FAMILY COURT OF AUSTRALIA

RE: KELVIN ***[2017] FamCA 78***

FAMILY LAW – CHILDREN – Medical Procedures – Where the applicant is the father of the child and seeks a declaration that the child is competent to consent to the administration of Stage 2 treatment for Gender Dysphoria (the treatment) or in the alternative the court make an order authorising the administration of Stage 2 treatment – Where orders are sought to maintain the confidentiality of the proceedings – Where an order is made dispensing with the rule requiring service upon the respondent, Director-General, relevant Department – Where a finding is made that the child is *Gillick* competent to consent to the treatment – Where orders relating to confidentiality are made – Where the applications are otherwise adjourned pending determination by the Full Court of the case stated to the Full Court.

FAMILY LAW – CHILDREN – Medical Procedures – Case stated to the Full Court – Whether the Full Court confirms its decision in *Re Jamie* (2013) FLC 93-547 and whether the Family Court should determine whether a child was *Gillick* competent to give informed consent to the treatment – If so, if a finding is made that a child is *Gillick* competent to give consent to the treatment whether the court should make a declaration the child is *Gillick* competent to give consent to the treatment or in the alternative make an order authorising the treatment.

Family Law Act 1975 (Cth)

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Re Harley [2016] FamCA 334
Re Jacinta [2015] FamCA 1196
Re Jamie (2013) FLC 93-547
Re Jason [2016] FamCA 772
Re Logan [2016] FamCA 87
Re Martin [2015] FamCA 1189
Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218

Fiona Kelly, 'Australian children living with gender dysphoria: does the Family Court have a role to play?' (2014) 22(1) *Journal of Law and Medicine* 105

Felicity Bell, 'Children with gender dysphoria and the jurisdiction of the Family Court' (2015) 38(2) *University of New South Wales Law Journal* 426

APPLICANT: The Father

RESPONDENT: The Mother

FILE NUMBER: By Court Order File Number is suppressed

DATE DELIVERED: 16 February 2017

JUDGMENT OF: Watts J

HEARING DATE: 16 February 2017

REPRESENTATION

By Court Order the solicitor's names have been suppressed

FINDING

1. The court finds that the child, Kelvin born … 2000, is *Gillick* competent to consent to Stage 2 treatment for Gender Dysphoria in Adolescents and Adults as classified in the *Diagnostic and Statistical Manual of Mental Disorders 2015* (Fifth Edition) DSM-5.

ORDERS

2. The requirement of Rule 4.10 Family Law Rules 2004 (Cth), that the Initiating Application filed 25 January 2017 be served on the prescribed child welfare authority, be dispensed with.

3. The applicant's Initiating Application filed 25 January 2017 for a declaration or in the alternative an order authorising treatment be adjourned pending determination by the Full Court of the special case stated to the Full Court.

4. The name of the child, Kelvin born … 2000, the child's family members and their occupations, the child's medical practitioners, this court's file number, the State or Territory of Australia in which these proceedings were initiated and any other fact or matter that might identify the child shall not be published in any way.

5. Only anonymised Reasons for Judgment and Orders shall be released by the court to non-parties without further contrary order of a Judge.

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

7. The applicants be at liberty to provide a copy of the un-anonymised finding and orders and un-anonymised reasons for judgment to all persons involved with Kelvin's treatment.

CASE STATED

8. Pursuant to s 94A(1) *Family Law Act 1975* (Cth), a special case be stated for the opinion of the Full Court on the following facts and questions:

The facts

The facts in this case are set out in Reasons for Judgment delivered on 16 February 2017.

Questions

1. Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults as classified in the *Diagnostic and Statistical Manual of Mental Disorders 2015* (Fifth Edition) DSM-5 (the treatment), requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent to the treatment?

2. Does the Full Court confirm that the Family Court of Australia and not the child's treating professionals should determine whether a child is *Gillick* competent to give consent to the treatment (Bryant CJ at [136]-[137], [140(e)]; Finn J at [186] and Strickland J at [196] *Re Jamie*)?

3. If the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie* (Bryant CJ at [139]; Finn J at [188] and Strickland J at [192]), if a finding is made that the child was *Gillick* competent to give informed consent to the treatment, should any application for a declaration that the child is *Gillick* competent to give consent to the treatment, be dismissed?

