FAMILY COURT OF AUSTRALIA

RE: QUINN ***[2016] FamCA 617***

FAMILY LAW – MEDICAL PROCEDURES – Childhood gender dysphoria –Where the child is 15 years of age – Consideration of whether the child is *Gillick* competent.

Family Law Act 1975 (Cth), s 67ZC

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Re Jamie (2013) FLC 93-547

APPLICANTS:	The Mother and the Father
RESPONDENT:	The Secretary, relevant Government Department
FILE NUMBER:	**By Court Order File Number is suppressed**
DATE DELIVERED:	29 July 2016
JUDGMENT OF:	Rees J
HEARING DATE:	26 July 2016

REPRESENTATION

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

ORDERS

IT IS DECLARED

(1) That the child Quinn, who was born on … 2001 is competent to consent to male chest reconstruction surgery for the purpose of treatment of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5").

IT IS ORDERED

(2) That the full name of Quinn, his family members, his hospital, the Independent Children's Lawyer, his medical practitioners, his school, this Court's file number, the State of Australia in which the proceedings were initiated, the name of Quinn's parents' lawyers, and any other fact or matter that may identify Quinn, shall not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the registry, file number, and lawyers' names and details, as well as the parties' real names) shall be released by the Court to non-parties without further contrary order of a Judge, it being noted that each party shall be handed one full copy of these orders with the relevant details included, to enable their execution, and one cover-sheet of Reasons for Judgment that includes the file number and lawyers' names.

(3) That no person shall be permitted to search the Court file in this matter without first obtaining the leave of a Judge.

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

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order File Number is suppressed

The Mother and the Father
Applicants

And

The Secretary, relevant Government Department
Respondent

REASONS FOR JUDGMENT

1. The Father and the Mother ("the applicants") are the parents of Quinn, born in 2001. Quinn identifies as male and wishes to have a bilateral mastectomy, colloquially referred to as "top surgery". The applicants ask the Court to determine that Quinn is competent to authorise the surgery.

2. In the alternate, the applicants ask the Court to order that they can authorise the procedure.

3. In these reasons, reference is made to guidelines published by the *World Professional Association for Transgender Health, Standards of Care* ("the WPATH Guidelines").

4. The guidelines set out the generally accepted interventions as follows:

    1. *Fully reversible interventions.* These involve the use of GnRH analogues to suppress oestrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (mostly commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to supress menses.
    2. *Partially reversible interventions.* These include hormone therapy to masculinise or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g. gynaecomastia caused by oestrogens), while other changes are not reversible (e.g. deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures. A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

5. Quinn has not commenced Stage 2 treatment.

6. Quinn's treating doctors recommend that Stage 3 treatment, 'top surgery', take place immediately.

7. The Secretary of the relevant Government Department ("the Secretary") has been served with the application. At the hearing of the application on 26 July 2016, the Secretary appeared by counsel.

8. An Independent Children's Lawyer ("ICL") has been appointed for Quinn.

9. At the hearing, all parties submitted that the evidence established that Quinn was competent to consent to the proposed surgery.

10. However, counsel for the Secretary submitted that, because the sequence of treatment recommended by Quinn's treating doctors is not strictly in accordance with the WPATH Guidelines, a dispute or controversy has arisen which requires the Court to determine whether the proposed procedure is in Quinn's best interests.

THE LAW

11. The issue of the role of the Family Court of Australia in cases involving childhood gender identity disorders was definitively explored in the decision of *Re Jamie* (2013) FLC 93-547 ("*Re Jamie*") by Bryant CJ, Finn and Strickland JJ. In separate judgments their Honours each determined that in cases where the proposed treatment is irreversible without surgical intervention, the issue for the Court is to determine whether the child is competent within the meaning of the decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 ("*Gillick* competent"). Their Honours held unanimously that in the event that the Court finds that the child is *Gillick* competent, then the authority of the Court is not required to authorise the treatment.

