FAMILY COURT OF AUSTRALIA

RE: SAM AND TERRY (GENDER DYSPHORIA) ***[2013] FamCA 563***

FAMILY LAW – CHILDREN – two similar but separate cases heard together with the consent of all parties – where the children the subject of the applications are both 16 years of age – where both have been diagnosed with gender dysphoria – where the experts are agreed that neither child is Gillick-competent – where their parents have each brought an application seeking orders authorising them to consent to Stage 1 and Stage 2 treatment – whether an order of the Court is necessary, or whether consenting to Stage 1 and/or Stage 2 treatment falls within the ambit of parental responsibility – consideration of *Marion's Case* – where Stage 1 treatment for each child is completely reversible and has no long-term side effects – where Stage 2 treatment carries significant risks and has irreversible effects – where the power to consent to the Stage 1 treatment proposed for the children falls within the ambit of parental responsibility – where Court authorisation is required for the proposed Stage 2 treatment – whether the treatment is in the children's best interests – where each child has significant comorbidities including depression which has manifested in self-harm and suicidal ideation – where the expert evidence is unanimous in terms of the unlikelihood of the children's conditions desisting – where the proposed treatment is in accordance with international guidelines and practices adopted in other hospitals in Australia – orders made enabling the parents to consent to the Stage 2 treatment proposed for their child.

Family Law Act 1975 (Cth)
Family Law Rules 2004 (Cth)

Gillick v Norfolk Area Health Authority [1986] AC 112
In re Jane (1989) FLC 92-007
Re a Teenager (1989) FLC 92-006
Re Alex: Hormonal treatment for gender identity dysphoria (2004) FLC 93-175
Re Brodie (Special Medical Procedure) [2008] FamCA 334
Re GWW and CMW (1997) FLC 92-748
Re Jamie (Special medical procedure) [2011] FamCA 248
Re Jodie [2013] FamCA 62
Re Lucy (Gender Dysphoria) [2013] FamCA 518
Re: Sean and Russell (Special Medical Procedures) (2010) 44 Fam LR 210
Secretary, Department of Health and Community Services v JWB and SMB ("Marion's Case") (1992) 175 CLR 218

APPLICANTS IN FILE …:	The parents of Sam
APPLICANTS IN FILE …:	The parents of Terry
INTERVENER:	The government department
FILE NUMBERS:	File numbers suppressed by court order
DATE DELIVERED:	31 July 2013
JUDGMENT OF:	Justice Murphy
HEARING DATE:	22 July 2013

REPRESENTATION

By court order, the names of counsel and solicitors have been suppressed.

ORDERS

IT IS DECLARED IN RESPECT OF THE CHILD SAM (… born … 1997) THAT:

1. As at 31 July 2013, Sam is not competent to give informed consent.

Stage 1 Treatment

2. The treatment recommended to be administered to Sam in respect of her Gender Dysphoria, namely the administration of GnHR analogue treatment (Lueprorelin Acetate, Depot Lucrin™) to achieve pubertal suppression ("Stage 1 Treatment") is not treatment of a type for which authorisation by this Court pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act") is required.

3. To avoid doubt, it is declared that … and/or … (Sam's parents) can consent to the treatment referred to in the preceding paragraph on Sam's behalf.

Stage 2 Treatment

4. The proposed treatment for Sam, being the administration of Oestradiol Valerate in such dose, in such manner and with such frequency as determined in consultation with her treating medical practitioners to induce female puberty (Stage 2 Treatment), is of a type for which authorisation by this Court pursuant to s 67ZC of the Act is required.

5. By this Order, Sam's parents are authorised to consent to the Stage 2 Treatment on behalf of Sam, under the guidance of Sam's treating medical practitioners including but not limited to her Endocrinologist, Professor H and her Psychiatrist Dr T.

IT IS FURTHER ORDERED THAT

6. So as to protect Sam:

    a. Sam's full name, her family members, her medical practitioners, this Court's file number, the State of Australia in which the proceedings were initiated and any other fact or matter that may identify Sam shall not be published in any way;

    b. Only anonymised Reasons for Judgment and Orders (with coversheets excluding the registry, file number, and lawyers' names and details, as well

as Sam's real name) shall be released by the Court to non-parties without further contrary order of a judge;

c. No person shall be permitted to search the Court file in this matter without first obtaining the leave of a judge.

7. To the extent that the exception provided for in s 121(9)(g) of the Act or the other provisions of that subsection do not otherwise authorise same, the applicants shall have leave to publish to Sam's treating medical practitioners a version of these Reasons which does not encompass the restrictions set out in paragraph 6.

IT IS DECLARED IN RESPECT OF THE CHILD TERRY (… born … 1997) THAT:

8. As at 31 July 2013, Terry is not competent to give informed consent.

Stage 1 Treatment

9. The treatment recommended to be administered to Terry in respect of his Gender Dysphoria, namely the administration of GnHR analogue treatment Lueprorelin Acetate (Depot Lucrin™) to achieve pubertal suppression ("Stage 1 Treatment") is not treatment of a type for which the Court is required to give authorisation pursuant to s 67ZC of the Act.

10. To avoid doubt, it is declared that … and/or … (Terry's parents) can consent to the treatment referred to in the preceding paragraph on Terry's behalf.

Stage 2 Treatment

11. The proposed treatment for Terry, being the administration of Testosterone Enanthate in such dose, in such manner and with such frequency as determined in consultation with his treating medical practitioners to induce male puberty (Stage 2 Treatment), is of a type for which authorisation by this Court pursuant to s 67ZC of the Act is required.

12. By this Order, Terry's parents are authorised to consent to Stage 2 Treatment on behalf of Terry, under the guidance of Terry's treating medical practitioners including but not limited to his Endocrinologist, Professor H and his Psychiatrist, Dr T.

IT IS FURTHER ORDERED THAT

13. So as to protect Terry:

a. Terry's full name, his family members, his medical practitioners, this Court's file number, the State of Australia in which the proceedings were

initiated and any other fact or matter that may identify Terry shall not be published in any way;

b. Only anonymised Reasons for Judgment and Orders (with coversheets excluding the registry, file number, and lawyers' names and details, as well as Terry's real name) shall be released by the Court to non-parties without further contrary order of a judge;

c. No person shall be permitted to search the Court file in this matter without first obtaining the leave of a judge.

14. To the extent that the exception provided for in s 121(9)(g) of the Act or the other provisions of that subsection do not otherwise authorise same, the applicants shall have leave to publish to Terry's treating medical practitioners a version of these Reasons which does not encompass the restrictions set out in paragraph 13.

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

FAMILY COURT OF AUSTRALIA

FILE NUMBERS: File numbers suppressed by court order

The parents of Sam
Applicants

The parents of Terry
Applicants

REASONS FOR JUDGMENT

1. Two sixteen-year-old children, A (born in 1997) and B (born in 1997) suffer from Gender Dysphoria. Their respective parents each bring proceedings seeking orders which, in effect, authorise them to consent to treatment on behalf of their children.

2. The issues raised by each such application are effectively identical. Each child has consulted the same endocrinologist (who has proposed the treatment the subject of the applications in each case). Each child has consulted the same psychiatrists. They, too, support the proposed treatment. In those circumstances, I determined (with the consent of all parties in each case) to hear the two applications together and to give this one set of Reasons.