4. In the alternative, if the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie* (Bryant CJ at [139]; Finn J at [188] and Strickland J at [192]), if a finding is made that the child was *Gillick* competent to give informed consent to the treatment, should any application for an order authorising the administration of the treatment, be dismissed?

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

6. If the answer to question 4 is no, given statements made by the Full

Court in *Re Jamie*, if a finding is made that the child was *Gillick* competent to give informed consent to the treatment, is the jurisdiction and power of the court enlivened, pursuant to s 67ZC of the Act, to make an order authorising the administration of the treatment?

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

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

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

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order File Number is suppressed

The Father
Applicant

And

The Mother
Respondent

EX TEMPORE REASONS FOR JUDGMENT

INTRODUCTION

1. Kelvin has been diagnosed as having gender dysphoria based upon DSM-5 diagnostic criteria.

2. Kelvin is currently 16 years old. He wishes to commence Stage 2 treatment for gender dysphoria.

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

    1. That the Court declares the child [Kelvin] born ...00 is competent to consent to the administration of Stage 2 treatment for the condition of Gender Dysphoria in Adolescents and Adults in the Diagnostic and Statistical Manual of Mental Disorders (2013) DSM-5.

    In the alternative:

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

4. In addition, Kelvin's father sought orders seeking confidentiality and restrictions on persons who shall be permitted to search the court file.

5. The matter first came before me on 2 February 2017 where I indicated to the solicitor for the father that I would not make any orders until there was evidence that the mother had been informed of the father's application.

6. In an affidavit filed 14 February 2017 the lawyers for the father confirmed that the mother had been served with the father's application on 6 February 2017 and the mother provided a letter dated 7 February 2017 in which she explains why she wholeheartedly supports this application.

THE LAW

7. A *Gillick* competent child is one who has achieved "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 189 and see 169, 194-195; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 ("Marion's case")).

8. The Full Court in *Re Jamie* (2013) FLC 93-547 determined:

    8.1. Stage 2 treatment for gender dysphoria is a special medical procedure which required the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent.

    8.2. The court's authorisation is not required if the child is *Gillick* competent and in those circumstances the decision is left to the child (Bryant CJ [139 – 140(d)]; Finn J [188] although at [140(d)] Bryant CJ adds the words "absent any controversy").

    8.3. The court and not the child's treating professionals should determine whether a child is *Gillick* competent as a threshold question (Bryant CJ at [136]-[137], [140(e)]; Finn J at [186] and Strickland J at [196]).

9. In *Re Jamie* at [139], Bryant CJ explicitly said, "That application however would only need to address the question of *Gillick* competence and once established the court would have no further role". At [188] Finn J said, "If the court was completely satisfied of the child's capacity to consent to stage 2 treatment, it would be unnecessary for it to have to authorise the treatment". At [192] Strickland J said that he agreed with the outcomes and generally for the reasons set out by the other two judges in the case.

10. The inquiry embarked upon is to establish or deny whether or not the court has jurisdiction to authorise Stage 2 treatment for gender dysphoria. If the child is not *Gillick* competent, then the court has jurisdiction (s 67ZC of the Act) and power (s 34(1) of the Act) to authorise the treatment. If the child is competent, then the jurisdiction and power is not enlivened and I interpret *Re Jamie* to mean that the appropriate outcome is that:

    10.1. A finding in respect of Gillick competence is recorded; and

    10.2. An order is made dismissing the application for authorisation of the treatment.

11. When conducting this inquiry, given the provisions of s 67ZC(1) of the Act are

not yet enlivened, the court is neither required to have regard to the best interests of the child as the paramount consideration (s 67ZC(2)) nor consider all the matters in s 60CB – s 60CG of the Act, although there may be an overlap between the facts relevant to making a finding about *Gillick* competence and some of the s 60CC(2) and (3) considerations, particularly s 60CC(3)(a) of the Act.

12. As Bryant CJ says at [139], the focus of the hearing is "the proposed treatment and its effects, and the child's capacity to make an informed decision". Nonetheless, any assessment of the child's competence does not take place in a vacuum and is made having regard to the child's welfare.