12. At paragraph 140 of her Honour's judgment, the Chief Justice said:

> I summarise the decision that I have reached in relation to these matters:
>
> a) Stage one of the treatment of the medical condition known as childhood gender identity disorder is not a medical procedure or a treatment which falls within the class of cases described in *Marion's case* which attract the jurisdiction of the Family Court of Australia under s 67ZC of the Act and require court authorisation.

b) If there is a dispute about whether treatment should be provided (in respect of either stage one or stage two), and what form treatment should take, it is appropriate for this to be determined by the court under s 67ZC.

c) In relation to stage two treatment, as it is presently described, court authorisation for parental consent will remain appropriate unless the child concerned is *Gillick* competent.

d) If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required**, absent any controversy.**

e) The question of whether a child is *Gillick* competent, even where the treating doctors and the parents agree, is a matter to be determined by the court.

f) If there is a dispute between the parents, child and treating medical practitioners, or any of them, regarding the treatment and/or whether or not the child is *Gillick* competent, the court should make an assessment about whether to authorise stage two having regard to the best interests of the child as the paramount consideration. In making this assessment, the court should give significant weight to the views of the child in accordance with his or her age or maturity. (Emphasis added).

13. Finn J said, at paragraph 188:

> If the court was completely satisfied of the child's capacity to consent to stage two treatment, it would be unnecessary for it to have to authorise the treatment. That could be left to the child. But if the court had any doubt about that capacity, then it would have to determine for itself the question of whether the stage two treatment should be authorised.

14. Strickland J said, at paragraphs 195 to 196:

> In relation to stage two treatment, I agree that the therapeutic benefits of the treatment need to be weighed against the risks involved and the consequences which arise out of the treatment being irreversible, but that given the nature of the changes that would result for the child that treatment should require court authorisation. This would not be the case though where the child is able to give consent to the proposed treatment.
>
> Whether the child is able to fully understand and give informed consent to stage two treatment, and thus court authorisation is not required, is a threshold issue that the court must decide. This is because of the requirement by the High Court majority in *Marion's case* that it is for the court to authorise medical treatment that is irreversible where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment, and where the consequences of such a wrong decision are particularly grave.

15. Absent any controversy about whether or not there is a dispute in relation to the proposed treatment, the issue therefore in relation to Quinn is whether or not he is *Gillick* competent to consent to the proposed surgery. If Quinn is determined to be *Gillick* competent, court authorisation for the proposed surgery is not required.

16. The ability of a child to make his or her own decision in respect of medical treatment depends upon that child having sufficient understanding and intelligence to make the decision. It is a question of fact in each individual case and falls to be determined on the evidence of the individual capacity of the particular child.

THE EVIDENCE

17. Quinn's mother swore an affidavit on 3 May 2016. She deposed that Quinn has dressed as a boy since he was four years old.

18. Quinn's mother deposed that Quinn has researched top surgery, and is following top surgery journeys of other transgender men on Facebook. He understands that the surgery will be painful and that it will have consequences for his ability to breast feed if he should change his mind in the future. Quinn's mother deposed that Quinn has never wavered in his insistence that he wishes the surgery to go ahead but rather that he becomes more depressed as time goes on because the surgery has not occurred.

19. Quinn has researched hormone therapy and wishes to begin testosterone treatment within the next twelve months. Quinn's mother deposed, "I am confident that [Quinn] is taking an intelligent, mature and measured approach to his future. [Quinn] wishes to commence a TAFE course next year as part of his year 11 studies as an introduction to his chosen [trade career]."

20. Quinn's father has sworn an affidavit on 3 May 2016 in which he deposed to his support for the application.

21. Dr H, a plastic and reconstructive surgeon, swore an affidavit on 17 May 2016 and provided a report dated 21 April 2016. Dr H deposed:

> [Quinn] has done his own research, and has trust and confidence in the doctor patient relationship, between me as the surgeon to carry out the procedure and himself. He is also trusting of his previous practitioners, and was disappointed in the past when he sort (sic) psychiatric advice at Headspace …, where there was a reluctance to encourage [Quinn] to make this application.