3. I am, of course, acutely aware that there are two decisions to be made – if indeed it is appropriate for the Court to make a decision at all. If an order is to be made, it must be determined as in the best interests of each child, by reference to each child's individual circumstances.

4. The Director-General of the relevant government department intervened, with the consent of all of the parties, and whilst no material was filed or read on the Director-General's behalf, submissions were made which supported the applications.

5. Neither the applicants, nor the Director-General sought the appointment of an Independent Children's Lawyer for either of the children. In circumstances where the expert evidence that the proposed treatment is urgently required is unanimous, the children's views are reflected in the proposed treatment (and have been put before the Court via affidavits, which will be addressed in more detail shortly), and the applicants, being the child's parents in each case, seek orders consistent with the treatment proposed by the experts, I considered that

it was not necessary to delay the final determination of the applications so as to appoint Independent Children's Lawyers for either child.

THE RESPECTIVE CONDITIONS AND THEIR CONSEQUENCES?

6. Child A shall be known in these Reasons as Sam, the name she has adopted. Sam is genetically and anatomically male in every respect. However, she identifies as female. The female pronoun will be used in respect of her throughout these Reasons.

7. Child B shall be known in these reasons as Terry, the name he has adopted. Terry is genetically and anatomically female in every respect. However, he identifies as male. The male pronoun will be used in respect of him throughout these Reasons.

8. Unanimous, extensive expert evidence, to which reference will shortly be made, is firm that each child suffers from a condition that meets the DSM-5 Gender Dysphoria (previously called "Gender Identity Disorder in the superseded DSM-IV). Indeed, the expert psychiatrists are agreed that both children meet the diagnostic criteria applicable to both children and to adolescents and adults:

> **Gender Dysphoria in Children**
>
> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
>
> 1. 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).
>
> 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
>
> 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
>
> 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
>
> 5. A strong preference for playmates of the other gender.
>
> 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

What Circumstances Affect Terry?

9. Terry, who has also been diagnosed with Asperger's Disorder, has, according to his father, "never liked doing typical girl things, like playing with dolls". Terry's father deposes that from "early childhood [I knew] that there was something very different about [[Terry]]. I knew that it was something different to being a 'tom boy', although I do not think that I could have explained what I noticed in [Terry] at that stage." Terry's father says that from about the age of seven or eight Terry started to cut his hair very short and when he was about 12 years old, "[Terry] started to talk about being a boy. He would only wear boy's clothes." His father says that Terry did not wear dresses after he was in about grade three at school, and if he was forced to wear the girl's school uniform, he would wear the girl's shorts.

10. Terry's mother deposes that from about the age of three, Terry refused to wear "pink or dresses or anything frilly" and from that time, she purchased clothes for Terry which were "gender neutral". Terry's mother also says that "[i]n about 2010 (when [Terry] was about 13 years old) he started to talk a lot … about being a girl. He told me that he hated being a girl and that he had been born in the wrong body and was really a boy."

11. During the hearing, counsel for Terry's parents sought leave to file an affidavit sworn by Terry, notwithstanding the provisions of s 100B(1) of the *Family Law Act 1975* (Cth) ("the Act"). In light of Terry's age, the nature of the disorder he is suffering from and the issues for determination in these proceedings, I granted leave to file and rely upon the affidavit. For similar reasons, I allowed Terry to be present in Court with his parents. In taking this unusual step, I considered:

- Terry's age and his level of maturity as revealed by the evidence;
- Expert opinion that Terry had both understanding and insight into his condition and his circumstances (albeit that the experts were agreed he was not "Gillick competent");

- The nature of the disorder and the number and nature of the psychological and medical consultations he had undertaken;
- My view that his voice should be heard in the proceedings and that the affidavit gave him an opportunity to do so in his own words;
- The fact that no conflict attends his parents between themselves and no conflict attends theirs and his position and those of the treating experts;
- His parents have given him unwavering support and what I consider to be the importance of each observing, respectively, the support given and the support received.

12. In his affidavit, Terry describes feeling "like a boy" "for as long as [he] can remember." Terry also recounts trying to cut his wrists "with a blunt pair of scissors" when his "periods began". Terry states that he is "here today, waiting for the treatment to be approved so I can go on and live my life like a normal teenage boy."

13. Terry's diagnosis of Gender Dysphoria arose after his father took him to the Emergency Department at a Hospital in 2011. His father had noticed what appeared to be "scars" on his chest, and thought that Terry had been self-harming. As it eventuated, Terry had been binding his breasts with electrical tape, which had resulted in serious abrasions. It was as a result of his admission to the Emergency Department that Terry received a tentative diagnosis of Gender Dysphoria.

14. Following his discharge, Terry was referred to Dr T, a consultant child and adolescent psychiatrist at the X Hospital and clinical director of a state children's health facility. Dr T first consulted with Terry in January 2012 and has seen Terry over ten times since then. In a report attached to an affidavit filed 15 July 2013, Dr T records that as a result of Terry's diagnosis of Asperger's Disorder, he was initially referred for a speech and language assessment and that Terry's results all fell within the average range for his age.

15. In terms of Terry's Gender Dysphoria, Dr T reports that there is a history of self-harm and suicidal ideation directly associated with that condition, but that Terry has benefited from psychological counselling and a trial of Fluoxetine which has "resulted in a subjective improvement in his overall mood". Dr T records Terry as stating that he has identified as being male "for as long as I can remember" and that he admitted "wishing that he was male since about five years of age". Dr T also notes that Terry stated that he has "always" dressed as a boy and "uses male changing rooms whenever possible" and that he now dresses exclusively as male and "wears unisex or male uniforms at school."

16. As with Sam, Terry's pubertal development is well advanced. As a result, Terry regularly experiences menses, which he describes to Dr T as "five days of torture every month … I hate who I am … I pray that it won't happen, then I

am depressed for five days … Nature playing a cruel joke every darn month." Dr T reports that during Terry's period he becomes "increasingly depressed and agitated" he often will not go outside and that, because Terry:

> … tries not to look at his genitals, due to the distress this causes, he is unable to use pads or tampons, describing it as too distressing to place the sanitary products 'down there'. Instead, he prefers to use pull-up 'nappies' as they are easier to pull off and on and he does not have to touch his genitals.

17. Terry's parents changed his school in late 2012 and since that time, Terry has been attending his new school exclusively as a male and "all his peers believe he is male". According to Dr T, Terry "fulfils the DSM-IV diagnostic criteria for Gender Identity Disorder (GID[1]). Based on his current age, [Terry] would fulfil the criteria for Gender Identity Disorder in Adolescents or Adults (F302.85), though had the symptoms as a child."

18. Dr T also notes that Terry would fulfil the DSM-IV diagnostic criteria for "recurrent, moderate, major depressive disorder". Terry's Gender Dysphoria "contributes to his symptoms of depression" and as noted earlier, Terry continues to take Fluoxetine (an antidepressant) daily. Terry is also attending psychological counselling, and has been referred by Dr T to a psychologist who has experience working with clients with Gender Dysphoria.

19. Dr T opines that it would be in Terry's best interests that he commence Stage 1 and Stage 2 hormone treatment (which will be discussed in more detail shortly) simultaneously and without delay.

20. Dr T describes the risk of not providing hormone treatment to Terry as including "the exacerbation of [Terry's] existing symptoms of anxiety and depression". According to Dr T "ongoing delay would increase [[Terry's]] risk of self-harm and even suicidal ideation. Terry's Gender Dysphoria has also contributed to difficulties socialising and developing a consistent supportive peer group. Delay would impact in his social skills; he remains anxious about being ostracised and 'outed' by his peers". Dr T can see no "purpose to delay[ing] such intervention until [[Terry]] is 18 years of age"; doing so "may increase [Terry's] anxiety and exacerbate his existing symptoms of depression".