13. In *Re Logan* [2016] FamCA 87 I referred to the comments of Austin J in *Re Jacinta* [2015] FamCA 1196 where his Honour took the view that the Full Court could not have literally meant that the court had no further role once the finding of *Gillick* competence is made. Austin J said:

> 25. Section 67ZC of the Act is one head of power under which disputes of this type are determined if the need arises (*Re: Jamie* at [140(b)]). Having found a child is "*Gillick* competent" to consent to Phase 2 treatment for Gender Dysphoria, the terms of s 67ZC of the Act are broad enough to permit the Court to declare that to be so. The alternatives to not granting such declaratory relief are either unpalatable or wrong.
>
> 26. It would be absurd for the Court to make no orders at all. The Full Court reluctantly decided to force parties to petition the Court for decisions relating to Phase 2 treatment because of its importance to the child's future (at [137], [138]). If, having positively determined the child's "*Gillick* competence", the Court then ended the proceedings without making any orders at all the child would be left to approach his or her doctors without a clear answer. The doctors would need to rummage through the Court's reasons (putting to one side the identification problems caused by pseudonyms and anonymisation of the Court's reasons) to determine whether or not the Court had decided the child did have sufficient competence to instruct them to administer Phase 2 treatment. Doctors will understandably not administer treatment unless informed and valid consent is given to them for such treatment by or on behalf of the patient. Declaratory orders issued by the Court solve that problem.

14. In *Re Logan* I was unable to agree that a finding of *Gillick* competence, which is prominently set out, would be difficult for doctors to find and understand or that the child would be left without a clear answer. In that case, having made the finding that the child in that case was *Gillick* competent to consent to the treatment, I dismissed the application for a declaration or order.

15. In *Re Jason* [2016] FamCA 772, Austin J said at [24] and [25]:

> I have previously expressed a view that, following upon findings such as those just reached, the proceedings should be determined by a declaration

being made about the child's competence, in reliance upon s 67ZC of the Act (see *Re: Jacinta* [2015] FamCA 1196 at [18]-[28]). That view is not shared by all (see *Re: Logan* [2016] FamCA 87 at [10]-[11]) and others consider the debate to be sterile (see *Re: Mackenzie* [2016] FamCA 610 at [6]).

Nonetheless, in my view, it remains appropriate to make a declaration. When the Court's jurisdiction is regularly invoked, the curial proceedings before it can only be properly determined by the Court making a decree which either dismisses the pending application or grants relief within the Court's power. The mere finding that a child is *Gillick* competent is not a decree and, without more, does not validly conclude the proceedings. That is best exemplified by the fact that an appeal lies only against a decree, since mere findings are only steps in the litigious process and not themselves decisive of rights (see s 94(1) of the Act; *Yule v Junek* (1978) 139 CLR 1 at 8, 14, 18, 21, 26; *Hay v Hay* (1998) FLC 92-819 at [22]-[28]).

16. Whilst acknowledging his Honour's view, I would point out that if a court makes a finding and as a result of that finding then by order dismisses the application, the court has made a decree against which an appeal lies. I also acknowledge the Full Court in *Re Jamie* has not been explicitly clear as to whether, once a finding of *Gillick* competence has been made, the court should then make an order or declaration pursuant to that finding. Bryant CJ at [139] seems to suggest that once the question of *Gillick* competence has been established, the court has no further role to play. Finn J at [188] explicitly says that once the court is completely satisfied of the child's capacity to consent to the treatment, it would be unnecessary for the court to have to authorise the treatment. Strickland J at [192] generally accepts these outcomes and reasons. Although I accept minds may differ, as I read what the Full Court has written in *Re Jamie*, once the court has made a finding of *Gillick* competence, the court should make no other decree other than one which dismisses the application.

BACKGROUND

17. Kelvin was born in 2000. He is an only child of his parents' relationship.

18. In 2003 Kelvin's parents separated. His mother lives interstate. Kelvin's father says that Kelvin's mother "moves and travels a lot". She has had a child from a new relationship.

19. When Kelvin was nine years old, he discovered the concept of transgender in a book and immediately identified with it.