22. Dr H deposed:

> In terms of Gillick competence, [Quinn] has been to see me twice now, regarding the operation. In his own words he was able to describe the operation, and the extent of scarring and the position of the nipple grafts.

> He is aware of the risks and complications of the surgery, and he's able to describe why this particular operation has the best chance of giving him an excellent aesthetic result.
>
> He was not adverse to discussing about risks and complications, and understands that the operation is essentially irreversible, but it's a decision that he makes to arrive at the destination that he is proceeding towards. In other words, he wants to live forever as a male. He does understand that complications can arise, that may influence the aesthetic outcome of the operation. He does understand, that achieving a male appearance, may not necessarily overcome all of his dysphoria, and that he may not achieve the degree of freedom that he hopes for, from the surgery alone.
>
> [Quinn] is currently in a good state of mind, having had his depression treated with medication, and his judgment does not appear to impair his vision to consent to the surgery.

23. Dr D, a consultant psychiatrist, reviewed Quinn on 1 April 2016 and again on 13 May 2016. Dr D stated in his report:

> I have assessed [Quinn's] capacity in regards to his undergoing male chest reconstruction surgery and feel that he is competent to the Gillick standard to provide consent. [Quinn's] psychiatric symptoms, while at times distressing, are not severe enough to affect his ability to retain existing and new information. There is no evidence of delirium or dementia which may also confound his capacity. [Quinn] is able to outline in detail what the surgery entails in a way which is appropriate to his level of maturity and education. He can quite clearly describe the advantages he sees to the treatment as well as the disadvantages. He is able to weigh the advantages and disadvantages and arrive at an informed decision regarding whether he should proceed with the treatment and understands that there may be unforeseen consequences at the time of his decision. [Quinn] is aware that the procedure will not ameliorate all his psychological and social difficulties. To the greatest extent possible he is free from pressure or pain that impairs his judgment.

24. Dr R, a counsellor and clinical supervisor, prepared a report dated 12 May 2016 in relation to Quinn's understanding. In her report, Dr R states:

> In preparation for this assessment to determine whether [Quinn] is competent to the *Gillick* standard to provide his consent, this report considers whether [Quinn] is:
>
> ***G)Able to comprehend and retain both existing and new information regarding the proposed treatment;***
>
> [Quinn] understands that both his breasts will be completely removed during Top Surgery and was cognisant of the likely pain following surgery,

the general discomfort, medical invasiveness (drips & drains) and the limited mobility necessary for healing in the weeks following surgery.

H) Able to provide a full explanation, in terms appropriate to his level of maturity and education, of the nature of the treatment;

[Quinn] explained that the surgical procedure for the double mastectomy for him is a "double incision with free nipple graft". He described that there are three layers of his body that would be effected by the surgery, the skin, fat and the muscle in the area of his chest. He described that there would be three horizontal incisions for each breast, two below the nipple and one above. He explained that the two incisions below the nipple would be "joined together" with the piece being removed. [Quinn] said that the surgeon would "graft his nipples back on in the right place."

I) Able to describe the advantages of the treatment;

[Quinn] will no longer have breasts but will have a physical presentation of a male chest. [Quinn] explained that he will "Be able to go swimming, play sport and go to sleep overs…I'll feel better. I don't belong in this body like it is…won't have pain from the binder, I'll be able to breathe properly…it will give me a chance to identify more as myself"

For the long term, [Quinn] stated that he would "be going to TAFE, meeting people and making new friends and I won't be worrying whether they can see breasts or what they are thinking" and later "I'll be more muscly and have a stable job as a [tradesman]."

J) Able to describe the disadvantages of the treatment;

When asked about the disadvantages of treatment [Quinn] said: "It might get infected and something might go wrong" and that "I won't be able to feel some spots afterwards" in reference to numbing in the chest area following surgery. [Quinn] added that "he would just have to stay on the couch and watch Netflix for weeks" and that he "might miss the formal" (end of term dance for his class).