21. In addition to Dr T, Terry has also consulted with another child, adolescent and adult psychiatrist, Dr M, who has provided a second opinion in respect of Terry's diagnosis of Gender Dysphoria. In a letter to the solicitor for the applicants, dated 15 January 2013, and attached to an affidavit filed 15 July 2013, Dr M says under the heading "Diagnosis" that Terry has a history of

---

[1] As noted by Dr T in his report, the DSM-5, which was released in mid-2013, has replaced the term "Gender Identity Disorder" with "Gender Dysphoria".

Gender Dysphoria "since a very young age of around three or four years of age":

> … [Terry] reported a classical history of gender dysphoria, of being considered a tomboy, of never being involved in female activities or interests. [Terry] has always associated with boys, been interested in boy areas, been involved in boy activities and considered himself a boy for as long as he can remember.

22. Dr M confirmed Dr T's diagnosis and noted his agreement with the treatment proposed by Professor H (discussed below), namely that Terry commence (simultaneously) Stage 1 and Stage 2 hormonal treatment as soon as possible. According to Dr M, any delay in that treatment would:

> … serve no purpose and lead to an escalation in [Terry's] level of distress and continued social difficulties for [Terry]. For example, the difficulties [Terry] has in dealing with his menstrual cycle each month within the school setting. [Terry] has always experienced Gender Dysphoria for as long as he can remember. These ideas have been constant and consistent in their nature and intensity. From my experience, they will not change and to delay treatment is to cause unnecessary distress and social integration difficulties for [Terry] during the time of adolescence…

23. In addition to Drs T and M, Terry has also consulted with Professor H, an endocrinologist and Professor of Paediatrics. In a letter to the solicitor for the applicants dated 4 June 2013, and attached to an affidavit filed 15 July 2013, Professor H records that she first met Terry and his father on 21 December 2011. She then met Terry and his father again on 7 February 2012, had an appointment with Terry on his own on 18 July 2012 and met again with Terry and his parents on 13 February 2013. Professor H reports that various baseline investigations have revealed that there is no genetic or hormonal disorder causing Terry's Gender Dysphoria; Professor H has "been unable to determine any abnormal medical or endocrinal reason for [Terry's] condition".

24. In terms of the treatment proposed for Terry, Professor H describes it as involving two stages:

> … The first stage will be pubertal suppression which will be achieved by administration of intramuscular GnHR analogs (leuprorelin acetate). This stage is completely reversible. The second stage of treatment would be administration of intramuscular testosterone esters with the aim of inducing male puberty. The treatment with intramuscular testosterone will induce irreversible physical changes.

25. In terms of the first stage, which involves pubertal suppression, Terry will be administered Depot Lucrin in a dose of 22.5mg every three months via

injection, with such dose and frequency to be potentially revised to achieve complete pubertal suppression. Terry will also receive injections of intramuscular testosterone as part of Stage 2 treatment with the dose to begin with 25mg/m^2 every two weeks increasing at six monthly intervals to a maximum of 100mg/m^2 every two weeks. Professor H reports that the proposed treatment is based on the Endocrine Treatment of Transsexual Persons; and Endocrine Society Clinical Practice Guideline published in the Journal of Clinical Endocrinology and Metabolism in September 2009, which has been adopted by the Australasian Paediatric Endocrine Group. Professor H also records that the proposed treatment is consistent with the recommendations in the American Endocrine Society Clinic Practice Guideline and is similar to treatment approaches in other centres in Australia.

26. Under the heading "Likely Long term physical effects on [Terry]" Professor H sets out what will occur as a result of Terry taking both the Stage 1 and Stage 2 hormones. Taking the Stage 1 hormones will achieve pubertal suppression, however, as Professor H notes, this treatment is completely reversible and "has no long-term negative impact on fertility or reproductive health". The Stage 2 hormone treatment, however, would, according to Professor H:

> … bring about increased muscle mass and decreased fat mass, increased facial hair and acne, the potential for male pattern baldness and increased libido. Testosterone will also result in clitoromegaly, temporary or permanent decreased fertility, deepening of voice and usually cessation of menses.

27. Professor H also outlines the risks associated with the proposed treatment. As noted, the effects of Lucrin, being the Stage 1 hormone treatment, are completely reversible. The administration of testosterone as proposed, however, is associated with:

> … a high long term risk of serious adverse outcomes, including breast or uterine cancer, and erythrocytosis with a haematocrit greater than 50%. There is also a moderate to high risk of severe liver dysfunction and temporary or permanent decreased fertility. The risks associated with treatment cannot be reduced, hence very careful monitoring is essential.

28. Professor H records that in her opinion "the proposed treatment is necessary for Terry's welfare as his mental health is being adversely affected by his current physical and hormonal status" and to delay treatment would result in Terry's "body habitus continuing to be female including breast development and body fat distribution. [Terry] would also continue to menstruate. This could adversely affect [Terry's] mental health."

What are Sam's Circumstances?

29. Sam's diagnosis of Gender Dysphoria arose out of what is now understood to be significant comorbid depression and general anxiety.

30. As with Terry, counsel for Sam's parents sought leave to file an affidavit sworn by Sam. While wishing to express her views in that form, Sam did not wish to be present in court. Both of her parents were in court. For the same reasons given in respect of Terry's affidavit, I granted leave to file the affidavit sworn by Sam.

31. In that affidavit, Sam describes feeling "internally that I was a girl" and "want[ing] to become a girl" since she was five. Sam further deposes that the proposed treatment will "make my way of life more normal as a girl as it always should have been."

32. Each of Sam's parents deposes to having "no particular concerns about [Sam] until about 2011". Sam's father states "there was nothing during [Sam's] childhood that caused me to think that she was identifying as a female". However, in late 2010/early 2011, Sam's parents became aware that she was self-harming. Sam subsequently attended upon a child psychologist at P Support Service. In April 2012 Sam's father received a phone call from Sam's then-school to notify him that Sam was not at school. Sam's father deposes to having found Sam outside the school grounds; he arrived "as the ambulance and police were arriving". Sam had telephoned the ambulance for assistance after she cut her arms.

33. As a result of that incident, Sam was admitted to the Adolescent Mental Health Ward at the Z Hospital. It appears that Sam was not diagnosed with Gender Dysphoria during that admission. Subsequent to her discharge, her parents depose to an escalation in the issues previously experienced by her. According to Sam's father, Sam would "break out of the house and cut her arms or legs" and Sam's mother found a number of "suicide notes".

34. Sam's mother deposes that on 31 May 2012, during their drive home from school, "[Sam] asked her 'if I would help her if we had lots of money'. I said that 'of course I would'. I recall [Sam] then saying 'I feel like I am a girl' and 'I am a girl'". Subsequent to that conversation, Sam's parents took her to a general practitioner, who then referred Sam and her parents to Dr M, who has earlier been referred to.

35. Dr M first saw Sam and her family on 24 July 2012. In a report attached to an affidavit filed 15 July 2013, Dr M notes that Sam:

> … reported that since the age of five she has experienced feelings of Gender Dysphoria. She reported at times during her early childhood years dressing in female clothes, never having male friends, never being involved in classical male-type activities, hobbies or sports-related activities. [Sam]

> reported that she kept these feelings secret. She did not share these feelings with friends at school or family members until quite recently in early 2012.

