

FAMILY COURT OF AUSTRALIA

RE: JAMIE

[2013] FamCAFC 110

FAMILY LAW – APPEAL – MEDICAL PROCEDURES – childhood gender identity disorder – point of law: is treatment of childhood gender identity disorder a medical procedure which requires court authorisation pursuant to the court’s welfare jurisdiction under s 67ZC? – two-phase treatment: “stage one” fully reversible, “stage two” found to be irreversible without surgical intervention – if provision of treatment (stage one or stage two) is in dispute, the court will make a determination under s 67ZC – if the child, parents and treating medical practitioners agree as to commencement of stage one treatment, *Marion’s case* does not apply and court authorisation is not required – stage two treatment falls within the ambit of *Marion’s case* because there is a significant risk of the wrong decision being made as to the child’s capacity to consent to treatment (“*Gillick* competence”) and the consequences of such a wrong decision would be particularly grave – if a child is not *Gillick* competent, the court must determine whether or not to authorise stage two treatment – if a child is *Gillick* competent, the child can consent to stage two treatment and no court authorisation is required – however, the question of whether or not a child is *Gillick* competent, even where the parents and treating doctors agree, is a matter to be determined by the court.

Care of Children Act 2004 (NZ)

Consent to Medical Treatment and Palliative Care Act 1995 (SA)

Family Law Act 1975 (Cth)

Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011 (Cth)

Family Law Reform Act 1969 (UK)

Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 (Cth)

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112

In Re Kevin (Validity of marriage of transsexual) (2001) FLC 93-087

In Re Marion (No 2) (1994) FLC 92-448

Minister for Immigration and Ethnic Affairs v Teoh (1995) 183 CLR 273

Re Alex: Hormonal Treatment for Gender Identity Dysphoria (2004) FLC 93-175

Re Bernadette (Special Medical Procedure) (2010) 43 Fam LR 467

Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 (“*Marion’s case*”)

Telfer & Telfer (Unreported, Family Court of Australia, Gun J, 11 July 1994)

APPELLANT PARENTS: The mother and the father

**INDEPENDENT CHILDREN’S LAWYER
(AS RESPONDENT):**

FIRST INTERVENER: A public authority

SECOND INTERVENER: Australian Human Rights
Commission

FILE NUMBER: File number suppressed by court
order

APPEAL NUMBER: Appeal number suppressed by court
order

DATE DELIVERED: 31 July 2013

JUDGMENT OF: Bryant CJ, Finn & Strickland JJ

HEARING DATE: 6 March 2012

LOWER COURT JURISDICTION: Family Court of Australia

LOWER COURT JUDGMENT DATE: 6 April 2011

LOWER COURT MNC: [2011] FamCA 248

REPRESENTATION

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

ORDERS

- (1) The appeal be allowed.
- (2) Order 1 of the orders made by the Honourable Justice Dessau on 28 March 2011 be set aside.
- (3) There be no order for costs.

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

THE FULL COURT OF THE FAMILY COURT OF AUSTRALIA

Appeal Number: File number suppressed by court order

File Number: Appeal number suppressed by court order

THE MOTHER AND THE FATHER

Appellant parents

And

INDEPENDENT CHILDREN'S LAWYER

Respondent

And

A PUBLIC AUTHORITY

First intervener

And

AUSTRALIAN HUMAN RIGHTS COMMISSION

Second intervener

REASONS FOR JUDGMENT

BRYANT CJ

INTRODUCTION

1. This is an appeal against orders of Dessau J made on 28 March and 6 April 2011 in a parenting case. The child concerned, "Jamie", aged almost 11 years at the time of hearing, was diagnosed as having childhood gender identity disorder. At first instance, the parents were asking the court to authorise them to consent to treatment on behalf of Jamie, under the guidance of Jamie's treating medical practitioners, for the administration of particular drugs designed to achieve suppression of certain hormones affecting the development of male features and particularly the onset of male puberty. The treatment, which occurs in two stages, comprises administration of puberty-suppressant

hormones (stage one) and oestrogen (stage two), and is common to children who are diagnosed with this condition. The treatment would enable Jamie, born a male, to live in her affirmed sex as a female.

