32. In October 2015 Kelvin commenced attending upon an accredited counsellor and mental health social worker.

33. In July 2016 Kelvin attended upon a psychiatrist.

34. In July and August 2016 Kelvin attended upon a psychologist.

35. Kelvin has experienced all aspects of the DSM-5 diagnostic criteria for Gender Dysphoria since he was nine years of age.

36. Kelvin has been diagnosed as having Gender Dysphoria as defined in the Diagnostic and Statistical Manual of Mental Disorders (2013) DSM-5.

37. Kelvin's history of Gender Dysphoria has resulted in significant problems with anxiety and depression including self-harming for which he has been prescribed medication. Kelvin's mental health has improved since taking steps towards a medical transition.

38. Kelvin has not undergone stage 1 treatment and as a consequence has experienced female puberty which has caused him significant distress.

39. Stage 2 treatment is necessary for Kelvin's ongoing psychological health and overall wellbeing.

40. Kelvin's parents both support Kelvin commencing stage 2 treatment for Gender Dysphoria.

41. Kelvin is now 17 years old. He wishes to commence stage 2 treatment for Gender Dysphoria.

42. Kelvin's father, by way of Initiating Application filed 25 January 2017, sought the following declaration and, in the alternative, the following order:

> That the Court declares the child [Kelvin] born ...00 is competent to consent to the administration of Stage 2 treatment for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (2013) DSM-5.
>
> **In the alternative:**
>
> That the court authorise the administration of Stage 2 treatment for the condition of childhood Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (2013) DSM-5 under s 67ZC of the *Family Law Act* on and from a date to be determined by the treating medical team of [Kelvin's] on the basis that it is in the best interests of [Kelvin].

43. In support of the father's application, he filed expert reports of Dr R, a psychologist, Dr S, a psychiatrist and Dr H an endocrinologist.

44. Kelvin has been found to be *Gillick* competent, to consent to stage 2 treatment for Gender Dysphoria, but no declaration or order to that effect has yet been made by the court.

45. Stage 2 treatment for Kelvin's Gender Dysphoria involves the administration of testosterone to initiate the secondary sexual characteristics and appearance of the male sex. These include facial hair, deepened voice, increased muscle/strength, body fat redistribution, cessation of menses, clitoral

enlargement and vaginal atrophy as well as skin oiliness/acne and scalp hair loss. Kelvin's physical changes will be those of masculinisation. On the positive side testosterone therapy typically results in increase muscle strength, stamina and energy levels. On the negative side there can be problems with acne and male pattern balding.

46. Adverse medical outcomes such as liver dysfunction, hypertension and polycythaemia are uncommon, particularly in Kelvin's age group.

47. Psychologically, the treatment will allow Kelvin to continue to develop his self-esteem, the confidence in his body and appearance and to consequently develop the congruence necessary for a healthy future outlook. The purpose of Kelvin undergoing stage 2 treatment is to further align Kelvin's physical gender characteristics with his inner gender identity. That treatment is necessary to promote Kelvin's wellbeing and to relieve his suffering. If the treatment were carried out, the short and long-term effects would likely include the further promotion of a healthy and integrated identity, positive self-concept and capacity to form relationships and evolve into a healthy and well-adjusted adult. Relief from ongoing gender identity-related cognitions of guilt and worthlessness, low mood and sadness would take place.

48. For Kelvin if stage 2 treatment was not carried out his overall health and wellbeing is almost certain to deteriorate especially as his mental and physical health is heavily dependent on the perception of himself as male.

49. If stage 2 treatment is not carried out Kelvin will experience ongoing intense frustration and feelings of isolation, disgust with his physical body (which Kelvin continues to actively experience with respect to his female genitalia) and consequent difficulty forming relationships. These factors are recognised as triggers for suicide attempts.

50. If the testosterone treatment is not carried out, there is a potential Kelvin may obtain illicit drugs which are common place in gymnasiums. These preparations are unregulated with no guarantee regarding their efficacy or safety. Kelvin using drugs in this way would not afford him the benefit of regular blood tests and periodic review. Medically supervised hormone treatment is an exercise in harm minimisation.

Court Outcomes, Delay and Costs

51. Between 31 July 2013 and 16 August 2017 the Family Court has dealt with 63 cases involving applications for either stage 2 or stage 3 treatment for Gender Dysphoria. In 62 of those cases the outcome has allowed treatment. The most common outcomes were:

    a) Declaring a child *Gillick* competent to consent (26)

    b) Finding the child is *Gillick* competent to consent (22)

c) Finding *Gillick* competence and making a declaration (7)

52. In the one case where an application was dismissed the child was 17 years and 11 months at the time of the hearing and the application was not supported by evidence that would allow the court to make a positive finding that the child was *Gillick* competent.

53. In 39 of the 63 cases the date of the filing of the Initiating Application is recorded in the judgment. The average time between filing and the making of a finding or orders was 26 days (23 days if two cases are removed from that sample where the trial judge gave reasons as to why those cases took 49 and 39 days respectively, which reasons were not related to the court delaying dealing with the matter).

54. In a qualitative study of 12 families undertaken by Fiona Kelly in 2016. Ms Kelly found that the average delay experienced by those families was eight months from the time that the process was initiated until the adolescent commenced treatment (that is a different period from the filing of an application to the provision of an outcome by the court). Fiona Kelly's 2016 study found the financial costs of the court proceedings varied between those 12 families between $8,000 and $30,000.

55. The fifth intervenor, the Royal Children's Hospital Gender Service in Victoria is a specialist unit comprising of a team from multiple disciplines including Paediatrics, Psychiatry, Psychology, Endocrinology, Gynaecology, Nursing and Speech Pathology. Since its commencement in 2003, the Gender Service has received 710 patient referrals including 126 between 1 January 2017 and 7 August 2017.

56. 96 per cent of all patients who were assessed and received a diagnosis of Gender Dysphoria by the 5th intervenor from 2003 to 2017 continued to identify as transgender or gender diverse into late adolescence. No patient who had commenced stage 2 treatment had sought to transition back to their birth assigned sex. No longitudinal study is yet available.

Other Inferences

57. Pursuant to s 94A(2) of the Act any other inference, whether of fact or law, which the Full Court might draw from the following documents which for the purposes of the case stated were before the judge:

a) Reasons for Judgment in *Re Kelvin* [2017] FamCA 78

b) *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-V) (pages 451 – 459)

c) Gender Dysphoria Decisions and Results since *Re Jamie*

d) World Professional Association for Transgender Health, *Standards of Care for the Health of Transexuals, Transgender and Gender Nonconforming People* (7th edition) 2011

e) The affidavit of Associate Professor Michelle Marian Telfer (unredacted) filed 8 August 2017

f) Hembree, W; Cohen-Kettenis, P; Delemarre-van de Waal, H; Gooran, LJ; Meyer III, WJ; Spack, NP; Tangpricha, V; and Montori, VM – 'Endocrine Treatment of Transexual Persons: An Endocrine Society Clinical Practice Guideline' (2009) 94(9) *Journal of Clinical Endocrinology & Metabolism*, 3132

g) Giordana, S – *Children with Gender Identity Disorder: A Clinical, Ethical and Legal Analysis*, Routledge, 2012

h) De Vries, A; McGuire, J; Steensma, T; Wagenaar, EC; Doreleijers, TA; and Cohen-Kettenis, PT – 'Young adult psychological outcome after puberty suppression and gender reassignment' *Pediatrics* 2014; 134: 696-704

i) Whithall, J – 'Childhood Gender Dysphoria and the Responsibility of the Courts' *Quadrant*, May 2017, pp 18-25

j) Steensma, TD; McGuire, JK; Kreukels, BPC; Beekman, AJ; and Cohen-Kettenis, PT – 'Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study' *Journal of the American Academy of Child & Adolescent Psychiatry Volume* 52(6) 582-590, June 2013

k) Vander Laan, DP; Postema, L; Wood, H; Dingh, D; Fantus, S; Hyuan, J; Leef, J; Bradley, SJ; and Zucker, KJ – 'Do Children With Gender Dysphoria Have Intense/Obsessional Interests?' *Journal of Sex Research*, 52(2) 213-219, 2015

l) Costa, R and Colizzi, M – 'The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systemic review' *Neuropsychiatric Disease and Treatment*, 2016: 12 1953-1966

THE QUESTIONS OF LAW

58. The following are the questions stated for the opinion of the Full Court in the case stated:

    1. Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) DSM-5 (the treatment), requires the court's authorisation pursuant to s 67ZC of

the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent?

2. Where:

   2.1. Stage 2 treatment of a child for Gender Dysphoria is proposed;

   2.2. The child consents to the treatment;

   2.3. The treating medical practitioners agree that the child is *Gillick* competent to give that consent; and

   2.4. The parents of the child do not object to the treatment

   is it mandatory to apply to the Family Court for a determination whether the child is *Gillick* competent (Bryant CJ at [136-137, 140(e)]; Finn J at [186] and Strickland J at [196] *Re Jamie*)?

3. If the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for a declaration that the child is *Gillick* competent, be dismissed?

4. In the alternative, if the answer to question 2 is yes, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for an order authorising the administration of the treatment, be dismissed?

5. If the answer to question 3 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make a declaration that the child was *Gillick* competent to give informed consent to the treatment?

6. If the answer to question 4 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make an order authorising the administration of the treatment?

PRELIMINARY ISSUES

59. There are three preliminary issues which need to be resolved before we can embark upon addressing the questions of law posed in the case stated.

The Court's Jurisdiction

60. Does the Family Court have jurisdiction to determine the father's application? If not, it would be unnecessary to answer the questions stated.

61. This question was addressed *in extenso* by the Attorney-General, who submitted that the Court does have jurisdiction. Neither the applicant father, nor ultimately any of the intervenors submitted otherwise, save and except it seems the Royal Children's Hospital. Only the Secretary for the Department of Family and Community Services submitted that the Court did not have jurisdiction to make the declaration of *Gillick* competence the father sought. We agree that the Court has jurisdiction for the following reasons, adopting much of what was said by the Attorney-General.

62. There are two issues, namely the extent to which s 67ZC(1) of the Act confers power to authorise treatment and make a declaration of *Gillick* competence, and the extent to which s 69H(1) of the Act confers jurisdiction upon the Court to do so.