36. Dr M also records that "[Sam] stated she continues to dislike her male genitalia … she reported thoughts of removing her male genitals and indeed had self-harmed in her genitals on one occasion in early 2012." At the time Dr M first saw Sam, she was involved in "…, an adolescent transgender support group which holds regular social events …. She had also been involved in counselling with an experienced transgender psychologist …"

37. Subsequent to the first consultation on 24 July 2012, Dr M met with Sam on six further occasions. Under the heading "Diagnosis", Dr M reports that:

> [Sam] satisfies the DSM-IV diagnostic criteria for Gender Identity Disorder. She has strong and persistent cross-gender identification. She has thought since a young age that she has always been a girl. She lives as a girl, wearing female clothes. She has discussed her transgender Dysphoria with her parents and also told her friends and extended family.

38. Whilst at the time of his report, Dr M had not been apprised of the proposed treatment plan for Sam, he proceeded to address the likely long term social and psychological effects for Sam if treatment, including the commencement of hormones which will feminise her body, were delayed. As will be discussed shortly, the proposed treatment for Sam comprises, as with Terry, the simultaneous administration of both Stage 1 and Stage 2 hormones.

39. According to Dr M, if Sam is treated with feminising hormones (Stage 2), this will lessen her psychological distress due to her Gender Dysphoria as it will "enable her to live as the adolescent girl, who she sees herself as, and will therefore improve her psychological well-being, correct her sense of identity and sense of self." If the proposed treatment is not provided, Dr M opines that "this … will increase her level of psychological distress and may well precipitate a psychological decompensation as happened in early 2012 where [Sam] was self-harming involving deliberate self-harm directed at her male genitalia."

40. Dr M considers delaying the treatment "will serve no purpose and will lead to an escalation in [Sam's] level of distress and will more than likely cause a re-occurrence of psychological and psychiatric disorder."

41. In addition to Dr M, Sam has also consulted with Dr T. In a report dated 4 July 2013, attached to an affidavit filed 15 July 2013, Dr T notes that Sam had first attended on his clinic on 10 December 2012 and had subsequently attended upon him on four other occasions. Dr T reports that Sam "presented with long-standing, well documented history of Gender Dysphoria since early childhood. Since adolescence, her Gender Dysphoria has escalated and has been complicated by significant, co-morbid depression, general anxiety and a range

of other mental health problems, including an eating disorder and social anxiety".

42. Dr T notes further that prior to his assessment of Sam in December 2012, "[Sam's] severe, undisclosed Gender Dysphoria has led to suicidal ideations and multiple episodes of self-harm". Dr T records, by reference to the discharge summary following Sam's admission to the Adolescent Inpatient Unit ("AIU") at the Z Hospital in May 2012, and also his communications with Dr L and Dr S who is noted as the clinical director of the AIU, that it was during her admission in May 2012 that Sam "stated that [she] had been struggling with [her] sexual identity, and in retrospect [her] gender identity since approximately eight years of age."

43. Subsequent to her discharge, Sam consulted with another psychiatrist at the Child and Youth Mental Health Service and a mental health nurse at the same facility. As a result of those consultations, Sam disclosed to her parents her "transgender identity".

44. Dr T reports that following his assessment of Sam, he concluded "that [Sam] met the DSM-IV diagnostic criteria for Gender Identity Disorder (to be known as Gender Dysphoria in the new version of the DSM-V) and referred [Sam] and her family to [Ms Y] for psychological support in the community."

45. In February this year, Sam was again admitted to the AIU as a result of a "rapidly developing, severe eating disorder, characterised by extreme pre-occupation with caloric intake, marked restrictive eating patterns, and episodes of purging." Dr T reports that Sam "had become pre-occupied with the emergence of coarse hair in a male pattern [and] she admitted believing that starving herself would decrease her own testosterone pattern, resulting in a reduction in break-through masculine secondary sex characteristics."

46. Sam has been taking Androcure and Diane-35 which is a combination of Oestradiol and Cyproterone as a means of reducing her secondary male characteristics. Whilst this regime has had some effect, as both Dr T and Professor H note, this regime does not meet the international practice guidelines, which are reflected in the treatment proposed by Professor H to be discussed shortly.

47. Dr T states in his report that Sam continues to experience "significant symptoms of anxiety and social phobia; at times, she is essentially housebound." Sam and her family have continued to engage in therapy with Ms Y and Sam has continued to take Fluvoxamine and Seroquel XR to treat her "anxiety and low mood."

48. As with Dr M, Dr T outlined the likely long-term physical, social and psychological effects of the proposed treatment for Sam. In Dr T's view, the hormone treatment "will reduce the risks of mental health problems" and

development of a female body habitus on hormone treatment will "likely reduce social anxiety and improve social functioning". According to Dr T, delay in providing treatment to Sam would result in ongoing Gender Dysphoria "with its associated mental health issues, with a significant risk of further suicidal and self-harming behaviours."

49. Sam has also consulted with Professor H, the endocrinologist whose recommendations in respect of Terry have been referred to earlier. Professor H's recommendations in respect of Sam are contained in a letter dated 4 June 2013 which is attached to an affidavit of Professor H filed 15 July 2013. In that letter, Professor H reports that baseline biochemical tests and chromosome analysis indicates that there is no endocrine reason for Sam's condition. Professor H also notes that Sam has been taking medications consisting of Androcure and Diane-35 to supress male hormone levels, the effect of which is that Sam's hormonal levels are consistent with female hormonal levels.

50. Professor H goes on to set out the treatment proposed for Sam:

> Stage 1: Pubertal suppression. This will be achieved by the use of GnRH analogue treatment (Leuprorelin Acetate, Depot Lucrin™). This treatment is completely reversible.
>
> Stage 2: This phase of treatment involves induction of female puberty. This will be done using oral Progynova (Oestradiol Valerate). The dose will initially be 1mg daily for 12 months, then increase to 2mg/day ongoing.

51. According to Professor H, the likely long term physical effects of the proposed treatment on Sam are as follows:

- Stage 1 of the treatment is entirely reversible;
- Stage 2 of the treatment "will bring about redistribution of body fat, decrease in muscle mass and strength, softening of the skin and decreased oiliness, decreased libido and erections, male sexual dysfunction, breast growth, decreased testicular volume, decreased sperm production, and decreased terminal hair growth. There is likely to be a long term adverse effect on fertility with a reduction in testicular size and sperm production…"

52. According to Professor H, if the treatment is not provided "there is a very high risk for [Sam's] mental health … There is also a high risk that [Sam] will illicitly seek medications to supress endogenous male hormone levels, and that this treatment would be unsupervised and therefore unsafe."

53. As noted with Terry, there is minimal risk associated with the Stage 1 treatment. Similar to Terry's position, there are, though, significant risks associated with the Stage 2 treatment. The most serious risk, according to Professor H, of the proposed oestrogen hormone treatment, is a risk of veinous thromboembolism (blot clots). There are however, means of mitigating the risk of thromboembolism, and Professor H proposes implementing those means of mitigation if the proposed treatment for Sam is authorised. Other risks associated with the oestrogen hormone treatment include gallstones, abnormal liver function, weight gain, high blood triglyceride levels, cardiovascular disease, hypertension, hyperprolactinoma or prolactinoma, type 2 diabetes and breast cancer.