2. The orders made by her Honour on 28 March 2011 were:
 1. That Mr and Mrs S shall be authorised to consent to treatment on behalf of their child Jamie under the guidance of Jamie's treating medical practitioners including but not limited to his endocrinologist Dr G and his psychiatrist Dr C, for the administration of Zoladex (a GnRH agonist) and cyproterone acetate in such dose, in such manner and with such frequency as determined in consultation with the treating medical practitioners to achieve suppression of gonadotrophins and testosterone to pre-pubertal levels.
 2. That the full name of Jamie, Jamie's family members and their occupations, the hospital, the Independent Children's Lawyer, Jamie's medical practitioners, Jamie's school, this Court's file number, the name of the Family Report writer, the State of Australia in which the proceedings were initiated, the name of the parents' lawyers, and any other fact or matter that may identify Jamie shall not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the registry, file number, and lawyers' names and details, as well as the parties' real names) shall be released by the Court to nonparties 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, for provision to the treating medical practitioners and 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.
 4. That otherwise all existing applications shall be adjourned for Reasons for Judgment and further orders on a date to be advised to the parties.
3. On 6 April 2011, her Honour delivered reasons for judgment and made further orders otherwise dismissing the parents' application and discharging the independent children's lawyer.
4. The genesis of the appeal is unusual because the matters raised on appeal were not the subject of dispute at trial and can be agitated now only because they raise a point of law. As far as Jamie is concerned, the orders sought for at least stage one treatment were made by Dessau J and treatment is underway. There is no appeal in respect to the effect of her Honour's orders. The appellants' case is that as the court does not have jurisdiction to authorise the parents to consent to

treatment (it being within their parental responsibility), the orders made were beyond jurisdiction and should be set aside.

5. The appeal has particular importance because it has potential relevance for a much wider range of children than just Jamie, whose parents are the appellants in this case. This is because the main issue is whether the treatment (proceeding in two stages) is a medical procedure (*Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (“*Marion’s case*”)) for which consent lies outside the bounds of parental authority and requires the imprimatur of the court.
6. As a result of the potential for this decision to affect other children by eliminating any need to make application to the court for consent to the procedure, in either of stage one and/or stage two of the generally accepted treatment, three parties in addition to the parents were involved in this hearing. The first, the independent children’s lawyer, was appointed at trial by Dessau J for Jamie. Secondly, upon the lodging of the notice of appeal, the Appeals Registrar gave notice of the appeal to the public authority. Notwithstanding the declining of an invitation to intervene at first instance, the public authority filed an application seeking to intervene in the appeal. In a separate judgment delivered 2 February 2012, this court granted leave to intervene to the public authority, pursuant to s 92 of the *Family Law Act 1975* (Cth) (“the Act”) upon the following conditions:
 - (a) the [public authority] is not permitted to call or tender any evidence in relation to the appeal; and
 - (b) the [public authority] is confined to making written and oral submissions in relation to Ground 1 in the Amended Notice of Appeal filed on 24 June 2011.
7. Thirdly, in the course of hearing submissions in relation to the application by the public authority, it became apparent that intervention on behalf of a federal entity, in addition to a state entity, would be appropriate. Upon invitation to the Attorney-General of the Commonwealth and the Australian Human Rights Commission (“AHRC”) to intervene in proceedings, the AHRC filed an application to intervene and an order was made by consent on 24 November 2011 providing for intervention.
8. Those diagnosed with childhood gender identity disorder are part of a group of persons generally referred to in current literature as persons who are transgendered. This is a description of a person who has the characteristics of one sex but who experiences him or herself as being of the opposite sex and who may have undergone hormonal and (usually in adulthood) surgical treatment to change some of their physical characteristics in order to conform more closely to the opposite sex.

9. Recently the Australian Government recognised this state by publishing *Guidelines on the Recognition of Sex and Gender* (“the Guidelines”) to standardise the evidence required for a person to establish or change their sex or gender in personal records held by Commonwealth departments and agencies.
10. In addition the *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth) received Royal Assent on 28 June 2013. This legislation and the Guidelines indicate that those who are transgendered are an identifiable group in our society and their right to live as a member of the sex with which they feel compatible is to be respected.

BACKGROUND TO THE PROCEEDINGS

11. It is convenient to set out passages from the judgment of the Full Court of 2 February 2012, at [3] to [11]:
 3. Although born with the physical characteristics of a male and having a non identical twin brother, Jamie began identifying with the female gender when she was about two and a half to three and a half years old. At the time of the hearing she was in grade five at school and since mid 2009 has been known exclusively as a girl, wearing girls’ clothing, being addressed as a girl by classmates and teachers, using the girls’ toilets, sleeping in the girls’ dormitory at camp and “generally presenting as a very attractive young girl with long blonde hair” (reasons for judgment [at first instance], paragraph 2).
 4. Jamie was diagnosed by the medical experts involved in the case with childhood gender identity disorder. The medical experts supported the parents’ application for Jamie to undertake the following special medical procedures:
 - a) the administration of puberty suppressant hormones such as implants of Zoladex (the gnRH agonist) at intervals and at a dosage as may be determined necessary to achieve suppression of gonadotropins and testosterone to pre-pubertal levels under the guidance of Jamie’s treating practitioners including but not limited to Dr G (endocrinologist), and Dr C (psychiatrist) (“Stage 1”);
 - b) additional treatment of oestrogen as may be considered appropriate by Jamie’s treating endocrinologist currently being Dr G (endocrinologist) and in consultation with and on the written advice of Jamie’s treating psychiatrist, currently Dr C (psychiatrist) (“Stage 2”).
 5. In the reasons for judgment her Honour observed that the medical practitioners were unequivocal as to the absolute urgency for Jamie

to start what is referred to as “Stage 1” treatment, to suppress male puberty. Her Honour noted (reasons for judgment [at first instance], paragraph 5):