K) Able to weight the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when he should proceed with the treatment;

[Quinn] confirmed that the advantages for him clearly outweigh what he sees as the disadvantages and appears to not be concerned about pain following surgery as he stated "It would be worth it."

L) Able to understand that the decision to proceed with the treatment could have consequences that cannot be entirely foreseen at the time of the decision;

> [Quinn] understands that he cannot fully know the consequences of the surgery and that at some time in the future he might be disappointed in the outcome or wish that there had been a different result.
>
> ***M) Able to understand the treatment will not necessarily all of any psychological or social difficulties that he has before the commencement of the treatment; and***
>
> [Quinn] is aware that Top Surgery will affect his physical body, specifically his chest only and that even though some psychological and social changes may follow, he has expressed that he is aware that he will have a level of responsibility for making decisions regarding his mental health and social networking likely to affect his long term happiness.
>
> ***N) Free, to the greatest extent possible, from 'temporary factors' such as pressure or pain that could impair his judgment in providing his consent to the treatment.***
>
> [Quinn] is experiencing significant anxiety due to the pressure on him to appear in court. [Quinn] stated "If I don't say the right thing, they won't let me have the surgery."

25. Dr R reported that Quinn's motivation and aspirations are inextricably connected to being perceived and treated as male.

26. Dr M, a paediatric endocrinologist, swore an affidavit and provided a report dated 12 April 2016.

27. Dr M reported:

> During my second meeting with [Quinn] and his mother…on 8 December 2015, I was satisfied that [Quinn] had a sufficient and age appropriate understanding of puberty suppression and the longer issues related to gender dysphoria. Thus, pubertal suppression therapy was commenced on 8th December 2015.

28. Dr M has discussed with Quinn the administration of testosterone (male type or androgen hormones), but Quinn has stated that he currently does not wish to seek such therapy although he acknowledged that he may wish to do so in the future. Dr M stated that she is satisfied that Quinn has a good knowledge and understanding of the effects of "top surgery". He understands that the surgery is irreversible.

29. It follows that Quinn is competent to consent to the proposed surgery.

IS THERE A DISPUTE OR CONTROVERSY?

30. Counsel for the Secretary relied upon the passage from the judgement of the Chief Justice in *Re Jamie,* which is set out at Paragraph 12 above, and particularly sub-paragraphs (b) and (d) of paragraph 140 of the judgement.

31. Counsel for the Secretary submitted that, because the proposed course of treatment deviates from the WPATH Guidelines, a dispute, for the purpose of (b), or a controversy, for the purpose of (d), exists such that the Court must determine whether the proposed course of treatment is in the child's best interests.

32. The ICL submitted that the WPATH Guidelines state (at page 21):

> **Irreversible Interventions**
>
> Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have live continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.
>
> Chest surgery in (female to male) patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. **However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.** (Emphasis added)

33. The WPATH Guidelines contemplate deviation from the path where the circumstances of the individual child and clinical judgement dictate.

34. In the present case, Quinn has not commenced stage 2 treatment which is anticipated to commence when Quinn turns 16 years of age. However, it is proposed that the top surgery take place immediately.

35. In a report dated 18 July 2016, Dr D, consultant psychiatrist, asked by the ICL, "*Are there any advantages or disadvantages of having top surgery before stage 2 treatment? If there are disadvantages, can these be managed or mitigated in any way*?", responded as follows:

> The advantages of having top surgery before stage 2 treatment are a decrease in his gender dysphoria and decreasing his physiological and physical pain due to his large bust. Additionally stage 2 hormonal treatment will masculinise [Quinn's] appearance where he will develop a hairy chest and face. This would be incongruent with a person with an E cup breast and would certainly contribute and potentially provoke abuse and stigmatisation which would detrimentally affect [Quinn's] mental state.