63. The relevant provisions of the Act are as follows:

    a) Section 69H(1), which is within div 12 of pt VII, provides:

    > **Jurisdiction of Family Court, State Family Courts, Northern Territory Supreme Court and Federal Circuit Court**
    >
    > (1) Jurisdiction is conferred on the Family Court in relation to matters arising under this Part.

    b) For present purposes, s 69ZE provides:

    > **Extension of Part to the States**
    >
    > (1) Subject to this section and section 69ZF, this Part extends to New South Wales, Victoria, Queensland, South Australia and Tasmania.
    >
    > (2) Subject to this section and section 69ZF, this Part extends to Western Australia if:
    >
    > (a) the Parliament of Western Australia refers to the Parliament of the Commonwealth the following matters or matters that include, or are included in, the following matters:
    >
    > (i) the maintenance of children and the payment of expenses in relation to children or child bearing;
    >
    > (ii) parental responsibility for children; or
    >
    > (b) Western Australia adopts this Part.
    >
    > (3) This Part extends to a State under subsection (1) or (2) only for so long as there is in force:

(a) an Act of the Parliament of the State by which there is referred to the Parliament of the Commonwealth:

(i) the matters referred to in subparagraphs (2)(a)(i) and (ii); or

(ii) matters that include, or are included in, those matters; or

(b) a law of the State adopting this Part.

(4) This Part extends to a State at any time under subsection (1) or paragraph (2)(a) only in so far as it makes provision with respect to:

(a) the matters that are at that time referred to the Parliament of the Commonwealth by the Parliament of the State; or

(b) matters incidental to the execution of any power vested by the Constitution in the Parliament of the Commonwealth in relation to those matters.

c) In addition, s 69ZH provides:

Additional application of Part

(1) Without prejudice to its effect apart from this section, this Part also has effect as provided by this section.

(2) By virtue of this subsection, Subdivisions BA and BB of Division 1, Divisions 2 to 7 (inclusive) (other than Subdivisions C, D and E of Division 6 and sections 66D, 66M and 66N), Subdivisions C and E of Division 8, Divisions 9, 10 and 11 and Subdivisions B and C of Division 12 (other than section 69D) have the effect, subject to subsection (3), that they would have if:

(a) each reference to a child were, by express provision, confined to a child of a marriage, and

(b) each reference to the parents of the child were, by express provision, confined to the parties to the marriage.

(3) The provisions mentioned in subsection (2) only have effect as mentioned in that subsection so far as they make provision with respect to the parental responsibility of the parties to a marriage for a child of the marriage, including (but not being limited to):

(a) the duties, powers, responsibilities and authority of those parties in relation to:

(i) the maintenance of the child and the payment of expenses in relation to the child; or

(ii) whom the child lives with, whom the child spends time with and other aspects of the care, welfare and development of the child; and

(b) other aspects of duties, powers, responsibilities and authority in relation to the child:

(i) arising out of the marital relationship; or

(ii) in relation to concurrent, pending or completed divorce or validity of marriage proceedings between those parties; or

(iii) in relation to the divorce of the parties to that marriage, an annulment of that marriage or a legal separation of the parties to that marriage, that is effected in accordance with the law of an overseas jurisdiction and that is recognised as valid in Australia under section 104.

(4) By virtue of this subsection, Division 1, Subdivisions C, D and E of Division 6, section 69D, Subdivisions D and E of Division 12 and Divisions 13 and 14 and this Subdivision, have effect according to their tenor.

d) Section 67ZC, which is within sub-div E of div 8 of pt VII, provides:

Orders relating to welfare of children

(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.

…

(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.

…

64. As to the power to authorise treatment and make a declaration of *Gillick* competence, the Explanatory Memorandum to the Bill which introduced

s 67ZC (Explanatory Memorandum to the Family Law Reform Bill 1994 (Cth)) at [319] recorded that it:

> provides the court with jurisdiction relating to the welfare of children in addition to the jurisdiction that the court has under Part VII in relation to children. This jurisdiction is the *parens patriae* jurisdiction explained by the High Court in *SMB and JWB; Secretary, Department of Health and Community Services* (Re Marion) (1992) 175 CLR 218.

65. Thus, as the Attorney-General submits, "s 67ZC(1) should be understood as conferring power on the Court, on the application of a parent, to grant any authorisation necessary in circumstances of the kind considered in *Marion's case*" (see *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 per Gleeson CJ and McHugh J at [51] – [53]).

66. Similarly, the Court has power to make a declaration, on the application of a parent, that a child is *Gillick* competent to consent to proposed treatment. As the Attorney-General identifies, there are three sources for that power, namely s 67ZC, the Court's general powers conferred by s 34(1) of the Act (see *R v Ross-Jones; Ex Parte Beaumont* (1979) 141 CLR 504 at 509 per Gibbs J), and the Court's power to make "parenting orders" (s 65D(1) and s 64B(2)(i)) (see *Re: Sarah* [2014] FamCA 208 at [30] – [43]; *Re Sean and Russell (Special Medical Procedures)* (2010) 44 Fam LR 210 at [96] – [108]; *Re Lucy (Gender Dysphoria)* (2013) 49 Fam LR 540).

67. We agree with the Attorney-General that the contrary view of Carew J in *Re: Jaden* [2017] FamCA 269 at [22] – [33] should be rejected. We note that the Secretary for the Department of Family and Community Services relies on this case in support of his submission that this Court has no power to make a declaration that a child is *Gillick* competent to consent to proposed treatment, but that submission cannot be maintained.

68. Carew J adopts an unduly narrow view of the provisions conferring power on the Court, whereas such provisions should in fact be construed as liberally as possible (for example see *PMT Partners Pty Ltd (In Liq) v Australian National Parks and Wildlife Service* (1995) 184 CLR 301 at 313 per Brennan CJ, Gaudron and McHugh JJ; *Conway v The Queen* (2002) 209 CLR 203 at [36] per Gaudron A-CJ, McHugh, Hayne and Callinan JJ). In particular, references in the legislation to "orders" should not be construed as to exclude "declaration".

69. Turning to the issue of jurisdiction, as explained by the Attorney-General, "the power to make orders of the kind [in question here] is confined to cases where this Court has jurisdiction in accordance with the terms of Div 12 of Pt VII", and "[t]he provisions operate differently in the case of a child of a marriage, on one hand, and the case of an ex-nuptial child, like Kelvin, on the other."

70. In the former case, s 69ZH applies, and even if s 67ZC(1) is read as only referring to a child of the marriage, the making of orders of the kind the subject of these proceedings falls within that paragraph (see the discussion of *Marion's case* in *P v P* (1994) 181 CLR 583, at 599 – 601 per Mason CJ, Deane, Toohey and Gaudron JJ).

71. In the latter case, s 69ZE applies. In accordance with s 69ZE(3), Pt VII of the Act applies to New South Wales because there is in force the *Commonwealth Powers (Family Law – Children) Act 1986* (NSW) ("the New South Wales Act") (see s 3(1) of that Act).

72. Section 69ZE of the Act and s 3(1) of the New South Wales Act engage s 51(xxxvii) of the Constitution, and relevantly the matter that is referred to the Parliament of the Commonwealth is "the custody and guardianship of, and access to, children" (s 3(1)(b) of the New South Wales Act).

73. As explained by the High Court in *P v P* (at page 601), provisions permitting parents to seek authorisation from the Family Court for the administration of treatment are "directly concerned with parental rights and the custody and guardianship of infants". In other words, such provisions are with respect to the guardianship of children, and the referral is sufficient to support the making of orders of the kind in issue here.

74. We note, as submitted by the Attorney-General, that this conclusion is not impacted by the change in language in the Act from the time of the New South Wales Act. As explained by Murphy J in *Re Lucy*, the bundle of rights comprising guardianship includes or is included within the notion of "parental responsibility" within the meaning of s 69ZE(3)(a) of the Act.

75. Nor is the conclusion denied by the terms of s 69ZH(2). As s 69ZH(1) makes clear, the application of Pt VII for which s 69ZH(2) provides, is "without prejudice to" its application apart from s 69ZH. Section 69ZH(2) thus makes provision for the application of Pt VII in addition to that for which s 69ZE provides (see also *Re Lucy* at [56] – [62]).

The Effect of New South Wales Legislation

76. What is the effect, if any, on these proceedings of s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) and ss 174 and 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

77. This was a question addressed by all of the intervenors, with only A Gender Agenda Inc. arguing that s 49 "has modified the common law so that a child of 16 is competent to consent to medical treatment (including Stage 2 treatment) and no assessment of *Gillick* competence is required" (Amended Submissions filed 14 September 2017 at paragraph 1). Of course, if A Gender Agenda Inc. is correct in this submission, then it would be unnecessary to answer question 2 of

the case stated. Once again though, we are persuaded by the submissions of the Attorney-General.

78. Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) provides:

> (1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
>
> (2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards.
>
> (3) This section does not affect:
>
> (a) such operation as a consent may have otherwise than as provided by this section, or
>
> (b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent.
>
> (4) In this section:
>
> …
>
> ***medical treatment*** means:
>
> (i) treatment by a medical practitioner in the course of the practice of medicine or surgery, or
>
> (ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.

79. That provision modifies the approach adopted by the courts in relation to medical treatment in two ways. First, s 49(1) provides that consent of the parent or guardian is effective as a defence to a claim of assault or battery, and that would be so even if the minor is *Gillick* competent to consent on their own behalf.

80. Secondly, s 49(2) provides that the minor's consent is effective to provide that same defence, and that would prima facie be so even if the minor is not *Gillick* competent.

81. As the Attorney-General submits, being limited to a claim by the minor for assault or battery:

> … where medical treatment is proposed to be administered to a child, s 49 does not provide an answer to the whole of the law's concern with the quality of that child's consent, or the parental consent on his or her behalf, identified in *Marion's case* … Treating doctors cannot rely on s 49 to provide an answer to a criminal charge if they do not obtain parental consent in the case of a child who is not *Gillick* competent or if, in relation to such a child, there is no application to the court to authorise treatment of a kind to which parents cannot consent. Accordingly, if … the circumstances are ones in which the common law requires authorisation by the court, that is not altered by s 49.
>
> (Submissions filed 30 August 2017 at paragraph 110)

82. In any event, because in this case Kelvin is *Gillick* competent, it is immaterial whether the effect of s 49(2) would have been to render Kelvin able to consent to stage 2 treatment, even absent such a finding.

83. Section 174(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) deals with emergency medical treatment, and stage 2 treatment cannot be characterised as such. Thus, it has no effect on these proceedings.

84. Section 175(1) of that Act limits the circumstances in which specified kinds of medical treatment (defined in s 175(5)) can be carried out on a child under 16 years of age. If stage 2 treatment can be brought within that category, s 175(2) provides alternatives to obtaining authorisation from the Family Court. However, it does not permit a child under 16 years of age to consent, or to authorise a child's parent to do so on his or her behalf. Thus it has no relevant effect in these proceedings, and in any event, Kelvin is over 16 years of age.