... She currently has the pubescent development of a 14-year-old male, and it is rapidly progressing. The concern was that physiological developments, such as a deepening voice, would be irreversible unless treatment was started. For that reason, the hearing in this case was brought forward.

6. At the end of the hearing on 28 March 2011 her Honour permitted Stage 1 treatment but determined that it was premature to make any order about Stage 2. Subsequently the published reasons dealt with her Honour’s reasons for this.

7. Relevantly, in the reasons for judgment her Honour noted the constraints of the Act and that the objects in s 60B(1) are to ensure that parents fulfil their duties and meet their responsibilities concerning the care, welfare and development of their children, and, in making decisions about a particular parenting order the best interests of the child are the paramount consideration (s 60CA). The primary and additional considerations for the Court in determining what is in a child’s best interests are set out in s 60CC(2) and (3). Her Honour noted relevantly for the appeal (reasons for judgment [at first instance], paragraph 33):

It is generally within the bounds of a parent’s responsibility to be able to consent to medical treatment for and on behalf of their child. There are however certain procedures, referred to in the authorities as ‘special medical procedures’, that fall beyond that responsibility and require determination by the court, as part of the court’s *parens patriae* or welfare jurisdiction (see [...] *Marion’s case*) [...]

8. Again, relevantly for the purpose of this application and the appeal her Honour said (reasons for judgment [at first instance], paragraph 33):

... There was no dispute in this case that the procedures proposed fall within the definition of special medical procedures.

9. Her Honour noted that in 1995 s 67ZC of the Act was inserted specifically providing that the Court has jurisdiction to make orders relating to the welfare of children. She observed that the procedure to be followed in applications for medical procedures is contained in Chapter 4, Division 4.2.3 of the Family Law Rules 2004 (Cth) and that r 4.09(2) identifies the evidence that must be included from “a medical, psychological or other relevant expert” in such a case. Her

Honour observed that childhood gender identity disorder has been considered in several reported decisions including *Re Alex: Hormonal Treatment for gender identity dysphoria* (2004) FLC ¶93-175, in which the relevant treatment was permitted.

10. Her Honour went on to consider the matters in r 4.09(2), and in a sensitively expressed conclusion determined that it was in the best interests of Jamie to authorise Stage 1 of the medical treatment. Her Honour noted that although in other cases, including her own previous decisions, Stages 1 and 2 have been dealt with at the one time, in view of the unusually young age of Jamie and the unlikelihood of her requiring further treatment until she was around 16 years of age, she could not decide what was likely to be in Jamie's best interests in six years time and declined to order Stage 2 treatment.
11. At the trial before her Honour apart from the medical experts she had evidence from a family report writer and there was an Independent Children's Lawyer appointed for Jamie. All were supportive of Stage 1 treatment commencing immediately. Her Honour noted in her reasons for judgment that she had made an order inviting the First Intervener and a State government department to intervene in the proceedings, particularly in view of Jamie's young age, but both declined.

THE APPEAL

12. In respect of the appeal itself, the Full Court further said:

12. The appeal was brought by the parents of Jamie ("the Appellants") who now rely on an Amended Notice of Appeal filed on 24 June 2011. They rely upon three grounds of appeal which are as follows:
 1. That, contrary to the view expressed by the learned trial Judge, treatment of the condition described as "childhood gender identity disorder" with which "Jamie" was diagnosed is not a special medical procedure which displaces the parental responsibility of the appellants to decide upon the appropriate treatment for their child.
 2. That Ground 1 be considered and allowed notwithstanding that no such submission was made to the learned trial Judge, and her Honour proceeded on that basis that:- "There was no dispute in this case that the procedures proposed fell within the definition of special medical procedures" (Judgment [at first instance] paragraph 33).