20. In 2013 Kelvin's father observed some behavioural changes in Kelvin. For example, he says he had his hair cut short, displayed masculine behaviour and began dressing as a male. Kelvin also threw out all of his 'female' clothing and purchased a chest binder. His father says that Kelvin's preferred gender at school was male and he presented himself as male.

21. Kelvin changed schools after year 7 because the school would not allow a

transgender person to continue attending. He attended a different high school for years 8 and 9. That school was supportive of Kelvin and made adjustments to accommodate him, for example, converting the staff toilets to gender neutral toilets.

22. In 2014 Kelvin attended the LGBTIQ 'Campout' on the NSW Central Coast, hosted by Twenty10.

23. In January 2014, when Kelvin was 13 years old, he disclosed that he was transgender to his father.

24. In April 2014, when he was in year 8, Kelvin transitioned socially. Since this transition, his father noticed that he was taking "selfie photographs", something he never did previously.

25. Throughout 2015 Kelvin attended upon Dr M and Dr C for referrals and for his general health and wellbeing.

26. In April 2015 Kelvin and his father relocated from a rural city to the state's capital city. At this time Kelvin changed secondary schools again. His current school have been supportive of him. At this school, Kelvin is known by his preferred name, Kelvin.

27. Shortly after his arrival in Sydney in April 2015, Kelvin attended an appointment with Mr N, psychologist. He has continued to see Mr N for 10 sessions.

28. In June 2015 Kelvin attended upon Dr H, endocrinologist. He attended a further appointment with Dr H in August 2016.

29. From October 2015 Kelvin commenced attending upon Ms F, an accredited counsellor and mental health social worker. He saw her for over 12 months every week for one hour sessions. At the end of October 2016, Kelvin commenced seeing Ms F once a fortnight.

30. On 26 July 2016 Kelvin attended one session with Dr S, psychiatrist.

31. On 5 July 2016 and 30 August 2016 Kelvin and his father attended upon Dr R, psychologist.

PROPOSED TREATMENT AND ITS EFFECTS

32. In a report dated 30 August 2016, Dr R, psychologist, opines that Kelvin has reported experiencing all aspects of the DSM-V diagnostic criteria for gender dysphoria since he was nine years of age. She states that Kelvin has not undergone Stage 1 treatment and has consequently experienced female puberty which has caused him significant distress. Kelvin is now receiving the oral contraceptive pill to cease his menstruation.

33. Dr R explains that Stage 2 treatment for gender dysphoria involves "the administration of *Testosterone* to initiate the secondary sexual characteristics and

appearance of the male sex. These include facial hair, deepened voice, increased muscle/strength, body fat redistribution, cessation of menses, clitoral enlargement and vaginal atrophy as well as skin oiliness/acne and scalp hair loss".

34. Dr R says that if the treatment is carried out, "[Kelvin's] expectation of his future is specifically that of a male. He stated "I will have a beard, top surgery and a male chest… I will pass all the time, have more confidence and be comfortable being seen as I want to be seen. I don't want to be sending mixed messages, I want people to be certain and see me as male. [Kelvin] explained that he will feel more confident socially to speak to people with a male voice"". She explains that psychologically, the treatment "will allow [Kelvin] to continue to develop his self-esteem, the confidence in his body and appearance and to consequently develop the congruence necessary for a healthy future outlook".

35. In his report dated 10 August 2016, Dr S, psychiatrist, opines that the purpose of Kelvin undergoing Stage 2 treatment is to "further align [Kelvin's] physical gender characteristics with his inner gender identity". He states that such treatment is "necessary to promote [Kelvin's] well-being and to relieve his suffering". If the treatment were carried out, Dr S says that the "short and long-term effects would likely include the further promotion of a healthy and integrated identity, positive self-concept and capacity to form relationships and evolve into a healthy and well-adjusted adult. Relief from ongoing gender identity-related cognitions of guilt and worthlessness, low mood and sadness would take place".

36. In a report dated 7 September 2016 Dr H, endocrinologist, states that the likely short and long term effects of the treatment on Kelvin are:

> Individuals with gender dysphoria who commence cross sex hormone therapy generally report improvements in psychological well being. An affirmation of their gender identity coupled with improvements in mood and anxiety levels typically results in improved social outcomes in both personal and work lives.
>
> The physical changes are those of masculinization. On the positive side testosterone therapy typically results in increase muscle strength, stamina and energy levels. On the negative side there can be problems with acne and male pattern balding. The accompanying manifestations of increased body hair and deepening of the voice are generally considered positive by transgender individuals in this setting. Adverse medical outcomes such as liver dysfunction, hypertension and polycythaemia are uncommon, particularly in this age group.