The Form and Content of the Case Stated

85. There are serious issues arising from the form and content of the stated case.

86. **First**, it is essential that the case state the ultimate facts found by the court below, but not the evidence upon which the ultimate facts were found (*De Simone v Bevnol Constructions & Developments Pty Ltd (No 2)* (2010) 30 VR 211 at 215).

87. Here, his Honour's order of 16 February 2017 stating the case identifies the facts as the facts "set out in [his] Reasons for Judgment delivered on 16 February 2017". At [17] – [31] of those reasons, a factual background of the matter is set out, but that appears to comprise the evidentiary facts before his Honour, rather than the "ultimate facts" found by his Honour. Fortunately, this alone does not prevent a full court from addressing the case stated. Here, on 25 August 2017 the primary judge amended the case stated by setting out in detail the facts agreed between the father, the Independent Children's Lawyer

("ICL") and the intervenors for the purposes of the case stated. That plainly overcomes the difficulty inherent in the original order, and enables this Court to perform its function, subject to one matter which we explain as follows.

88. It is unclear from the case stated and from the submissions we have received, what we are to do with the contents of [51] – [54] set out above under the heading "Court Outcomes, Delay and Costs". In no sense can they be described as ultimate facts, and they are plainly not facts relevant to the questions asked. We were given no meaningful assistance by any of the parties in understanding on what basis these paragraphs find their way into the stated case, and thus we propose to ignore them.

89. At first blush [55] and [56] set out above might be seen to be in that same category, but there were helpful submissions made by at least two of the intervenors as to the use that we can make of those paragraphs despite them not being able to be described as ultimate facts found by his Honour. Those submissions explained how those paragraphs, based as they are on the affidavit of Associate Professor Michelle Marian Telfer filed 8 August 2017 (see [57(e)] above), demonstrate the advances in medical science in treating and understanding Gender Dysphoria, and we will take those paragraphs into account where appropriate.

90. **Secondly**, and perhaps more importantly, a primary judge has no power to reserve a question that does not arise on the facts stated, and it is **inappropriate** for a full court to answer such a question (*Director of Public Prosecutions, South Australia v B* (1998) 194 CLR 566 at [11] – [12] per Gaudron, Gummow and Hayne JJ; *Bass v Permanent Trustee Co Ltd* (1999) 198 CLR 334 at [47] – [49] per Gleeson CJ, Gaudron, McHugh, Gummow, Hayne and Callinan JJ).

91. Here, *prima facie*, question 1, and possibly question 2, are in that category.

92. In relation to question 1, it is only relevant to the circumstance of a child who is **not** *Gillick* competent, since the Full Court in *Re Jamie* made it clear that the Court's authorisation for treatment is not required in the case of a child who is *Gillick* competent. However, his Honour found that Kelvin is *Gillick* competent to consent to stage 2 treatment for Gender Dysphoria, and that is a fact stated for this Court. Thus, the question of whether Court approval is required where the child is **not** *Gillick* competent, does not arise on the facts stated.

93. As to question 2, his Honour has found that Kelvin is *Gillick* competent, and thus it might be thought that the question of whether it is mandatory to apply to the Court for a determination on *Gillick* competence does not arise on the facts stated.

94. The Attorney-General argues that question 1 does arise on the facts stated "because of the link between questions 1 and 2". He submits that question 2

arises on the facts stated, notwithstanding his Honour's finding of *Gillick* competence, because "no dispositive orders have yet been made on the application made by Kelvin's father", and "[i]f an application to the Court is unnecessary, that may be a factor tending against the making of any orders by the primary judge, in the exercise of his Honour's discretion" (Submissions filed 30 August 2017 at paragraph 79).

95. If that submission is correct, and question 2 does arise and can be answered, the link with question 1 is said to be that that question "arises at least as a step along the way to answering question 2" (Submissions filed 30 August 2017 at paragraph 80).

96. In relation to question 2, it is plainly arguable that his Honour has gone too far by concluding that Kelvin is *Gillick* competent and then stating a case as to whether it is mandatory to apply to the Court for that very determination. The first application made to his Honour was for a declaration that Kelvin is *Gillick* competent, and his Honour has proceeded on that application and then made the necessary finding. The fact that he has not yet made dispositive orders can only be seen to provide a basis for questions 3 to 6 of the stated case.

97. Further, that outcome is consistent with the terms of s 94A(1) itself. That subsection provides that a primary judge can seek the opinion of a Full Court "before the proceedings are further dealt with". Here, the relevant finding has been made, and before taking the next step, a question can be asked of the Full Court as to what if any order or declaration should be made. Any question about whether it is mandatory to make an application to determine *Gillick* competence is hypothetical given the stage the proceedings have reached.

98. It could reasonably be argued that what his Honour should have done, given the stage that the proceedings had reached, was to complete the case and let any aggrieved party appeal.

99. What then of question 1? If question 2 does not arise on the facts stated, then nor does question 1, given the "link" relied on is that the answer to question 1 affects the answer to question 2.

100. However, if we are wrong about question 2, does question 1 still arise? In our view it does not.

101. It is an insufficient basis to support a question simply because, as the argument goes, if the answer to question 1 is no, then the answer to question 2 is also no. Question 1 cannot be confined to being a question that arises as a step along the way to answering question 2. Primarily, it is a stand-alone question which as explained above simply does not arise on the facts stated, and it is hypothetical.

102. In these circumstances it is "inappropriate" for this Court to answer questions 1 and 2. However, that does not mean we cannot in fact answer the questions; to do so is only "inappropriate". Given that this case stated has advanced to the

point of a hearing, in which we have received extensive submissions from all parties, we intend to answer questions 1 and 2. Indeed, as senior counsel for the first intervenor said during oral submissions:

> Can I briefly also address your Honours on whether question 1 arises or perhaps how it arises. In my submission, it does arise for this court's determination, because although questions 1 and 2 have been, if you like, conceptually teased out as two separate questions, fundamentally, the issue confronting the trial judge and now confronting this court, is who can give authorisation for treatment, stage 2 treatment, for a person, a young person with gender dysphoria. Should it be the court? Could it be the parents? Could it be the child? That's the overarching issue that confronts the court.
>
> (Transcript, 21 September 2017, p 67, l 10 – 17)

103. We also take comfort that it is open to this Court to answer questions 1 and 2, in what the High Court said in another context in *Bass v Permanent Trustee Co Ltd* (per Gleeson CJ, Gaudron, McHugh, Gummow, Hayne and Callinan JJ at [51] – [52]).

104. Finally, as noted by the Attorney-General (Submissions filed 30 August 2017, at paragraph 2), the issues raised in this case are of "general importance" and need to be resolved "as soon as possible". We agree with that sentiment, although it is disappointing that the call for legislative intervention following *Re Jamie* went unheeded.

105. The **third** matter of concern is the issue of "inferences".

106. Section 94A(2) of the Act provides as follows:

> **Case Stated**
>
> …
>
> (2) The Full Court may draw from the facts and the documents any inference, whether of fact or of law, which could have been drawn from them by the Judge.

107. In relation to the facts stated, neither the applicant, the ICL nor any of the intervenors identified any inference that could be drawn from those facts for the purposes of the case stated.

108. However, on 25 August 2017 the primary judge made the following order:

> 2. Subject to any other order the Full Court might make, no later than seven days before the commencement of this matter is listed before the Full Court each party and the Independent Children's Lawyer give to all other parties, the Independent Children's Lawyer and the Appeals Registrar notice of any inference to be drawn from any document referred to in paragraph 50 of the Facts in the Stated Case.

109. On 29 August 2017 his Honour amended that order by changing the paragraph number referred to from 50 to 52.

110. As can be seen the heading immediately above [57] herein (which was paragraph 52 in the case stated), reads “Other Inferences”, and then the paragraph lists a number of documents, including his Honour’s reasons for judgment.

111. In accordance with his Honour’s order, the Australian Human Rights Commission and the Secretary for the Department of Family and Community Services filed further written submissions setting out the inferences that they suggest can be drawn from the documents in [57] above. The Royal Children’s Hospital also tendered to this Court at the hearing of the stated case a written submission responding to the submissions of the Secretary for the Department for Family and Community Services.

112. The other intervenors took the position that:

   a) no inference need be drawn from the documents because all relevant factual information for the purposes of the case stated is contained in the agreed facts, and indeed some of those facts, and in particular those explaining the current state of medical science in relation to the treatment of Gender Dysphoria are drawn from the material in the documents in [57] above; and

   b) in any event, no inference should be drawn that is contrary to the agreed facts or that is controversial (*Fowles v The Eastern and Australian Steamship Co Ltd* (1913) 17 CLR 149 at 196 per Gavan Duffy and Rich JJ), or where there is doubt about what inference should be drawn.

113. At least one intervenor queried whether any inference could be drawn given that the admissibility of the documents was in question. The provenance of many of the documents was unclear, the qualifications and expertise of the authors of most of the documents had not been established, and none of the authors had been the subject of cross-examination before the primary judge, or at all. Thus, applying the terms of s 94A(2), if the documents were not admissible before the primary judge, and his Honour could not draw any inference of fact or law from them, then we are not able to draw any inference.

114. We accept though that all relevant and necessary information that might be drawn from those documents is before us in the stated facts, and we do not propose to draw any further inferences.

THE BROADER CONTEXT FOR THE CASE STATED

115. Before proceeding to deal with each of the questions stated, we cannot help but observe that this case, and other earlier cases involving Gender Dysphoria, have attracted widespread media attention. Insofar as the reporting of the legal

issues is concerned, at least some of the reports have, at best, been incomplete and, at worst, inaccurate.

116. We think it important to emphasise that the Court in this case is concerned to examine, within the confines of the questions stated, whether there is any role for the Family Court in cases where there is no dispute between parents of a child who has been diagnosed with Gender Dysphoria, and where there is also no dispute between the parents and the medical experts who propose the child undertake treatment for that dysphoria. To paraphrase counsel for the Royal Children's Hospital, the question is why should the family of a child in one wing of the Hospital be forced to come to court before recommended medical treatment commences when the family of a child in another wing of the Hospital is not required to do so, in circumstances where both forms of treatment carry a significant risk of making the wrong decision as to a child's capacity to consent and with both forms of treatment the consequences of a wrong decision are particularly grave.