> Society has begun to accept transgender individuals however I am highly doubtful that they would accept an individual with a beard, hairy chest and E cup bust. This would further exacerbate and distress [Quinn] as his physical appearance; particularly his breasts would be markedly incongruent with his masculinised appearance and would engender more confusion for [Quinn] and others as he would have a mix of secondary sexual characteristics. The disadvantages to having top surgery before stage 2 treatment are [Quinn] would normally have had hormonal treatment for 12 months and live in his male gender, allowing him to become socially accustomed to his new gender before undertaking largely irreversible surgical interventions. If [Quinn] has top surgery he will be better able to present as a male, which will improve his self-confidence and reduce his gender dysphoria and be able to socialise as a male before commencing hormone treatment.

36. Dr D was further asked by the ICL, "*Do you have any concerns (medical, psychological, or any other concerns) about [Quinn] undergoing top surgery before commencing stage 2 treatment*?" Dr D responded:

> Generally my preference would be for an individual to undertake stage 2 treatment for 12 month period before considering surgical intervention. [Quinn's] situation is unique in that his large bust causes both psychological and physical pain. If he were to undertake hormonal treatment prior, even with binding his breasts, his bust would be noticeable. With the testosterone induced changes in his body and voice lead to the potential for abuse and increase stigmatisation and worsening of gender dysphoria. I believe the risk of this occurring greater than any of the possible psychological sequelae of [Quinn] having the top surgery before commencing stage 2 treatment.

37. Dr R, asked to state the advantages and disadvantages of Quinn having top surgery before stage 2 treatment, replied:

> Advantages:
>
> - If [Quinn] were to begin stage 2 treatment prior to having top surgery, he would develop facial hair and a male voice while still having the appearance of large breasts which although bound, are of a size that cannot be hidden. This physical appearance would exacerbate his feelings of gender dysphoria and therefore intensify his distress and anxiety.
> - [Quinn's] mental health is almost certain to improve with top surgery as his history of anxiety, depression and self-harm is clearly linked to his gender dysphoria and in particular the size of his breasts. Top surgery will allow [Quinn] to feel more confident in his

body and presentation as a male as he will no longer need to hide his breasts with binding, clothing and posture.

- With top surgery [Quinn] will no longer suffer the severe discomfort, health and physical limitations of having size E breasts and needing to bind.
- Following the top surgery stage 2 treatment will allow [Quinn] to attain the secondary sexual characteristics of masculinity.

Disadvantages:

- I am not aware of any disadvantages that [Quinn] would experience by having top surgery prior to stage 2 treatment.

38. Dr H stated:

> I have no concerns about [Quinn] undergoing top surgery before commencing stage 2 treatment, however I do have concerns about him, delaying treatment because of the psychological impact and the physical difficulties in dressing as he is at present, especially with his plans for ongoing education.

39. Thus, there is no disagreement between Quinn's treating medical practitioners, or between his treating medical practitioners and his parents, that the proposed procedure, that is, to carry out the top surgery before Quinn commences stage 2 hormone treatment, is the most appropriate treatment for Quinn.

40. The criteria for surgeries and in particular for breast/chest surgery set out in the WPATH Guidelines at page 59 states "Hormone therapy is not a prerequisite."

41. Whilst I accept that the "generally accepted interventions" set out in the WPATH Guidelines, suggest that the stages should proceed in order, these are guidelines and not rigid rules. Guidelines must give way to clinical decisions about individual patients.

42. I do not consider that the fact that Quinn's treating doctors have recommended that the procedures be performed in an order different from that specified in the guidelines, creates a dispute or controversy within the context of the comments of the Chief Justice at paragraph 140 of *Re Jamie*. Accordingly, it is not necessary for the Court to determine whether or not the course of action proposed by the treating doctors is in Quinn's best interests.

43. If I am in error in this conclusion, then counsel for the Secretary submits that a finding should be made, having regard to the evidence of all of Quinn's treating doctors, that the proposed procedures are in his best interests and that the Court should authorise those procedures.

44. I accept that submission.

45. The proposed course of treatment is in Quinn's best interests.

I certify that the preceding forty-five (45) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Rees delivered on 29 July 2016.

Associate:

Date: 29 July 2016