54. As with Terry, Professor H notes that the proposed treatment is consistent with the international practice guidelines published in the Journal of Clinical and Endocrinology and Metabolism, which has been adopted by the Australasian Paediatric Endocrine Group and is consistent with treatment plans adopted in other hospitals in Australia. In Professor H's opinion, the treatment cannot be delayed until Sam is 18 as a result of the fact that Sam is "already suffering significant mental health co-morbidities, including self-harming behaviour." Further, in light of the suboptimal treatment regime which Sam and her parents have sourced for her, there is the significant risk, as Professor H recognises, that Sam may well seek illicit unsupervised treatment of her condition, which would carry significant medical risks.

DOES THE COURT HAVE JURISDICTION?

Should the Court Intervene in Parental Decision Making?

55. The evidence plainly reveals two sets of loving, caring, committed parents motivated solely to do what is best for their respective child who, plainly, they love deeply. Equally, the evidence reveals that each set of parents has faced the very significant challenges posed by their child's condition with intelligence, compassion and courage. Their care and commitment has extended to consulting and working with medical practitioners who, on any view, have very significant expertise in dealing with conditions of the type under discussion. It can also be gleaned from the evidence that those medical experts are themselves dedicated to caring for these children with compassion and commitment.

56. There is, then, wholly absent from the current circumstances either of the two broad foundations which, in the usual course of events, the law has for intervening in the lives of parents seeking to parent as they see fit. First, within the province of the laws and courts of the States, is the asserted right of the State exercised on behalf of the community to remove children from parents and/or remove rights from parents when it is determined that those

rights should be forgone by reason of the inability, incapacity or unwillingness to protect children from significant risks of harm. The second major limitation, within the province of Commonwealth law and this Court, occurs when parents, or others properly concerned with the care, welfare and development of children, are in conflict and unable to agree and, as a result, seek orders from the Court. The justification for interference with parental rights in that situation rests in the rule of law; in a civilised society, a coherent system of principles and impartial adjudication should prevail over unprincipled disorder.

57. However, if, as in each case here, neither of those two broad justifications for intervention in the rights, duties and responsibilities inherent in responsible parenting exists, does this Court have jurisdiction and power to intervene? More fundamentally, by reference to what principles does the law seek to intervene in what might be seen as a fundamental right for parents to parent according to what they consider is in their child's best interests?

58. Examples of the justification for intervention by this Court in parental decision-making in situations of the instant type are given by Nicholson CJ *In re Jane* (1989) FLC 92-007 (at 77,256):

> The consequences of a finding that the Court's consent is unnecessary are far-reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious or quasi-cultural reasons, or the sterilisation of a perfectly healthy girl for misguided, albeit sincere, reasons. Other possibilities might include parental consent to the donation of healthy organs such as a kidney from one sibling to another.

In *Re Alex: Hormonal treatment for gender identity dysphoria* (2004) FLC 93-175 the former Chief Justice gives the example of the decision in *Re GWW and CMW* (1997) FLC 92-748 where it was proposed to harvest bone marrow blood cells from a healthy child so as to transplant them to the child's aunt who was suffering from leukaemia.

59. In those cases, and others like them, the Court's intervention is justified on the basis that the Court should have a role in safeguarding children including, in some cases, where decisions are sought to be made by loving and caring parents.

60. An integral part of that role is to preserve a child's right to later make for themselves important decisions including, crucially, the broader right to become the adult that he or she wishes. The recognition of that can be seen in the Court ordering that treatment not take place so as to preserve a later Gillick-competent or adult decision by the child (see, for example, *Re Jodie* [2013] FamCA 62, *Re Jamie (Special medical procedure)* [2011] FamCA 248, *Re Brodie (Special Medical Procedure)* [2008] FamCA 334). Those same factors can also see distinctions being made by the Court in respect of the nature of the

proposed treatment or procedure which is authorised and, in particular, whether the proposed treatment is reversible or not (see, for example, *Re Alex: Hormonal Treatment for Gender Identity Disorder* [2004] FamCA 297 and *Re Lucy (Gender Dysphoria)* [2013] FamCA 518).

61. Particular challenges and difficulties attend situations where a child, by reason of the nature and severity of their disabilities, will never attain Gillick-competence and parents seek to make decisions with irreversible and serious consequences for that child's future life. Decisions in those sorts of cases may involve conflicting positions being taken by, for example, the child's parents and those who argue that such actions impinge on the rights and dignity of disabled persons (examples include, *Re a Teenager* (1989) FLC 92-006 and *In re Jane*).

62. If this Court is to assume the role just outlined, questions must be asked about its jurisdiction to intervene and the circumstances that govern the exercise of power when it does so.

A Question of Parental Responsibility?

63. For the purposes of the Act, each parent has, by reason of being a parent, "parental responsibility" for their child (s 61C). All parents, including the parents of Terry and Sam, have, as a result, "all the duties, powers, responsibilities and authority which, by law, parents have in relation to children" (s 61B). Those rights, duties and authority include, in the usual course, consenting to medical treatment or procedures for their children. No order of the Court is required, in the usual course, for parents to give permission for treatment or procedures for those children – doing so falls within the ambit of parental responsibility (*Secretary, Department of Health and Community Services v JWB & SMB (Marion's Case)* (1991) 175 CLR 218).

64. However, the right and authority of parents to make decisions in respect of medical treatment or procedures is subject to two broad limitations relevant to the present discussion.

65. First, when a child is "Gillick-competent", they can themselves give informed consent to medical treatment or procedures. That principle emerges from *Gillick v West Norfolk A.H.A* [1986] AC 112. The test of whether a child is capable of giving informed consent is when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed." The principle and test is part of the law of Australia (*Marion's Case* at 238, per Mason CJ, Dawson, Toohey and Gaudron JJ). A decision that a child is Gillick-competent brings with it the consequence that the child's informed consent takes precedence over the wishes – indeed, instructions – of his or her parents about that treatment or procedure.

66. Secondly, in circumstances where a child is not Gillick-competent, there exists a narrow band of "special cases" involving medical procedures in respect of which parents cannot give informed consent on behalf of the child and court authorisation is necessary. Within that narrow band of cases, because informed consent cannot be given by *either* child *or* parent there is, absent a court order, no basis upon which a medical practitioner can lawfully proceed to administer the treatment or perform the procedure.

67. An adult of full capacity can give consent for such treatment or procedures as they see fit. A Gillick-competent child is, for the purposes of giving informed consent, in the same position as an adult; he or she can give informed consent for whatever treatment or procedures they see fit[2]. However, ahead of adulthood or Gillick-competence, lies territory in which the Court must, if satisfied of its appropriateness in the child's best interests, provide the requisite authority so as to permit the treatment or procedure. (Additionally, as mentioned, there are cases where, by reason of disability, a child will never achieve Gillick-competence of which *Marion's Case* is an example).

68. This Court has jurisdiction to hear and determine matters within Part VII, and to make orders under that Part, in respect of both children of a marriage and ex-nuptial children (see the discussion, for example, in *Re Lucy*). The Court has jurisdiction and power to make "parenting orders" which can include orders in respect of "any aspect of the care, welfare or development of the child or any other aspect of parental responsibility for a child" (s 65D; ss 64B(1) and (2)(i)). Some disputes (for example, a dispute between separated parents as to whether a routine medical procedure should take place) can be the subject of parenting orders because the subject of those orders is within the purview of parental responsibility – specifically, the right and authority of a parent to consent to routine medical treatment.