117. The decision in each case that comes before the Court relates to the specific circumstances of the individual child the subject of the proceedings. They are neither prescriptive nor permissive of broader issues that may be raised in public debate. Importantly the Court has always recognised the exquisitely difficult decisions confronting parents in these cases and what we consider is an appropriate concern about intruding into the lives of parents whom the evidence reveals to be loving, caring and supportive of their child. For example, as was said by Murphy J in *Re Sam and Terry (Gender Dysphoria)* (2013) 49 Fam LR 417:

> 102. … a decision that court authorisation is necessary can be seen to intrude upon the lives of loving, caring and committed parents who live daily their children's difficulties, who are intimately aware of the day-to-day difficulties confronted by their children and who deal with their numerous (serious) concerns on a daily basis. Those exceptionally difficult day-to-day tasks are accompanied by a miscellany of difficult day-to-day decisions and those decisions fall upon them, not others. I also accept that parents who fit that description can legitimately say that they know their children better than anyone, much less a court, ever will. There is real legitimacy to a position adopted by parents who fit that description that it is them, and not the court, who, together with appropriately qualified expert clinicians, are best placed to decide what is right for their children. I am also not unaware that cost and stress will attend court authorisation. As I said in *Re Sean and Russell*, it would be sad if the courtroom was to replace a caring, holistic environment within which an approach by parents and doctors alike could deal with difficult decisions.

118. Further, it is important to point out that in each and every case in which authorisation has been sought from this Court for treatment for Gender Dysphoria relying upon *Re Jamie* and, before it, *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175 ("*Re Alex*"), the decision has been informed by comprehensive evidence from a miscellany of medical specialists from different disciplines (for example, psychiatry, psychology, paediatrics, and endocrinology) and by evidence from parents, or those otherwise charged directly with the care, welfare and development of the child concerned. That evidence has revealed, without exception, a careful, comprehensive and considered medical/psychiatric assessment involving multiple disciplines.

119. By way of corollary, in no case has contradictory evidence been forthcoming, including from the Independent Children's Lawyers, to challenge the desirability of the relevant treatment. At least some of the parties in this case use that fact to argue that court proceedings, with the attendant stress and expense, have no practical utility and suggest that this, of itself, is a significant pointer to this Court holding that there is no role for courts in the process, absent a dispute between parents or between parents and doctors. However, we accept that the fact that there has, at least until now, been a requirement for court involvement, may in itself serve as a filter of the types of case where stage 2 treatment is recommended and undertaken. The issue we must determine is whether the law should now require such a filter in cases of Gender Dysphoria, when no such filter is required in most cases involving other medical conditions.

QUESTION 1

Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) DSM-5 (the treatment), requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent?

The Application of *Marion's Case*

120. The first stated question posed in the case stated begs, implicitly, a more fundamental question, namely whether any principle or principles emerging from the decision of the High Court in *Marion's case* bound the Court in *Re Jamie,* and binds this Court, to find that court authorisation is required for stage 2 treatment of Gender Dysphoria.

121. The argument here is that the Full Court in *Re Jamie* incorrectly interpreted and applied the principles in *Marion's case*. It is said that the plurality in *Marion's*

case only dealt with sterilization which was “non-therapeutic”, and their decision does not provide a basis for requiring court authorisation where the treatment is therapeutic.

122. Further, it is argued that in speaking of “[c]ourt authorization [being] required, first, because of the significant risk of making the wrong decision, either as to a child’s present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave” (at 250) the plurality in *Marion’s case* were still only referring to non-therapeutic sterilization.

123. Before dealing with those arguments it is important to recognise the context in which decisions about the authority of parents to authorise medical treatment for their non-*Gillick* competent children arise. The right and responsibility of parents to decide upon medical treatment for their non-*Gillick* competent children, reflected through the prism of the children’s best interests, is the default position, not the exception. (See for example *State of Queensland v B* [2008] 2 Qd R 562; *Re Inaya (Special Medical Procedure)* (2007) 38 Fam LR 546). In *Marion’s case,* the plurality put it this way (at 239 – 240):

> Where this parental power exists, two principles are involved. First, the subjective consent of a parent, in the sense of a parent speaking for the child, is, ordinarily, indispensable. That authority emanates from a caring relationship. Secondly, the overriding criterion to be applied in the exercise of parental authority on behalf of a child is the welfare of the child objectively assessed. That these two principles become, for all practical purposes, one is a recognition that ordinarily a parent of a child who is not capable of giving informed consent is in the best position to act in the best interests of the child. Implicit in parental consent is understood to be the determination of what is best for the welfare of the child.

124. Any court authorisation for that treatment is a departure from the exercise of a right and responsibility ordinarily vested in parents. Of course, routine treatments for everyday medical conditions embrace that parental right and responsibility and do not require court authorisation. However, other circumstances may dictate the need for court intervention. For example disputes between parents or experimental or novel treatment or treatment for unusual or novel conditions can present difficulties; those circumstances may require a determination by a court of the best interests of the relevant child, in other words by a source other than those who would usually be regarded as being “in the best position to act in the best interests of the child”.

125. In addition, other proposed treatments, or treatments for other conditions, collectively described in *Marion’s case* [at 232, 239, 240, 249, 250 and 253] as “special cases” are productive of a requirement for court authorisation irrespective of unanimity on the part of parents and the medical experts. In those “special cases” the usual parental right and responsibility for deciding

upon their child's care is abrogated in favour of court determination. *Marion's case* dealt with one such treatment in the circumstances of the girl for whom it was proposed. A central component of deciding whether *Marion's case* requires this Court to answer to the first stated question in the affirmative is deciding whether the decision is specific to the treatment proposed for "Marion" and/or to cases directly analogous to her circumstances.

126. In strict point of principle, *Marion's case* is binding upon this Court only in respect of non-therapeutic sterilization of a child who is not *Gillick* competent and who, by reason of disability, will never be *Gillick* competent. Needless to say, however, any statements by the High Court which might be seen, strictly, as obiter are, and should be, highly persuasive where relevant.

127. The first point to be made is that statements made in *Marion's case* by both the plurality and by Brennan J in the course of discussing the scope of parental power to consent to medical treatment on behalf of children who are not *Gillick* competent are indicative of the principles enunciated not being restricted to sterilization. For example, in posing the question "Is sterilization a special case", the plurality said, at 239, that if it is clear that the child (through intellectual disability) is:

> … incapable of giving valid informed consent to medical treatment, the second question arises; namely, whether there **are kinds of intervention** which are, **as a general rule,** excluded from the scope of parental power to consent to; **specifically** whether sterilization is such a kind of intervention.
>
> (Emphasis added)

128. Similarly, as the plurality later acknowledged at 240, the arguments advanced, at least from the Commonwealth were to the effect that "there are **kinds of intervention** which are excluded from the scope of parental power …" (Emphasis added).

129. In their joint judgment Mason CJ, Dawson, Toohey and Gaudron JJ said this (at 249 – 250):

> There are, in our opinion, features of a sterilization procedure or, more accurately, factors involved in a decision to authorize sterilization of another person which indicate that, in order to ensure the best protection of the interests of a child, such a decision should not come within the ordinary scope of parental power to consent to medical treatment. Court authorization is necessary and is, in essence, a procedural safeguard. Our reasons for arriving at this conclusion, however, do not correspond precisely with any of the judgments considered. We shall, therefore, give our reasons. But first it is necessary to make clear that, in speaking of sterilization in this context, we are not referring to sterilization which is a by-product of surgery appropriately carried out to treat some malfunction or disease. We hesitate to use the expressions

> "therapeutic" and "non-therapeutic", because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.
>
> As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child's present or further capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.

130. As can be seen it was recognised by the plurality in *Marion's case* that there is an "unclear dividing line between cases which must be authorised by a court and those which may not" (also see *Re Sean and Russell* and *Re Sam and Terry*). Equally, the distinction between what might be regarded as "therapeutic" or "non-therapeutic" is in some cases by no means easy to draw. As Brennan J said in *Marion's case,* at 274, "… factual difficulties are unavoidable in deciding whether medical treatment is therapeutic or non-therapeutic".

131. The decision in *Marion's case*, and more specifically the comments made within it, examples of which we have just given, have not been taken as limiting the cases in which court authorisation is required to sterilization (for example see *Re GWW and CMW* (1997) FLC 92-748 per Hannon J at 84,108; *Re Sean and Russell* at [61]; and *Re Sam and Terry* at [83] – [85]). What became unclear though, as the law developed, is whether those comments were only applicable where the treatment was non-therapeutic.

132. In *Re Jamie,* both Finn J and Strickland J referred to and relied on what Brennan J (who was in dissent, but not on this point) said in *Marion's case* as to the therapeutic/non-therapeutic distinction. His Honour explained it in the following way (at 269):

> It is necessary to define what is meant by therapeutic medical treatment. I would define treatment (including surgery) as therapeutic when it is administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered. "Non-therapeutic" medical treatment is descriptive of treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychological disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes.

133. The important point his Honour there makes in relation to therapeutic medical treatment is in the proviso, namely "provided the treatment is appropriate for and proportionate to the purpose for which it is administered." That introduces an element of proportionality into the discussion, and that is what was picked up by their Honours (for example see Finn J at [180]). In other words, it is necessary to weigh up the therapeutic benefits of the treatment against the risks.

134. Evident from what Brennan J said, and in the reasons of the plurality, is a focus upon the means by which the parameters of parental authority might be determined. It is recognised that treatment that might have grave or irreversible consequences can nevertheless fall within the scope of parental authority because of the purpose to which the treatment is directed. Equally, treatment that might not meet the description of having "grave or irreversible consequences" might nevertheless fall outside of the scope of parental authority because of its novelty, or its experimental nature, or its place outside of accepted medical science and, as such, may render it treatment that "is administered chiefly for other purposes".

135. Of course, challenges to a form of treatment that might fit that description can be the province of individual challenge by a person or body with relevant standing. Issues of the instant kind arise when a particular treatment poses the question, as the majority put it in *Marion's case,* "Is [the] procedure a kind of intervention which is, **as a general rule**, excluded from the scope of parental power?" (Emphasis added).

136. Because the issue at hand is a general rule applicable in all cases of a particular type and the focus is upon the limit of parental authority, the "special cases" in which parental authority is abrogated must take account of the fact that:

> Proportionality and purpose are the legal factors which determine the therapeutic nature of medical treatment. Proportionality is determined as a question of medical fact. Purpose is ascertained by reference to all the circumstances but especially to the physical or mental condition which the treatment is appropriate to affect.
>
> (*Marion's case,* per Brennan J at 274).

137. Thus, we consider that no binding principle emerging from *Marion's case* *requires* this Court, or *required* the Court in *Re Jamie,* to hold that court authorisation is necessary for stage 2 treatment for Gender Dysphoria for a child who is not *Gillick* competent.