37. Dr R explains that if the procedure is not carried out, "[Kelvin's] overall health and well-being is almost certain to deteriorate without testosterone especially as his mental and physical health is heavily dependent on the perception of himself as male. Research also indicates the negative long-term effects of non-treatment of Gender Dysphoria … When asked how he would feel if he could not have

Phase 2 treatment he replied "It would affect my mental health, I need to pass all the time and I don't want to be misgendered"".

38. Similarly, Dr S opines that if the treatment is not carried out, Kelvin will experience "ongoing intense frustration and feelings of isolation, disgust with his physical body (which Kelvin continues to actively experience with respect to his female genitalia) and consequent difficulty forming relationships. These factors are recognized as triggers for suicide attempts. Approximately one third of transgender individuals are reported to have attempted suicide at least once during adulthood pre-treatment".

39. If the treatment is not carried out, Dr H states that a potential scenario if the treatment were not carried is "for individuals to obtain illicit drugs which are common place in gymnasiums. These preparations are unregulated with no guarantee regarding their efficacy or safety. Such treatment does not afford an individual the benefit of regular blood tests and periodic review. Therefore, at the very least, medically supervised hormone treatment can be considered an exercise in harm minimisation."

THE CHILD'S CAPACITY TO MAKE AN INFORMED DECISION

40. Kelvin's father gives the following evidence:

> As a decision-maker, [Kelvin] adopts a structured approach. [Kelvin] critically evaluates issues that affect him. [Kelvin] is open to the views of others. For example, in 2014 after considering identity related issues that affected him, [Kelvin] decided to change his name. After concluding he had nothing to hide, [Kelvin] informed family and friends of his transition.
>
> …
>
> [Kelvin] is aware of the difference Stage 2 treatment will make to his everyday life, such as the administration of testosterone by needle approximately every 3 weeks. He understands the effects of testosterone with respect to facial hair growth, body fat redistribution, voice deepening, possible hair balding and likely clitoral enlargement.
>
> [Kelvin] understands the irreversible effects of Stage 2 treatment, but in his opinion the advantages outweigh the disadvantages.
>
> [Kelvin] is considering top and bottom surgery in the future, specifically after turning 18.

41. In her report dated 30 August 2016, Dr R, psychologist, states that Kelvin understands the nature of Stage 2 treatment and the impact that it is likely to have on him and says he is focussed on the "benefits he will gain as he explained the significant positive difference that these aspects … will make to him". She says he is also aware of the possible risks of taking testosterone which are: polycythaemia; weight gain; acne; androgenic alopecia (balding); sleep apnoea; elevated liver enzymes; hyperlipidaemia; destabilisation of certain psychiatric

disorders; cardiovascular disease; hypertension; type 2 diabetes; loss of bone density; breast cancer; cervical cancer; ovarian cancer and uterine cancer. She says that he has weighed the advantages and disadvantages of the treatment and believes the advantages he hopes to receive "clearly outweigh the medical risks and possible disadvantages". She concludes that "[Kelvin] expressed that he is under no added pressures at the moment and therefore feels that his decision-making is clear regarding access testosterone in order to treat his Gender Dysphoria".

42. In his report dated 10 August 2016, Dr S, psychiatrist, opines:

> With reference to the Gillick standard, [Kelvin] demonstrated a capacity to be able to comprehend and retain existing and new information, and provide a full age-appropriate explanation of the nature of the treatment. He was able to discuss meaningfully both the advantages and disadvantages, weigh these up and arrive at a position to proceed with the treatment. He could comprehend the possibility of unforeseen consequences, and that the treatment will not act as a universal panacea. He was ostensibly free of any pressure, pain or other factors that might influence his decision-making capability.