69. The reference to "routine" medical treatment is made so as to raise a point of distinction with other forms of medical treatment or procedures the authorisation of which does not fall within the ambit of parental responsibility. The distinction is demanded by reason of the decision in *Marion's Case.* The plurality in that case held (at 257) that "… the Family Court has no power … to *enlarge the powers* of a guardian [or parent] … so that he or she can consent to [treatment falling within the narrow band of special cases requiring authorisation]" (emphasis added).

70. As a result, within the narrow band of "special cases" to which that statement is directed, the Court's jurisdiction and power to make the relevant order is not to be found by reference to Part VII's provisions relating to "parenting orders", including, in particular, parenting orders dealing specifically with aspects of the

---

[2] It is appreciated that, at a practical level, a conservative approach might be adopted by medical practitioners to the question of whether a child is Gillick-competent and that discussions between medical practitioners, child and parents may well occur.

parental responsibility for a child (ss 64B(1) and (2)(i)). As *Marion's Case* makes clear, the orders sought by each of Terry's and Sam's parents require the Court to exercise the jurisdiction purported to be conferred upon it by the terms of s 67ZC of the Act – that is, the so-called "welfare jurisdiction".

The "Welfare Jurisdiction"

71. Recently, in *Re Lucy* I attempted to examine the path by which jurisdiction is given by reference to that section. I hold to the views I expressed there, in particular at [30]-[36]. Specifically, as the High Court has made clear, although the term "welfare jurisdiction" is frequently used to describe the jurisdiction exercised by the Court referenced to s 67ZC when making orders authorising a medical procedure, that section is not, despite its wording, itself a source of jurisdiction. If the power is to be validly exercised, jurisdiction must be found by "attaching" s 67ZC to a "matter" contained, relevantly, in Part VII.

72. *Re Lucy* involved an application by a government department, not a parent. The jurisdictional difficulties potentially confronted as a result of that fact are not confronted here. The applicants in each of the proceedings here are parties to a marriage, and each subject child is a child of a marriage. As a result, the jurisdiction conferred by s 67ZC can readily attach to a matter within Part VII, namely the parental responsibility of each of Sam's and Terry's parents.

73. Section 67ZC, "attached" to the "matter" of parental responsibility, provides, then, the jurisdiction for the Court to make orders of the type sought.

74. Given jurisdiction, two further questions must be answered before power is exercised to make the orders sought. Are either of Terry or Sam Gillick-competent and, if not, is the proposed treatment of the nature and type for which court authorisation is required?

Gillick-Competence

75. Each of Dr T and Professor H are of the view that neither Terry nor Sam is Gillick-competent. The applications themselves are an indication that each of the parents agree. The Department does not suggest otherwise.

76. While I accept that each of Terry and Sam evidence a significant degree of maturity and insight into their respective conditions, no other evidence before me suggests the requisite sufficiency of understanding so that it might be concluded that either child "understand[s] fully" what is proposed and, thus, is Gillick-competent.

The Nature of the Proposed Treatment – "Special Cases"

77. The fact that neither Terry nor Sam is Gillick-competent raises, as the plurality in *Marion's Case* identified, the "second question"; does the proposed treatment come within the "kinds of [medical treatment] which are, as a general

rule, excluded from the scope of parental power to consent to …" (at 396). It can be seen that the question posits the nature (or, perhaps, extent) of the medical treatment at the centre of the question necessary to be answered as a pre-condition to the necessity for the Court to exercise power. As the judgments in that case expressly make clear, the distinction between treatment for which authorisation is required, and treatment for which it is not, is not always easy to draw.

78. Brennan J held (at 419 and 427):

> 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.
>
> …
>
> … Limits on parental authority are imposed by the operation of the general law, by statutory limitations or by the independence which children are entitled to assert, without extra-familial pressure, as they mature. Within these limits, the parents' responsibilities and powers may be exercised for what they see as the welfare of their children. Within those limits, the parents' authority is wide enough to permit them to authorise therapeutic medical treatment for a child, whether or not the child consents to the administration of that treatment. A fortiori, if the child is incompetent to give consent, whether by reason of age, illness, accident or intellectual disability, *the parents have the responsibility and power to authorise the administration of therapeutic medical treatment, whether or not that treatment involves sterilisation. Such a power is exercised without question when the treatment does not involve sterilisation … It cannot be right to deny therapeutic treatment to a child unless the parents first obtain the leave of a court.* The power to authorise therapeutic medical treatment exercisable by parents who are guardians and custodians of a child is exercisable by duly appointed guardians and custodians according to the nature of the treatment and the urgency with which it needs to be administered.
>
> (Emphasis added in each case)

79. The plurality (Mason CJ, Dawson, Toohey and Gaudron JJ) held (at 404)[3]:

> We hesitate to use the expression "therapeutic" and "non-therapeutic", because of their uncertainty. *But it is necessary to make the distinction, however unclear the dividing line might be*.
>
> … As a starting point, sterilisation 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 authorise sterilisation as a special case. Court authorisation 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*.
>
> (Emphasis added in each case).

80. In *Re Alex*, Nicholson CJ was confronted with factual circumstances virtually identical to those which, in this case, pertain to Terry. There is of course the important distinction that Alex, at 13, was younger than Terry. However, the treatment proposed in that case (both Stage 1 and Stage 2) was, relevantly, the same as that proposed for Terry. In referring to the issues arising from the decision of the High Court in *Marion's Case* just referred to, the former Chief Justice said:

> 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. To my mind, *their Honours were seeking in that case to distinguish medical treatment which seeks to address disease in or malfunctioning of organs*. In the context of sterilisation for example, they would seem to have had in mind a malignant cancer of the reproductive system which required an intervention that was medically indicated for directly referable health reasons. *The present case does not lend itself to such a comparison*.
>
> 196. In light of my analysis in this section, I am therefore satisfied that the treatment plan in the present case falls within the category of cases that require court authorisation. 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.

---

[3] Whilst the plurality in *Marion's Case* did not specifically refer to "psychiatric conditions", they did not seek to distinguish "malfunction" and "disease", the therapeutic treatment of which parents could consent to in the exercise of their parental responsibility, from "psychiatric conditions" as referred to by Brennan J.

> Also, *it cannot be said on the evidence that the treatment is to cure a disease or correct some malfunction.*

(Emphasis added in each case).

81. With the greatest of respect to the former Chief Justice, I respectfully do not agree that a finding that a particular condition falls outside those described by the plurality in *Marion's Case* as "a special case" leads to a finding that the treatment would "thereby not [be] within the jurisdiction of this Court", if a child is a child of a marriage and his/her parents are the applicants.[4] If the proposed treatment is a "special case", it falls within the jurisdiction arising by s 67ZC attaching to the matter of parental responsibility in Part VII. If the proposed treatment is not a "special case", any orders sought fall within the ambit of "parenting orders" relating to an aspect of parental responsibility (s 64B(1) and (2)(i)). In the former case, the Court *must* authorise the treatment, if it is to take place, by exercising power referable to jurisdiction conferred by s 67ZC in the manner earlier spoken of. In the latter case, the Court *may* make a parenting order by reference to the court's jurisdiction to make orders of that type given by s 69ZH in respect of the matters in Part VII.