138. However, dicta in *Marion's case* is strongly persuasive of the proposition that the types of medical treatment for which court authorisation is required are neither closed nor confined to sterilization of a child who is not, and never will be, *Gillick* competent. Rather, as a general rule, whether court authorisation is

required will be dependent upon the entirety of the circumstances surrounding the particular treatment.

139. The same dicta is indicative of the importance of ascertaining whether a particular treatment is therapeutic or non-therapeutic in treating the "cosmetic deformity, pathological condition or psychiatric disorder" in question. That in turn must depend upon, among other things, evolving medical science which, notoriously, occurs at a very rapid pace.

The Background to *Re Jamie*

140. In the lead up to *Re Jamie* the state of the law was very much influenced by the decision of Nicholson CJ in *Re Alex*, being the first case in which the Family Court had been asked to provide authorisation for treatment for a young person who was born biologically female but who identified as male. The treatment sought was both stage 1 and stage 2, and his Honour found that court authorisation was necessary for both stages, presumably it seems on the basis that (at [195]):

> The current state of knowledge would not, in my view, enable a finding that the treatment would clearly be for a "malfunction" or "disease" and thereby not within the jurisdiction of this Court as explained by the majority in *Marion's* case …

His Honour also reasoned (at [196]):

> … There are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery …

141. As was sought to be emphasised in *Re Jamie* (at [79]), Nicholson CJ in *Re Alex* found that the application before him "would seem a novel one and [he] was not referred to any Australian or overseas authority with similar fact characteristics". The "novel" application before his Honour and, by inference, the "novel" treatment to which the application referred, shaped Nicholson CJ's interpretation which, in turn, shaped single-instance judgments thereafter. It is important to understand that *Re Jamie* occurred in that context and was the first decision of the Full Court in which these issues were determined.

142. The evidentiary context in which applications were heard subsequent to Nicholson CJ's judgment is also important in understanding how the law developed. It was assumed that the law required court authorisation for (relevantly) stage 2 treatment and there was an absence of contradictory argument and contrary evidence placed before the Court accordingly. Thus, whatever reservations were held by judges or concerns for the expense and stress that court authorisation required, decisions were given accordingly and those decisions in turn gave shape to the decision in *Re Jamie.*

143. For example, despite the sentiments expressed in the passage earlier quoted, in *Re Sam and Terry*, the reasons for judgment which were delivered on the same day as the reasons for judgment in *Re Jamie*, Murphy J found that stage 2 treatment in that case was "therapeutic" and then said this:

> 99. Yet, I do not consider that the judgments in *Marion's Case* when read as a whole intend the assignation to a treatment that it is "therapeutic" or "non-therapeutic" to be *of itself* solely determinative of the question of whether court authorisation is required. Rather, when read as a whole, the judgments in *Marion's Case* suggest a test that consists of assessing *together* the purpose of the treatment and its potential consequences.
>
> 100. The proposed stage 2 treatments for each of Terry and Sam carry significant risks and will also have irreversible effects on each of them in differing ways. For each, the proposed hormonal treatment carries an increased risk of breast cancer and may adversely affect fertility. The treatment will also have irreversible physical effects, such as, in Terry's case, the growth of facial hair and deepening of voice and, in Sam's case, the redistribution of muscle mass and body fat. Those side effects are significant in themselves but they are also significant because they are side effects designed to effect hormonal changes and overt manifestations consistent with a gender different to each child's birth gender.
>
> 101. There are, I think, "significant risk[s] of making the wrong decision, … as to [each child's] present or future capacity to consent" and I think that when the consequences are expressed as being steps on the path to changing gender, the consequences can be described as grave. As Nicholson CJ put it in *Re Alex* "[t]here are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery".
>
> …
>
> 103. However, the High Court in *Marion's Case* also pointed out that, sometimes, the immediate interests of parents may conflict with the long-term interests of children who are currently unable to (lawfully) consent to treatment which they desire. Sometimes a longer view might also conflict with immediate desires of children, even those whose views are mature. And, so too, might a longer view conflict with a recommendation of medical practitioners. Those circumstances do not necessarily lead to a result that a court will reach a conclusion different to the parents or the child or doctors (or a combination of them). But, it does, in my view, mean that a court should be the decision-maker who considers all of the relevant interests and considerations and the decision-maker who,

> among those interests and considerations, predominates what it considers to be the best interests of the relevant children.

(Emphasis in original)

The Decision in *Re Jamie*

144. In *Re Jamie* the question before the Full Court was whether court authorisation was required for both stage 1 and stage 2 treatment of children with Gender Identity Dysphoria. In other words, were the treatments medical procedures for which consent lies outside the bounds of parental authority and require the imprimatur of the Court.

145. Before the Court were the appellant parents, an ICL, and two intervenors, namely the public authority, and the Australian Human Rights Commission. We note that the Commonwealth Attorney-General was invited to intervene but that invitation was not taken up.

146. The ICL's position, and that of the public authority, was that court authorisation was required for both stage 1 and stage 2 treatment, relying primarily on *Re Alex* (e.g. see [35] – [38], [39] – [45]). The Australian Human Rights Commission submitted that absent a dispute about the proposed course of treatment, court authorisation should not be required for stage 1 (see [47]), but otherwise in relation to stage 2 treatment (for example see [52]).

147. Bearing in mind that *Re Jamie* was an appeal, limited by the grounds of appeal and the reasons of the trial judge, the Full Court agreed with the trial judge's findings on the evidence, and in particular the medical and expert evidence before her Honour, that stage 1 treatment is therapeutic in nature, and is fully reversible. Further, that it is not attended by grave risk if a wrong decision is made, and it is for the treatment of a malfunction or disease, being a psychological rather than a physiological disease. Thus, absent a controversy, it fell within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.

148. In adopting those findings the Full Court departed from *Re Alex,* explaining that not only the state of medical science had moved on, but the Court's understanding of the same had evolved.

149. As to stage 2 treatment, again, on the evidence, and in particular the medical and expert evidence before the trial judge, the Full Court agreed with the trial judge's findings that although stage 2 treatment is therapeutic in nature, it was also irreversible in nature (at least not without surgery). Thus, as Finn J said at [182]:

> … in a case such as this, the therapeutic benefits of the treatment would have to be weighed or balanced against the risks involved and the consequences which arise out of the treatment being irreversible, and this

would seem to be a task appropriate for a court, given the nature of the changes that stage two of the treatment would bring about for the child.

150. In other words, and recalling what Brennan J said at 269 in *Marion's case*, and for those reasons, it was for the Court to authorise such treatment.

Departure from *Re Jamie*

151. It seems that the first stated question has been interpreted as asking this Court to "overrule" the Full Court decision in *Re Jamie*, but that is not what the question requires. In its terms it asks whether this Full Court "confirm[s] its decision in *Re Jamie* … to the effect that Stage 2 treatment … requires the court's authorisation … unless the child [is] *Gillick* competent to give informed consent".

152. That question can and should be answered by considering whether it is appropriate to now depart from *Re Jamie* in order that the law is able to effectively reflect the current state of medical knowledge. It is readily apparent that the judicial understanding of Gender Dysphoria and its treatment have fallen behind the advances in medical science.

153. That is the primary focus of the submissions of the Australian Human Rights Commission, and it is recognised as an available and necessary approach by the applicant, the ICL and each of the other intervenors. For example, the Attorney-General put it this way:

> 32. One example not mentioned in this catalogue is the possibility that a common law rule formulated by a previous intermediate appellate court on the basis of a particular factual understanding comes to be seen as plainly wrong because the factual understanding has altered. That may be so because the factual material upon which the first court proceeded was, even at the time, infirm. But it may also be so because, due to developments in science or some other relevant field, the generally accepted factual understanding has changed. In either case, a sufficient change in factual understanding may warrant a departure from a previous decision.

(Submissions filed 30 August 2017)

154. That this is the appropriate approach here is exemplified in the question itself. It refers to "Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) DSM-V", but that edition was not the edition that was before the Court in *Re Jamie*, and thus to that extent as well, the question is flawed, although that is not the point we are making here. The edition before the trial judge and the Full Court in *Re Jamie* was DSM-IV, which was published in 1994 and then updated in 2000.

155. DSM-V was mentioned by Bryant CJ in *Re Jamie* (at [69] and [91]), but that was because it had only just been published, namely in May 2013. At the time of the hearing of the appeal in 2012, DSM-IV was the edition that was before the Full Court, and there was no application to reopen the hearing of the appeal to make submissions in relation to the changes brought about by the fifth edition.

156. As explained in the oral submissions of senior counsel for A Gender Agenda Inc., the change from the fourth edition to the fifth edition in May 2013 was significant. In the former edition the "condition" was described as a Gender Identity Disorder, but in the latter edition it is described as Gender Dysphoria. Thus, it is no longer described as a "disorder", and further, and significantly, there was

> … a change from the recognition of gender identity disorder to a recognition of gender dysphoria and, of course, the latter focusses very much on the dysphoria as the disorder to be treated rather than the issue of identity, and identity itself is no longer regarded as any kind of pathology.
>
> (Transcript, 21 September 2017, p 66, l 20 – 23)

157. Subtyping by sexual orientation was also deleted in DSM-V, and the diagnosis for children was separated from that for adolescents and adults.

158. For a child to now be diagnosed with Gender Dysphoria, there must be a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six identified criteria. These criteria must include "a strong desire to be of the other gender or an insistence that one is the other gender, or some alternative gender different from one's assigned gender". For adolescents, "there must be a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two identified criteria – no criterion is mandatory. For both, the condition must also be associated with clinically significant distress, or impairment in social, school, occupational or other important areas of functioning" (DSM-V, page 451).

159. There is no question that the state of medical knowledge has evolved since the decision in *Re Jamie*. Apart from the change from DSM-IV to DSM-V, importantly, there is the development of standards of care for the treatment of Gender Dysphoria in young people. As again explained by senior counsel for A Gender Agenda Inc.:

> … There's international standards developed by the international transgender health body that are found in document [57(d)], but also we would say, importantly, referred to in the case stated in paragraph 3, so they are picked up and acknowledged in the case stated as an international set of standards and, of course, there's the Australian standards that are

> annexed to the Telfer affidavit and also referred to in the body of the case stated at paragraph 4. And so the court can see that, those standards are being developed and, plainly enough, the Australian standards were not in place at the time that *Re Jamie* was decided.
>
> (Transcript, 21 September 2017, p 66, l 27 – 35)

160. Senior counsel continued:

> In addition, we have evidence from Dr Telfer which has made its way into the case stated at paragraph [55] about the experience of the gender service of the Royal Children's Hospital over a period from 2003 to 2017, which also encompasses, therefore, new medical knowledge and, in particular, at paragraph [56] Dr Telfer's affidavit – I'm sorry the case stated, picking up from Dr Telfer's affidavit, the case stated records as a fact that 96 per cent of patients treated for gender dysphoria at the Royal Children's Hospital continue to identify as transgender into late adolescence and so one sees some evidence there about persistence of gender dysphoria. Again, we would say that data is new.
>
> (Transcript, 21 September 2017, p 66, l 37 – 45)

161. And finally, and very importantly, as also put by senior counsel for A Gender Agenda Inc., there is increased knowledge of the risks associated with not treating a young person who has Gender Dysphoria (see [17] – [23] above).