43. In his report dated 7 September 2016 Dr H, endocrinologist opines that there was "no evidence or history of a psychiatric or psychological disorder influencing Kelvin's desire and decision to undergo treatment with masculinizing hormones. Similarly, Kelvin has no history of substance abuse affecting his judgment". Further, he concludes that "[Kelvin] is able to comprehend the nature of the treatment such that he is able to provide informed consent, according to the *Gillick* standard. [Kelvin] is aware of the potential benefits and negative effects of treatment, including the effects on fertility. [Kelvin] is aware that some of the effects of testosterone, such as deepening of the voice and scalp hair loss, are permanent and remain even if treatment is discontinued. [Kelvin] is cognisant of the fact that the treatment may have unforeseeable consequences. [Kelvin's] expectations of treatment are realistic such that he does not expect treatment to address all future psychological and social difficulties that he may encounter".

THE CHILD'S WELFARE

44. Kelvin's father is his primary carer.

45. Kelvin has not seen his mother in around two years and has expressed a wish not to see her. Kelvin's father says that Kelvin's mother is supportive of Kelvin's "transition" and has expressed that Kelvin is at liberty to contact her if he needs to.

46. Since April 2015 Kelvin's attendance at school has improved and his academic grades are good. His father says that Kelvin enjoys applying himself at school and meets regularly with his school counsellor.

47. Kelvin's father says that Kelvin has a small group of friends both at and outside

of school whom he socialises with. He says that "all of [Kelvin's] friends are understanding and supportive of [Kelvin's] transition and have re-enforced this at various times throughout their friendship".

48. Kelvin's father says that Kelvin made the decision to decrease the frequency of his sessions with Ms F because he did not have as much to talk about with her anymore and there were "less bad issues to talk about". He states:

> There has been a noticeable difference in [Kelvin] since he has been seeing [Ms F]. Despite brief moments of dysphoria, [Kelvin's] underlying attitude and confidence has improved. For example, [Kelvin] has arranged his own month long international trip … in 2017. His knowledge and awareness of Stage 2 treatment has also influenced his positive outlook.
>
> [Kelvin] has a better outlook on life. [Kelvin] has been more positive since his appointments with [Ms F]. We have had a few joint sessions with [Ms F], which has also improved our relationship.
>
> When [Kelvin] does experience brief moments of dysphoria now, he stays positive by focusing on his end goal of wanting acceptance for who he is. [Kelvin] affirms his motivation daily with positive literature and motivational quotes. [Kelvin] has positive quotes within his bedroom and an on his laptop.

49. Kelvin's family members have accepted his request to be recognised as male. Kelvin's father's friends are very supportive of Kelvin. Kelvin's father says that initially Kelvin's paternal grandparents expressed reluctance towards his transition but "have come around over time".

50. Dr R states in her report:

> [Kelvin] described his experience of puberty as "I thought … 'this really shouldn't be happening to me'" and regarding his body stated "I feel very revolting". When asked is there any part that stands out he replied "All of it really".
>
> …[Kelvin's] father reported that puberty "probably came as a bit of a shock … he doesn't like his body" and "when he asked for a binder 3-4 years ago, I got him one straight away … the binder allowed him to be more comfortable with his appearance".
>
> [Kelvin] explained that in the past he has self-harmed when he felt frustrated about the lack of progress in his gender transition. He spoke about his response to the self-harm incident, he said "I scared myself, now I've flatlined". By this [Kelvin] meant that he calms himself in response to difficult feelings instead of acting on them.

51. Dr R concludes that "[Kelvin's] motivation and aspirations are inextricably linked to being perceived and treated as a male. Indeed, [Kelvin's] vision for a satisfying and successful future is dependent on the administration of

Testosterone in order for him to be perceived and treated as male." She recommends that [Kelvin] receive Stage 2 treatment and that to do so is necessary for his ongoing psychological health and overall wellbeing.