82. Secondly, and again with the greatest of respect to his Honour, I hold to the view I expressed in *Re Lucy*, particularly at [94] and [95], in respect of the preceding paragraphs of his Honour's judgment. Specifically, I respectfully disagree that the categories of treatment that are not a "special case" are as confined as what his Honour suggests. In my view, Nicholson CJ's view pays no regard to what Brennan J said quite specifically about "psychiatric disorders". Brennan J was careful to include "a psychiatric disorder" among those conditions in respect of which "therapeutic" treatment can be administered without court authorisation (provided it is "appropriate and proportionate") and, Brennan J was, with respect, equally careful to include treatment for a psychiatric condition among those treatments for which court authorisation is necessary when the treatment is "inappropriate or disproportionate" or treatment for a psychiatric condition that is administered "chiefly for … purposes" other than treatment of the disorder.

83. I hold to the views expressed in *Re: Sean and Russell (Special Medical Procedures)* (2010) 44 Fam LR 210 that Court authorisation is necessary only in respect of the type of procedures or treatment analogous to those described in *Marion's Case.* Reference to the judgments in *Marion's Case* mark court authorisation as necessary in respect of a non-Gillick-competent child in a "special case" which is determined by reference to the following factors:

---

[4] In *Re Alex*, the applicant was a government department. In that event, I consider, respectfully, that the jurisdictional issues discussed in *Re Lucy* apply

- Treatment which does not involve "preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder";
- Treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder;
- Treatment given other than for the "chief purpose" of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder;
- The "urgency" of the proposed treatment;
- Where there is the combination of a "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 where the "consequences of a wrong decision are particularly grave".

84. As a result, it is, in my view, not possible to be didactic about whether authorisation is required by reference to a particular type of condition or a particular description of a condition. That, I consider with great respect, is at least partly the point being made by the plurality in *Marion's Case* in the passage quoted above. A clitorodectomy whose purported justification is wholly "cultural" or "religious" would plainly require court authorisation; I am by no means convinced that unanimous medical opinion that the procedure was required to treat a cancer would require authorisation (see, for a perhaps less extreme, but analogous, example, *Re Sean and Russell*).

85. Equally, cases involving treatment for Gender Dysphoria may not require court authorisation because the nature of the treatment is required to ameliorate a psychiatric disorder and the nature of the proposed treatment is such that the risk of error and the consequences for the child are eliminated or alleviated because the treatment is "reversible" (see, for example, *Re Lucy*). Other cases of Gender Dysphoria may, by reference to those or similar relevant factors, require authorisation.

86. Given that there is clear evidence before me that each of Terry and Sam suffer from Gender Dysphoria and that Gender Dysphoria is a psychiatric condition, it remains to consider whether the combination of circumstances in each of Terry's and Sam's case marks either as a "special case" requiring authorisation.

Terry and Sam's Treatment and Circumstances – "Special Cases"?

Stage 1 Treatment

87. Dr M opines that whilst Gender Dysphoria is:

> … listed in the DSM-IV criteria diagnostic manual, there has been much debate about whether it should continue to be in the DSMIV or the text book of psychiatric diagnoses. This condition does not require psychiatric treatment. The treatment it requires is gender transition which is a medical and surgical process. The role of the psychiatrist is to confirm the diagnosis, exclude other psychiatric co-morbidities and provide psychological support during the transition process.

88. That Gender Identity Disorder (albeit renamed as Gender Dysphoria) remained in the version of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") most recently updated this year, and given the DSM is intended to "assist trained clinicians in the diagnosis of their patients' *mental disorders*" and was, indeed, relied upon by both Dr T and Dr M to diagnose the children, plainly, in my view, demonstrates that Gender Dysphoria falls within the ambit of "psychiatric disorders"/"mental condition" referred to by Brennan J in *Marion's Case.* In any event, however categorised, Dr M is plainly of the view that each of the children suffers from a condition that needs treatment as a matter of urgency and, in that, there is unanimity among the experts

89. The proposed Stage 1 treatment earlier described is, in my view, plainly therapeutic in the sense earlier outlined. It is sought to be administered to ameliorate a psychiatric disorder/mental condition and that is its chief purpose. It is in accordance with the international practice guidelines for the diagnosed condition.

90. The proposed Stage 1 treatment is completely "reversible", the only adverse physiological side effect is the potential for the children to not reach their projected height, but bone density testing conducted by Professor H indicates that both children have reached, or are very close to reaching, their adult height. The treatment acts to suppress further pubertal development, but that development can recommence if treatment ceases. In that sense, noting the "reversibility" of the treatment, the risks associated with error of diagnosis are low and the consequences of treatment cannot otherwise be described as "grave".

91. I consider that court authorisation is not required to undertake Stage 1 treatment for either Terry or Sam. The corollary is that I consider it within the ambit of parental responsibility of the parents of each of Terry and Sam to give consent to that treatment.

Stage 2 Treatment

92. There is clear, unanimous, evidence emerging from the expert opinion that each of Terry and Sam suffers from Gender Dysphoria. Equally, it can be found that it is a "psychiatric disorder"/"mental condition". I consider that the proposed Stage 2 treatment (the administration of testosterone via intramuscular injection to Terry and the administration of oestrogen orally for Sam) is proposed for the chief purpose of preventing or removing the condition of Gender Dysphoria. By reference to the evidence before me as to the international practice guidelines and the absence of alternative treatments and the nature and severity of the manifestations of the condition suffered by each child, I consider the proposed treatment to be "appropriate and proportionate" to the purpose of "removing the condition".

93. The nature and severity of the manifestations of the condition in each of Terry and Sam persuade me that there is urgency attaching to the administration of treatment and that postponing Stage 2 treatment until either adulthood or Gillick competence is reached by either child would run contrary to the expert medical evidence before me.

94. Each of the experts identifies that the proposed treatment not only accords with the clinical practice guidelines, but is, at present, the only treatment available for individuals suffering from Gender Dysphoria.

95. Contrary to the situation in *Re Alex* in which Nicholson CJ observed "I do not understand the expert witnesses to be ruling out the possibility that with adolescent development Alex may reconsider his gender identity as a male and that if such a change in self-image transpires, he may come to view himself as a lesbian", there is no such suggestion from any of the experts in respect of either Terry or Sam. Indeed, each of Dr M and Dr T consider it highly unlikely that either child's Gender Dysphoria will "desist" and neither raise any suggestion that the symptoms suffered by Terry and Sam stem other than from Gender Dysphoria (for example, from confusion in respect of their sexual orientation). Drs M and T report that both children have a "classical" "history" of Gender Dysphoria.

96. Further, both Terry and Sam have had, and continue to have, extensive involvement with various psychologists and, in Sam's case, a transgender support group. If there were any concerns that the symptoms manifested by Terry and Sam were the result of confusion with their sexual identity as opposed to Gender Dysphoria, I consider it highly likely that signs of that would have emerged. I particularly have in mind the views of each of the children's parents who, I feel confident, would each be alive to the prospect of an alternative explanation for their children's manifest behaviours and would have explored it with appropriate experts.

97. Both children will be monitored by appropriately qualified professionals, including Professor H, during the administration of the Stage 2 hormones and, as Professor H identified, the treatment can be stopped if either child demonstrates signs of distress or their condition alters to such an extent as to warrant a reassessment of it and/or the proposed treatment.

98. All of those factors point, in my view, to the treatment being classified as "therapeutic" and I am not prepared to dismiss it as such by reason of the nature of the condition or because the Stage 2 treatment might be but a step in a later, post-competence or post-childhood, process of wide-ranging and extensive treatment and procedures.