162. The consensus of the applicant, the ICL and all but one of the intervenors, is that the development in the treatment of and the understanding of Gender Dysphoria allows this Court to depart from the decision of *Re Jamie*. In other words, the risks involved and the consequences which arise out of the treatment being at least in some respects irreversible, can no longer be said to outweigh the therapeutic benefits of the treatment, and court authorisation is not required. This is so, of course, only where the diagnosis has been made by proper assessment and where the treatment to be administered is in accordance with the best practice guidelines described in the case state.

163. The one intervenor who is out of step is the Secretary for the Department of Family and Community Services. The Secretary says in effect that court authorisation of stage 2 treatment should continue to be required. But for the reasons we have given, we do not agree with that submission.

164. The treatment can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court.

165. It is also important to note that that outcome is not unexpected. As some of the intervenors record, *Re Jamie* can be viewed as being decided at a particular point in time, and at a particular stage in the development of legal principle, and even more importantly of medical science (for example see the applicant's

submissions filed 5 June 2017 at paragraph 34). It would not be heresy to suggest that, in relation to stage 2 treatment, *Re Jamie* would be decided differently today.

166. Thus, to the extent that the question can be answered, and despite the flaw in it, the answer is "no".

167. We note though that in answering that question we are not saying anything about the need for court authorisation where the child in question is under the care of a State Government Department. Nor, are we saying anything about the need for court authorisation where there is a genuine dispute or controversy as to whether the treatment should be administered; e.g., if the parents, or the medical professionals are unable to agree. There is no doubt that the Court has the jurisdiction and the power to address issues such as those.

168. That is sufficient to dispose of this question, but unless there be any doubt about the validity of that approach, we need do no more than look at the principles relevant to when intermediate courts of appeal may depart from their own earlier decisions.

169. The submissions of the applicant, the ICL and three of the five intervenors, namely, the Attorney-General, A Gender Agenda Inc., and the Royal Children's Hospital, all focus on the well settled principle that a later Full Court will consider itself free to depart from an earlier decision if that decision can be said to be "plainly wrong" (for example see *Nguyen v Nguyen* (1990) 169 CLR 245 per Dawson, Toohey and McHugh JJ at 268 – 270; *Gett v Tabet* (2009) 254 ALR 504 at [261] – [301]; and *F Firm & Ruane and Ors* (2014) FLC 93-611 at [163]). It is said that this Court should find that the decision in *Re Jamie* fits that description.

170. Although it is not specified in the context of the plea to "overrule" *Re Jamie,* we assume that what is being referred to is that part of the decision in *Re Jamie* where the Full Court upheld the trial judge in finding that court authorisation was required for stage 2 treatment, and in finding that it was for the Court to determine whether a child is *Gillick* competent. Indeed, it is always necessary to be acutely aware of the specific questions asked in a case stated, and the former issue arises in question 1 of that case, and the latter issue in question 2.

171. However, in our view, it is unnecessary and indeed inappropriate for this Court to find that *Re Jamie* was "plainly wrong" in order to answer question 1 and question 2.

172. Although the general approach of intermediate appellate courts is that they should follow their previous decisions unless persuaded that they are "plainly wrong", the application of that approach is dependent on a finding that no distinction can be drawn between the facts on which the prior decision is based and the facts before the subsequent court (*F Firm & Ruane and Ors* at [163]).

Here, it is beyond doubt that a relevant distinction can be made and there are "legally relevant factual differences between the two cases".

173. In his written submission, as referred to already, the Attorney-General says (at paragraph 32) that an example of where a previous decision can be found to be "plainly wrong" is where "a common law rule formulated by a previous intermediate appellate court on the basis of a particular factual understanding comes to be seen as plainly wrong because the factual understanding has altered". The Attorney continued, "[t]hat may be so because the factual material upon which the first court proceeded was, even at the time, infirm. But it may also be so because, due to developments in science or some other relevant field, the generally accepted factual understanding has changed. In either case, a sufficient change in factual understanding may warrant a departure from a previous decision."

174. That submission is undoubtedly correct, but rather than being a basis to find the previous decision "plainly wrong", it is an example of where a subsequent court can depart from an earlier decision without needing to find that that decision was "plainly wrong" in the sense that that is usually understood, namely, there being an error of law (see *Gett v Tabet* at [261] – [301]). As the former Justice Heydon noted in a 2009 article, "How Far Can Trial Courts and Intermediate Appellate Courts Develop the Law?" (2009) 9 *Oxford University Commonwealth Law Journal* 1 at n67:

> On occasion a decision may be overturned, not because it was wrong when decided, but because it is thought that new circumstances make a new rule desirable: *Australian Consolidated Press Ltd v Uren* (1967) 117 CLR 221 (PC) 241.

(Also see *Telstra Corporation Ltd v Treloar* (2000) 102 FCR 595 per Branson, Finkelstein and Gyles JJ at [28]).

175. We have set out above the legally relevant factual differences in the evidence before the Full Court in *Re Jamie* as compared with the stated facts here (also see transcript, 21 September 2017, p 44, l 12 – 28, p 45, l 1 – 8). In short, those differences relate to the advances in medical science regarding the purpose for which the treatment is provided, the nature of the treatment, and the risks involved in undergoing, withholding or delaying treatment.

176. We pause to note that senior counsel for A Gender Agenda Inc. submitted (at transcript, 21 September 2017, p 64, l 29 – 37) that the bases on which an earlier decision can be departed from, namely where there is effectively a factual distinction, and where it can be argued that the earlier decision was "plainly wrong" are "alternatives". However, that is not strictly in accordance with authority, and the first enquiry is always whether there is a factual difference between the two cases that has relevant legal significance. If there is, then the earlier decision can be departed from on that basis, and it is

unnecessary to consider whether the earlier decision was “plainly wrong”. That also accords with the principle highlighted in *Nguyen v Nguyen* at 269, that a finding that a previous decision was “plainly wrong” should be made only with caution, and in particular only where necessary for determination of the matter before the court. Clearly, this is not such a case.

177. We confirm that in our view, it is unnecessary, and by reference to the questions posed in this case stated, inappropriate, for this Court to find that *Re Jamie* was “plainly wrong”. The stated question can and should be answered by considering whether it is appropriate to now depart from *Re Jamie* in order that the law effectively reflects the current state of medical knowledge.

QUESTION 2

Where:

2.1. Stage 2 treatment of a child for Gender Dysphoria is proposed;

2.2. The child consents to the treatment;

2.3. The treating medical practitioners agree that the child is *Gillick* competent to give that consent; and

2.4. The parents of the child do not object to the treatment

is it mandatory to apply to the Family Court for a determination whether the child is *Gillick* competent (Bryant CJ at [136-137, 140(e)]; Finn J at [186] and Strickland J at [196] *Re Jamie*)?

178. Again it is necessary to put what was said about *Gillick* competence in *Re Jamie* into context.

179. Bryant CJ relevantly stated:

> 136. The second and more vexing question posed is who should determine the question of *Gillick* competence. Is it the medical doctors, or is it necessary for an application to the court to be made for an assessment as to whether the child is competent to give informed consent to the procedure?
>
> 137. With some reluctance I conclude that the nature of the treatment at stage two requires that the court determine *Gillick* competence. In *Marion’s case*, the majority held that court authorisation was required first because of the significant risk of making the wrong decision as to a child’s capacity to consent, and secondly because the consequences of a wrong decision are particularly grave.
>
> 138. It seems harsh to require parents to be subject to the expense of making application to the court with the attendant expense, stress and possible delay when the doctors and parents are in agreement

> but I consider myself to be bound by what the High Court said in *Marion's case*.

180. It is said that her Honour has erred because nothing was said in *Marion's case* about who should determine *Gillick* competence, and certainly it was not suggested that the court should be tasked with that responsibility.

181. That is entirely correct, but her Honour is not suggesting otherwise in those paragraphs. What her Honour is saying is that because court authorisation is required where there is the significant risk of making the wrong decision and the consequences of a wrong decision are particularly grave, it was also appropriate that the Court determine *Gillick* competence. In other words, the nature of the treatment requires that to be the case (also see Finn J at [185] – [186]).

182. Now, of course, if as appears to be the case, the nature of the treatment no longer justifies court authorisation, and the concerns do not apply, then there is also no longer a basis for the Court to determine *Gillick* competence.

183. Again, there is no need to consider whether the Full Court in this respect was "plainly wrong" in order to depart from that aspect of the decision. In other words, as we have identified, there is a factual difference between the two cases that has relevant legal significance, or as the Attorney-General would put it, there has been a change in the factual understanding on which the earlier decision was based.

184. Thus, the answer to question 2 is "no".

QUESTIONS 3 – 6

185. Questions 3 and 4 only arise if the answer to question 2 is yes. Given that this Court's answer to question 2 is no, it is unnecessary to answer those questions.

186. Questions 5 and 6 are consequential to the answers to questions 3 and 4, and given it is unnecessary to answer questions 3 and 4, it is also unnecessary to answer questions 5 and 6.

AINSLIE-WALLACE & RYAN JJ

187. The relevant facts, statutory provisions and the questions in the stated case are set out in the joint judgment of Thackray, Strickland and Murphy JJ. We agree with the conclusion reached, that a child who is capable of giving informed consent (*Gillick* competent) can authorise stage 2 treatment for Gender Dysphoria and it is not necessary for a court exercising jurisdiction under the *Family Law Act 1975* (Cth) ("the Act") to so find. We also agree that where a child is incapable of giving valid consent, those who have parental responsibility for the child may authorise treatment; again, without requiring the court's imprimatur.

188. Our reasoning which leads to that conclusion differs to their Honours' because we are of the view that the Full Court in *Re: Jamie* (2013) FLC 93-547 ("*Re Jamie*"), having determined that stage 2 treatment was therapeutic, should not have applied the principles propounded in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 ("*Marion's case*") concerning authorisation of a particularly grave non-therapeutic procedure for a child who did not and would never have the capacity to consent.