52. Dr S states:

> As feminising changes of puberty progressed, so has the severity of [Kelvin's] anatomical and social role dysphoria. Voice, body and menstruation dysphoria have been only partially and temporarily mitigated by daily chest binding and by the initiation of oral contraceptive medication. [Kelvin] had begun to self-harm by cutting last year, a measure of his pronounced emotional distress.
>
> Since steps towards medical transition have begun … [Kelvin] endorsed some relief of his mood, sleep, enjoyment and energy. He continues to suffer worthless and guilty cognitions but reports a sense of growing hopefulness. [His father] corroborated this improvement though continues to observe [Kelvin's] mood instability and periods of low mood and sadness. [Kelvin] feels well supported by family and friends. He continues to see [Ms F] weekly with some improvement in his at times severe social anxiety and school absenteeism.
>
> On Mental State examination, [Kelvin] presented as of average stature, dressed and appearing as very male in black beanie and coloured zipper jacket, dark pants and boots. He displayed a warm and reactive affect and was forthcoming and well versed in understanding his current status and the options for further transition. There was no psychotic, pervasive depressive or suicidal features.
>
> I believe [Kelvin's] identity as male to be stable and enduring.

53. In his report dated 7 September 2016 Dr H, endocrinologist, states that Kelvin's history of gender dysphoria has resulted in significant problems with anxiety and depression for which he has not been prescribed medication. He states that Kelvin's "schooling has suffered as a consequence of the pervasive influence of gender dysphoria … The issue of gender incongruity has no doubt been compounded by the fact that his pubertal development has not matched those of his male friends and peers".

CONCLUSION

54. Having regard to all of the matters referred to, I am satisfied that Kelvin is *Gillick* competent, given that he has sufficient understanding and intelligence to enable him to understand fully what is proposed by Stage 2 treatment. It follows that I shall make a finding that Kelvin is *Gillick* competent to consent to Stage 2 treatment for Gender Dysphoria.

CONFIDENTIALITY

55. It is appropriate to make orders for confidentiality and restrictions on persons

who shall be permitted to search the court file, as sought.

CASE STATED

56. I have earlier referred to the different views as to what approach should be taken at first instance to the type of application that has been made in this case following what the Full Court said in *Re Jamie*. I am also mindful of the wider controversy at first instance (for example, *Re Martin* [2015] FamCA 1189; *Re Harley* [2016] FamCA 334) and more generally in academic writings (for example, Fiona Kelly, 'Australian children living with gender dysphoria: does the Family Court have a role to play?' (2014) 22(1) *Journal of Law and Medicine* 105; Felicity Bell, 'Children with gender dysphoria and the jurisdiction of the Family Court' (2015) 38(2) *University of New South Wales Law Journal* 426) as to whether or not *Re Jamie* was correctly decided. The father has agreed for a special case to be stated for the opinion of the Full Court, pursuant to s 94A(1) of the Act, on the following facts and questions:

The facts

The facts in this case are set out in Reasons for Judgment delivered on 16 February 2017.

Questions

1. Does the Full Court confirm its decision in *Re Jamie* (2013) FLC 93-547 to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults as classified in the *Diagnostic and Statistical Manual of Mental Disorders 2015* (Fifth Edition) DSM-5 (the treatment), requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act"), unless the child was *Gillick* competent to give informed consent to the treatment?

2. Does the Full Court confirm that the Family Court of Australia and not the child's treating professionals should determine whether a child is *Gillick* competent to give consent to the treatment (Bryant CJ at [136]-[137], [140(e)]; Finn J at [186] and Strickland J at [196] in *Re Jamie*)?

3. If the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie* (Bryant CJ at [139]; Finn J at [188] and Strickland J at [192]), if a finding is made that the child was *Gillick* competent to give informed consent to the treatment, should any application for a declaration that the child is *Gillick* competent to give consent to the treatment, be dismissed?

4. In the alternative, if the answer to question 2 is yes, given statements made by the Full Court in *Re Jamie* (Bryant CJ at [139]; Finn J at [188] and Strickland J at [192]), if a finding is made that the child was

Gillick competent to give informed consent to the treatment, should any application for an order authorising the administration of the treatment, be dismissed?

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

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

57. Accordingly, the applicant's Initiating Application filed 25 January 2017 for a declaration or in the alternative an order authorising treatment be adjourned pending determination by the Full Court of the special case stated to the Full Court. The finding that has been made that Kelvin is *Gillick* competent to consent to Stage 2 treatment for Gender Dysphoria will enable Kelvin to consent to the commencement of treatment immediately.

I certify that the preceding fifty-seven (57) paragraphs are a true copy of the ex tempore reasons for judgment of the Honourable Justice Watts delivered on 16 February 2017.

Associate:

Date: 16.2.2017

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