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."

102. I am aware that 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.

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.

Conclusion as to Authorisation

104. I am of the view that court authorisation is required in respect of the Stage 2 treatment proposed for each of Terry and Sam.

IS AUTHORISATION IN THE CHILDREN'S BEST INTERESTS?

Terry's Best Interests

105. Many of the issues discussed earlier are directly relevant to a consideration of Terry's best interests. The nature of the condition with which Terry suffers and the exact nature of the proposed treatment and its risks and long term effects, has been discussed earlier in these Reasons.

106. As noted, Stage 1 is completely reversible. Stage 2 carries significant risks, including risks of uterine and breast cancer. It will result in irreversible physical changes such as growth of facial hair and a deepening of Terry's voice. There is also the potential for Terry's fertility to be adversely affected.

107. Those matters are, of course, very significant. There is, however, unanimous expert opinion about grave immediate consequences for Terry if the treatment is not administered. Both Drs T and M refer extensively to the nature and extent of Terry's depression, with Dr T opining that Terry would meet the diagnostic criteria for "recurrent, moderate, major depressive disorder". Both psychiatrists are similarly agreed that delay in providing the treatment to Terry

will serve “no purpose”. Importantly, each consider delay will likely exacerbate his “existing symptoms of depression” and “cause unnecessary stress and social integration difficulties for [Terry] during his adolescence” as well as “increase [[Terry’s]] risk of self-harm and even suicidal ideation.”

108. Each of the experts agrees that the proposed treatment (which is in accordance with international practice guidelines) is the only treatment available for Terry. Terry has and continues to consult with psychologists and has had a number of consultations with Dr T. There is no evidence before me, nor anything which suggests that there may be additional or alternative treatment available for Terry. The alternative of no Stage 2 treatment has the potential serious consequences just referred to.

109. I have direct evidence of Terry’s views by virtue of the affidavit sworn by him. The views expressed are completely consistent with the views contained in the reports of both Drs T and M; Terry identifies completely as a male, is distressed by his periods, and wants the treatment so that he can “go on and live [his] life like a normal teenage boy.” They are views of a mature, albeit depressed, child. Of course, the *possibility* of a later change in view cannot be discounted but that possibility must be measured against the strength and depth of Terry’s current views and the real probability of significant consequences of actions contrary to those views.

110. Both Terry’s parents, and the psychiatrists, indicate that Terry’s feelings and preferences have been apparent, in some form or another (for example, in his refusal to wear “pink” or “frilly” clothes) since he was a toddler. Each of Dr M and Dr T has the view that it is highly unlikely that Terry’s symptoms and, importantly, his psychological distress, will desist without the proposed treatment. Terry is known as a male at school and uses a binder to hide his breasts and a device in his pants to mimic the appearance of male genitalia. He is, on all accounts, completely committed to assuming a male form to the greatest extent possible and the treatment proposed is intended to facilitate the commencement of that transition.

111. Terry’s parents are, on all accounts, and plainly on the evidence before me, completely supportive of Terry’s wishes and accepting of his condition. They agree to and support the proposed treatment.

112. I am persuaded by the unanimous medical and other evidence before me that the proposed treatment is in Terry’s best interests.

Sam’s Best Interests

113. As with Terry, the symptomology of Sam’s Gender Dysphoria is earlier discussed in these reasons, as is the distress and comorbidities associated with her condition. Each are directly relevant to a consideration of whether the proposed treatment is in Sam’s best interests.

114. As with Terry, I have direct evidence of Sam's views; she deposes to having "always" felt like a girl and to wanting the proposed treatment so that her "…way of life [can be] more normal as a girl as it always should have been."

115. Whilst both Sam's parents depose to Sam having a "normal" childhood and to being unaware of Sam's distress until relatively recently, each of Dr M and Dr T record Sam as indicating she has experienced feelings of Gender Dysphoria since she was a young child but that she had "kept these feelings secret" and did not "share [them] with friends at school or family members until quite recently in early 2012."

116. Sam dresses as a female, wears makeup, is receiving laser treatment to reduce the appearance of facial hair and has been on a "suboptimal" hormone regime as a means of minimising her masculinising characteristics.

117. The treatment proposed for Sam is agreed as between the experts and is consistent with international guidelines and the practices at other hospitals in Australia; there is no less invasive treatment option. Both Drs T and M express the view that the treatment proposed is the "only" treatment available for Sam. The possibility of *no* treatment brings with it very grave, immediate, risks of harm.

118. As referred to, Sam has a tragic history of self-harm, which both Dr T and Dr M associate with her Gender Dysphoria. Both doctors opine that delay in providing the treatment proposed will increase her psychological distress and there is a very significant risk that delay will "precipitate a psychological decompensation as happened in early 2012 where [Sam] was self-harming involving deliberate self-harm directed at her male genitalia."

119. The experts are agreed as to Sam's diagnosis and treatment. It is important to emphasise that each of these experts is concerned that, just as with Terry, the condition is not (an extreme form of) confusion as to sexual identity. The condition is quite distinct from the sometimes difficult issues arising from uncertainty or confusion about sexual orientation.

120. The proposed treatment, as with Terry's, consists of two "stages" of hormone treatment to be administered simultaneously. Stage 1 carries no long term risks and is completely reversible. Stage 2 for Sam will involve the administration of oestrogen orally as a means of feminising her body. That treatment will "enable [[Sam]] to live as the adolescent girl, who she sees herself as, and will therefore improve her psychological well-being, correct her sense of identity and sense of self."

121. There are significant risks associated with the Stage 2 treatment and it will have irreversible effects. In terms of the former, there is a risk of thromboembolism. Professor H indicates that there are means of mitigating that risk which will be employed by her if treatment proceeds. In terms of the

effects, there is the potential that Sam's fertility will be adversely affected. She will also experience a redistribution of body fat and muscle mass resulting in an irreversible change in her body shape.

122. Those risks and changes must be considered in the context of the risks of delaying treatment. As noted, there are significant comorbidities associated with Sam's Gender Dysphoria including depression and anxiety which have manifested in serious episodes of self-harm and in an Eating Disorder. The experts are agreed that delay in treatment carries the attendant risk of suicidal ideation and self-harm. Professor H also considers that a delay in the proposed treatment may, in light of the "suboptimal" regime Sam is presently on, see Sam source oestrogen herself and self-administer. That course of conduct carries very significant medical risks.

123. Notwithstanding the fact that Sam's parents were not aware of Sam's feelings of Gender Dysphoria until relatively recently, they agree with and support the proposed treatment. Their support has manifested practically already by their having facilitated laser treatment to reduce Sam's facial hair and sourcing hormones (albeit in what has been termed a "suboptimal" regime by Professor H) to alleviate Sam's distress.

124. I am satisfied, by reference to the totality of the expert and other evidence before me, that the proposed treatment is in Sam's best interests.

PRIVACY AND ANONYMISATION

125. As indicated at the hearing, I will make "the usual orders" preserving Terry's and Sam's anonymity. I consider it appropriate to make orders of the type usually made in cases involving applications of the type in these proceedings, protecting not only the names of the children, but also other information (such as medical practitioners, lawyers and others involved in the case).

I certify that the preceding one hundred and twenty-five (125) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Murphy delivered on 31 July 2013.

Associate:

Date: 31 July 2013