189. *Marion's case* was central to the approach adopted in *Re Jamie* and is important for what it does and does not say. *Marion's case* does not stand for the proposition that consent to a therapeutic procedure which has grave or irreversible consequences is outside the scope of parental power or outside the consent of a competent child. Nor does it erect a freestanding obligation to obtain a court finding that a child is *Gillick* competent before his or her consent can be given effect. In our view the principles that emerge from *Marion's case* when applied to *Re Jamie* should have resulted in the conclusion that in relation to stage 2 treatment for Gender Dysphoria the court has no role to play unless there is a dispute about consent or treatment.

Marion's case and medical and surgical procedures

190. To give context to the discussion which follows, it was established in *Marion's case* that the welfare jurisdiction conferred on the Family Court encompasses the substance of the traditional *parens patriae* jurisdiction. It follows that just as the *parens patriae* jurisdiction is very broad, so too is the Family Court's welfare jurisdiction, subject to the Constitution, whether overriding or recognised by the Act (*Marion's case* at 294; *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 at 390). The Court's power is, in fact, broader than that of a parent or guardian as the Court is able to authorise action, for example non-therapeutic sterilization, which is beyond the scope of parental authority.

191. Although the jurisdiction is very broad, it is exercised cautiously. In deciding to control or ignore the parental right the Court should do so only when judicially satisfied that the welfare of the child requires that the parental right should be suspended or superseded (*Marion's case* at 280).

192. *E. (Mrs) v Eve* [1986] 2 S.C.R. 388 ("*Re Eve*"), a decision of the Canadian Supreme Court, was approved by the High Court in *Marion's case* as to the scope of the *parens patriae* jurisdiction and makes it clear that the *parens patriae* jurisdiction exists for the purpose of taking care of those who are not able to take care of themselves (*Re Eve* at 425 – 426; *Marion's case* at 258). The jurisdiction must be examined in accordance with its informing principle; namely, to do what is necessary for the benefit, and in the interests, of the person in need of protection (*Re Eve* at 414, 427). In other words, as explained in *Re Eve*, the jurisdiction is informed by the purpose it serves.

193. *Marion's case* was concerned with the administration of non-therapeutic treatment to prevent pregnancy of a child who would never have the capacity to consent to the procedure. It came after *Re Eve* which concluded that as the *parens patriae* jurisdiction could only be exercised for the benefit of the incompetent person and non-therapeutic sterilization could not safely be said to be in the person's best interests, the procedure could not be authorised under that jurisdiction. In *Marion's case* the High Court concluded that, in the exercise of the welfare power, the court could authorise non-therapeutic sterilization as a special category or case.

194. A hysterectomy was proposed for Marion for the purpose of preventing pregnancy and menstruation with its psychological and behavioural consequences. An ovariectomy was proposed to stabilise hormonal fluxes so as to eliminate behavioural responses and consequential stress. Marion's parents applied to the Family Court for an order authorising these surgeries or, in the alternative, a declaration that they could consent to the procedures. In deciding that the parents could not consent to the procedures without court authorisation, the High Court distinguished between "therapeutic" and "non-therapeutic" procedures and qualified parental power in relation to a decision to authorise a particularly grave, non-therapeutic procedure for a child who lacked the capacity to give informed consent.

195. At 249 – 250, Mason CJ, Dawson, Toohey and Gaudron JJ said:

> There are, in our opinion, features of a sterilization procedure or, more accurately, factors involved in a decision **to authorize sterilization of another person** which indicate that, in order to ensure the best protection of the interests of a child, such a decision should not come within the ordinary scope of parental power to consent to medical treatment. Court authorisation is necessary and is, in essence, a procedural safeguard. Our reasons for arriving at this conclusion, however, do not correspond precisely with any of the judgments considered. We shall, therefore, give our reasons. But first it is necessary to make clear that, in speaking of sterilization in this context, **we are not referring to sterilization which is a by-product of surgery appropriately carried out to treat some malfunction or disease**. We hesitate to use the expressions "therapeutic" and "non-therapeutic", because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.
>
> As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot

> consent, and secondly, because the consequences of a wrong decision are particularly grave.
>
> (Our emphasis)

196. It was accepted that sterilization was a step of last resort, which was a convenient way of saying that alternative and less invasive procedures had failed and it was medically certain that no other procedure or treatment would work. The gravity of the decision was such that, given the child's lack of capacity, it was important that the decision to authorise was taken free from the potentially conflicting interests of those charged with caring for the seriously disabled child (*Marion's case* at 251, 259).

197. If there was any doubt that the constraints on parental power to authorise medical procedures discussed in *Marion's case* were limited to non-therapeutic procedures which have the features identified in the paragraphs quoted above, that uncertainty was dispelled in *P v P* (1994) 181 CLR 583 ("*P v P*").

198. In *P v P*, a parent of a 16 year old girl, who was mentally disabled and lacked the capacity to consent, applied for an order from the Family Court to authorise an operation to render the child permanently infertile. The child was resident in New South Wales where the proposed sterilization would take place. Certain state laws prohibited the carrying out of the proposed sterilization unless it was in accordance with an order of the Supreme Court of New South Wales. In the course of deciding that the state law did not qualify the general welfare jurisdiction conferred on the Family Court and that the Court had jurisdiction to make the proposed order, the plurality of Mason CJ, Deane, Toohey and Gaudron JJ explained the ratio of *Marion's case* as follows (at 597):

> The distinction which s. 45(2) of the *Guardianship Act* draws between the "special treatment" which is "necessary" to save life or prevent serious damage to health and other "special treatment" is, in the case of a medical procedure involving sterilization, imprecise and difficult to apply in a borderline case. Nonetheless, some such distinction has commonly been seen as of critical importance in cases dealing with the power of parents or the jurisdiction of courts to authorize such a procedure in the case of an incapable child. A comparable but more precise (and more stringent) distinction was drawn by the Court in *Secretary, Department of Health and Community Services v J.W.B. and S.M.B. (Marion's Case)* (38) where the majority judgment of Mason C.J., Dawson, Toohey and Gaudron JJ. makes clear that the decision in that case that the authorization of a medical procedure involving sterilization "falls outside the ordinary scope of parental powers and therefore outside the scope of the powers, right and duties of a guardian under … the *Family Law Act*" (39) **is confined to sterilization which is not "a by-product of surgery appropriately carried out to treat some malfunction or disease**" (40). It is convenient to refer to sterilization which is not a by-product of such surgery as "planned sterilization".

(Our emphasis)

199. For present purposes, the propositions to be drawn from *Marion's case* are:

- Sterilization (which is invasive, irreversible and major surgery) is medical treatment to which a legally competent person can consent (234);
- It is primarily the prospect of surgical intervention which attracts the interests of the law because, without legally effective consent, such intervention would constitute an offence and a tort (232 – 235);
- In the case of a child, a parent generally has, at common law and under the Act, power to consent to medical treatment of their child (237);
- At common law, a parent is no longer capable of consenting on the child's behalf when the child achieves a sufficient understanding and intelligence to enable him or her to fully understand what is proposed (*Gillick* competent) (237 – 238);
- Where a child is not *Gillick* competent, the scope of parental power to consent to medical treatment is wide but does not extend to non-therapeutic sterilization (239 and 250);
- The reasons why non-therapeutic sterilization of an incapable child is outside the parental power to consent to medical treatment are:

  (a) It requires invasive, irreversible and major surgery;

  (b) There is a significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about the best interest of a child who cannot consent; and

  (c) The consequences of that wrong decision are particularly grave (250 – 252); and
- Where a child is not *Gillick* competent, it is necessary to apply to the court to authorise non-therapeutic sterilization in accordance with Part VII of the Act (257).

200. *Marion's case* does not:

- Foreclose taking a similar approach to the necessity for authorisation of analogous non-therapeutic medical or surgical treatment for a child who lacks legal capacity;
- Address the situation of a *Gillick* competent child who refuses permission for medically necessary treatment; or
- Support court intervention in relation to therapeutic procedures to which a legally competent person can consent.

201. It follows that factors such as the gravity of the intervention only arise for consideration if the proposed treatment is non-therapeutic. We thus agree with the submission of the Royal Children's Hospital that based on *Marion's case* there is no reason in principle to distinguish between the approaches to be taken to the forms of therapeutic treatment of Gender Dysphoria.

Re Alex and the approach to Gender Dysphoria

202. *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175 (*"Re Alex"*) was the first case in which the Family Court was asked to authorise treatment for a child diagnosed with Gender Dysphoria (then known as Gender Identity Disorder). A finding that Alex was *Gillick* competent was not made and the application was brought by the child's legal guardian who sought authorisation for stage 1 and stage 2 treatment. The case was conducted on the basis that stages 1 and 2 comprised a clinical program which should be viewed as a single regime.

203. In deciding that court authorisation was required for both stages, Nicholson CJ summarised the effect of *Marion's case* as follows:

> 152. However, two further issues arise from the High Court of Australia's decision in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) FLC 92-293; (1992) 175 CLR 218 (*Marion's* case) which is the relevantly binding Australian authority:
>
> - whether the child or young person is himself competent to consent; and
> - whether the subject matter of the application is a "special medical procedure" to which a parent or guardian cannot consent.
>
> 153. *Marion's* case involved an application for the sterilisation of a 14-year-old teenager with a severe intellectual disability for the purpose of "preventing pregnancy and menstruation with its psychological and behavioural consequences". The gravamen of the decision was that if a child or young person cannot consent her/himself to a medical procedure, parental consent (which for present purposes may be equated with that of a guardian) is ineffective where the proposed intervention is:
>
> - invasive, permanent and irreversible; and
> - not for the purpose of curing a malfunction or disease.

204. Nicholson CJ was not satisfied that the proposed treatment addressed a "malfunction" or "disease" and it was thus "not within the jurisdiction of this Court as explained by the majority in *Marion's* case" [195]. However, even though only stage 2 involved irreversible consequences, because the

application was presented as "a single package" and because "[t]here are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex", the scope of parental power to consent to medical treatment was qualified and court authorisation was required for both procedures [196].

205. *Re Alex* was generally followed and the question of the approach to gender dysphoria did not arise for consideration by the Full Court until *Re Jamie*. However, over time the expert evidence adduced in the cases reflected advances in medicine and by 2013 at least one judge was satisfied that stage 1 treatment was therapeutic and that for a child who could not validly consent, approval for treatment was within the scope of parental responsibility (*Re Lucy (Gender Dysphoria)* (2013) 49 Fam LR per Murphy J).

206. Murphy J took the same approach in *Re Sam and Terry (Gender Dysphoria)* (2013) 49 Fam LR 417 ("*Re Sam and Terry*") and went on to conclude that stage 2 treatment was also therapeutic. However, his Honour was of the view that *Marion's case* did not exclude qualifying parental power in relation to procedures that were therapeutic and was satisfied that court authorisation for stage 2 was required. His Honour said:

> 99. Yet, I do not consider that the judgments in *Marion's* case when read as a whole intend the assignation to a treatment that it is "therapeutic" or "non-therapeutic" to be *of itself* solely determinative of the question of whether court authorisation is required. Rather, when read as a whole, the judgments in *Marion's* case suggest a test that consists of assessing *together* the purpose of the treatment and its potential consequences.
>
> 100. The proposed Stage 2 treatments for each of Terry and Sam carry significant risks and will also have irreversible effects on each of them in differing ways. For each, the proposed hormonal treatment carries an increased risk of breast cancer and may adversely affect fertility. The treatment will also have irreversible physical effects, such as, in Terry's case, the growth of facial hair and deepening of voice and, in Sam's case, the redistribution of muscle mass and body fat. Those side effects are significant in themselves but they are also significant because they are side effects designed to effect hormonal changes and overt manifestations consistent with a gender different to each child's birth gender.
>
> 101. There are, I think, "significant risk[s] of making the wrong decision, … as to [each child's] present or future capacity to consent" and I think that when the consequences are expressed as being steps on the path to changing gender, the consequences can be described as grave. As Nicholson CJ put it in *Re Alex* "[t]here are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the

> direction of the opposite sex, even where the Court is not asked to authorise surgery."

207. The approach adopted in *Re Sam and Terry* resonates with that which was adopted in *Re Jamie*.

Re Jamie

208. It is important to observe at the outset that the Full Court in *Re Jamie* considered itself bound by the principles emerging from the High Court decision in *Marion's case* and it is in the application of *Marion's case* that we consider the decision in *Re Jamie* to be plainly wrong. In our view the submissions of the applicant, A Gender Agenda Inc., the Royal Children's Hospital, the Attorney-General and the ICL which argue *Re Jamie* was plainly wrong should be addressed.

209. We do not agree that the factual differences between *Re Jamie* and this case foreclose consideration of whether the former is plainly wrong. The statements of principle made in *Re Jamie* attributed to *Marion's case* are erroneous. We are concerned that unless this is made clear, there is a risk that in the future *Re Jamie* might be interpreted as providing a basis for court involvement in therapeutic procedures which on a proper application of *Marion's case* come within the scope of parental authority or the capacity of a legally competent child. These cases rarely involve a contradictor and the relief sought is almost always given (facts 46 and 47; [51] and [52] above). As this case demonstrates the opportunity for appellate consideration rarely arises. The issue should not remain unresolved.

210. Although it was submitted by the public authority in *Re Jamie* that the proposed treatment to be administered in stages 1 and 2 was not to address a malfunction or disease of the body, and, consistent with *Marion's case* was thus non-therapeutic, the Court found that Gender Identity Disorder is a psychological condition recognised in both the DSM-IV and DSM-V. Bryant CJ said:

> 98. Thus where the question is whether the treatment relates to a disease or malfunctioning of organs, including psychological or psychiatric disorders, then, in my view, if the treatment is in response to a disorder, even a psychological or psychiatric one, it is administered for therapeutic purposes. …

211. So too at [176] Finn J considered that nothing in *Marion's case* restricted the consideration of therapeutic and non-therapeutic procedures to those addressing only bodily as opposed to psychological malfunction or disease.

212. This finding having been made, it followed that the proposed treatment was solely therapeutic, having no non-therapeutic application.

213. From that decision, it would then follow that if the Court was in fact to apply the principles in *Marion's case*, that in respect of neither stage 1 nor stage 2 treatment was anything required other than the consent of the legally competent child or, absent capacity, that of the child's parents.

214. However, the Court distinguished between the nature and consequences of the treatment to be administered in stages 1 and 2 and concluded that as the effects of stage 1 treatment are wholly reversible, no court authorisation was required whereas it was necessary in relation to stage 2. In drawing a distinction between two aspects of the same therapeutic regime we consider the Court in *Re Jamie* to have erred. This is revealed at [137] in the reasons of Bryant CJ where her Honour said:

> With some reluctance I conclude that the nature of the treatment at stage two requires that the court determine *Gillick* competence. In *Marion's case*, the majority held that court authorisation was required first because of the significant risk of making the wrong decision as to a child's capacity to consent, and secondly because the consequences of a wrong decision are particularly grave.

215. See too at [177] where Finn J said:

> Brennan J, in his reasons in *Marion's case*, was able to explain the therapeutic – non-therapeutic distinction (including, it should be noted, particularly for present purposes, in relation to psychiatric disorders) in the following way (at 269):
>
> > It is necessary to define what is meant by therapeutic medical treatment. I would define treatment (including surgery) as therapeutic when it is administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered. "Non-therapeutic" medical treatment is descriptive of treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes.

216. Her Honour concluded that the definitions of Brennan J were of assistance in determining the issues in *Re Jamie* [178].

217. At [180] her Honour said:

> Stage two of the proposed treatment presents greater problems if only because it is, … "irreversible in nature" … This consideration must, in my view, remain important, even when it is accepted that the treatment can be categorised as therapeutic, and in this regard the concept of proportionality referred to by Brennan J must come into play.

218. Finn J therefore concluded:

> 181. In the passage cited above from the majority judgment in *Marion's case*, it was recognised that some forms of medical treatment are irreversible and yet do not require court authorisation. However, their Honours proceeded to hold that such authorisation was required at least for sterilization "because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent", and also because of the "particularly grave" consequences of a wrong decision.
>
> 182. Such risks of a wrong decision and the grave consequences of a wrong decision must similarly exist in relation to stage two of the proposed treatment in this case when regard is had to the effects of that treatment as explained by Dessau J in the passages from her Honour's reasons earlier set out. Thus, in my view, in a case such as this, the therapeutic benefits of the treatment would have to be weighed or balanced against the risks involved and the consequences which arise out of the treatment being irreversible, and this would seem to be a task appropriate for a court, given the nature of the changes that stage two of the treatment would bring about for the child.
>
> …
>
> 186. Nevertheless, I have concluded that at least the question of a 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.

219. Strickland J agreed at [195] and [196] that the therapeutic benefits of stage 2 treatment needed to be balanced against the risk of making a mistake as to the competence of the child and the consequences attendant on the irreversibility of the treatment. His Honour also found that court authorisation was required where the child was not *Gillick* competent and whether the child was *Gillick* competent was a threshold matter which the court must decide.

220. We agree with Felicity Bell in her article "Children with Gender Dysphoria and the Jurisdiction of the Family Court" (2015) 38(2) *University of New South Wales Law Journal* 426 at 441 that this interpretation of Brennan's J's dissenting judgment disregards its broader context, namely his conclusion that neither parents nor the courts have the power to authorise a non-therapeutic

medical procedure of a person who lacked capacity to consent. Brennan J found it was thus necessary to define what is meant by therapeutic medical treatment and said that treatment is therapeutic when administered "for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered" (at 269).

221. Brennan J said at 274:

> It needs no argument to show that a malignant tumour of the uterus justifies the performance of an hysterectomy or that multiple cysts on an ovary may dictate its surgical removal. However, where menstruation produces or is likely to produce a psychiatric disorder of such severity as to require its suppression … consideration must be given to the different treatments reasonably available and appropriate to suppress menstruation and to their medical advantages and disadvantages in order to ensure that the least invasive of the treatments is selected. Proportionality and purpose are the legal factors which determine the therapeutic nature of medical treatment. Proportionality is determined as a question of medical fact. Purpose is ascertained by reference to all the circumstances but especially to the physical or mental condition which the treatment is appropriate to affect.

222. Thus it can be seen that Brennan J defined therapeutic treatment by the twin considerations of purpose and proportionality. Thus, as Bell writes at 441 "the question of proportionality goes to determining the initial, fundamental question of whether the treatment is therapeutic, which is 'determined as a question of medical fact'. It is not balanced *against* undertaking a therapeutic treatment" (emphasis in original).

223. In *Re Jamie* it was not suggested that the proposed treatment was not appropriate or proportional to treat the condition of Gender Identity Disorder or that it was to be administered for a purpose other than the identified treatment of the disorder. There could thus be no argument that both stages of treatment were therapeutic in the sense defined by Brennan J.

224. Despite finding the treatment to be administered in both stages to be therapeutic in nature, the Court distinguished between the two not by reference to whether the treatment was therapeutic or not but by reference to the consequences of the administration of that treatment; that is, that it was irreversible. As counsel for the Royal Children's Hospital submitted, to do so is to confuse the nature, form and characteristics of therapeutic treatment with the consequences of that treatment and to do so is not giving effect to the determination in *Marion's case*.

225. In our opinion, by eliding the outcome of therapeutic treatment with the risks and consequences identified in *Marion's case* which removed non-therapeutic sterilization from the realm of parental consent, we are of the view that the Full

Court erred in its application of *Marion's case* and thus the decision should not be followed.

Conclusion

226. We therefore answer the questions in the case stated by Watts J as follows:

Question 1: Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) DSM-5 (the treatment), requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent?

Answer: No.

Question 2: Where:

2.1 Stage 2 treatment of a child for Gender Dysphoria is proposed;

2.2. The child consents to the treatment;

2.3. The treating medical practitioners agree that the child is *Gillick* competent to give that consent; and

2.4. The parents of the child do not object to the treatment

is it mandatory to apply to the Family Court for a determination whether the child is *Gillick* competent (Bryant CJ at [136-137, 140(e)]; Finn J at [186] and Strickland J at [196] *Re Jamie*)?

Answer: No.

Question 3: If the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for a declaration that the child is *Gillick* competent, be dismissed?

Answer: Unnecessary to answer.

Question 4: In the alternative, if the answer to question 2 is yes, if a finding is made that the child was *Gillick* competent to give informed consent, should any application for an order authorising the administration of the treatment, be dismissed?

Answer: Unnecessary to answer.

Question 5: If the answer to question 3 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make a declaration that the child was *Gillick* competent to give informed consent to the treatment?

Answer: Unnecessary to answer.

Question 6: If the answer to question 4 is no, given statements made by the Full Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make an order authorising the administration of the treatment?

Answer: Unnecessary to answer.

I certify that the preceding two hundred and twenty-six (226) paragraphs are a true copy of the reasons for judgment of the Honourable Full Court (Thackray, Strickland, Ainslie-Wallace, Ryan & Murphy JJ) delivered on 30 November 2017.

Associate: A. Becker

Date: 30 November 2017