3. Further and in the alternative to Ground 1, once the diagnosis of childhood gender identity disorder was established and accepted and the treatment approved, the learned trial Judge erred in law and the exercise of discretion in concluding that the treatment for the disorder should be the subject of a further application to the Court when the “stage 2” is about to commence.
13. As is clear from the grounds themselves, only Ground 3 raises an issue which was agitated at trial. The first ground asserts that childhood gender identity disorder is not a special medical procedure which displaces the parental responsibility of the Appellants to decide upon the appropriate treatment for their child. It is conceded in Ground 2 that this is not a matter agitated at trial.
 14. Notwithstanding that this issue was not agitated at trial, if her Honour erred in law then the jurisdiction of an appellate court to correct that error can be invoked: *Coulton v Holcombe* (1986) 162 CLR 1, *Suttor v Gundowda Pty Ltd* (1950) 81 CLR 418 and *Metwally v University of Wollongong* (1985) 60 ALR 68.
13. This being so, there are only really two grounds of appeal: the first is Ground 1 and the second is Ground 3, which is in the alternative.
 14. If the Full Court finds merit in Ground 1 it may still be necessary to consider Ground 3 as the treatment has two distinct stages separated in time by several years. In the course of argument, the public authority agitated the position that stage one and stage two treatment might need to be considered independently, and it was possible that stage one might theoretically fall outside the definition of a ‘special medical procedure’, but stage two might not.
 15. Consequent upon the grounds of appeal, the relief sought by the appellants in their amended notice of appeal dated 24 June 2011 was the following:
 1. [A declaration that:]
 - a. the treatment for the medical condition known as CHILDHOOD GENDER IDENTITY DISORDER is not a special medical procedure which attracts the jurisdiction of the Family Court of Australia under s. 67ZC of the Family Law Act; and
 - b. the parents of “Jamie” do not require permission from the Family Court of Australia, or any other [c]ourt of competent jurisdiction to authorise such treatment for their child as they may be advised is appropriate.
 2. In the alternative to Order 1 that the Applicant Mother and Applicant Father be authorised to consent to the following special

medical procedures on behalf of their child, ... (“Jamie”) born ... 2000:

- a. The administration of puberty suppressant hormones, such as implants of Zoladex (a GnRH agonist) at intervals and at a dosage as may be determined as necessary to achieve suppression of Gonadotrophins and testosterone to pre-pubertal levels under the guidance of Jamie’s treating medical practitioners including by [sic] not limited to [Dr G] (Endocrinologist) and [Dr C] (Psychiatrist); and
 - b. Additional treatment of oestrogen as may be considered appropriate by Jamie’s treating Endocrinologist, currently being [Dr G] (Endocrinologist) and in consultation with and on the written advice of Jamie’s treating Psychiatrist, currently being [Dr C] (Psychiatrist).
3. That for all publication and reporting purposes the file number of this case and the names and other identifying features of the parties, the child, the witnesses, the members of the Full Court, the location of the registry, counsel and solicitors involved in this case be suppressed.
16. The last order was not the subject of any submissions; however a suppression order was made in the appeal on 7 June 2011.

APPELLANTS’ SUBMISSIONS

17. The appellants’ written submissions assert that any definition of the law concluding that this condition (and other cases with an identical diagnosis) is not a *special medical procedure* must of necessity “be limited to circumstances where there is unanimous agreement between the relevant people involved with the welfare of the child including, if appropriate, the child” (appellants’ written submissions, 2 September 2011, at [11]).
18. The appellants accepted that one exception would be where the child in question was under the care of a state government department, such as in *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175 (“*Re Alex*”). The appellants submitted that it “would be an important safeguard for children in care to ensure that the Court looked at their matter given the absence of a parent whose focus is on the welfare and needs of their own child” (appellants’ written submissions, 2 September 2011, at [11]).
19. The appellants submitted further that their submissions should not be read as in any way “seeking to remove the oversight of the Court where there is a genuine controversy surrounding the question being determined, for example, if the parents are unable to agree” (appellants’ written submissions, 2 September 2011, at [12]).

20. The appellants submitted that this matter is one where there was unanimous agreement between the parents and all of the experts about the correct treatment to be administered to Jamie. At first instance, her Honour had ordered that the public authority and a state department be invited to intervene in the proceedings, but neither organisation accepted that invitation. The independent children’s lawyer supported the treatment sought and the matter proceeded at trial without an effective contradictor.

21. In support of Ground 1, the appellants submit that the present case, as with all cases of childhood gender identity disorder, can be distinguished from the facts in *Marion’s case*. In that case, the High Court (per Mason CJ, Dawson, Toohey and Gaudron JJ) said at 250:

But first it is necessary to make clear that, in speaking of sterilization in this context, we are not referring to sterilization which is a by-product of surgery appropriately carried out to treat some malfunction or disease. We hesitate to use the expressions “therapeutic” and “non-therapeutic”, because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.

As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in my opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child’s present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.

22. An effective formulation of the ratio of *Marion’s case* is to be found Nicholson CJ’s decision in *Re Alex* at [153]:

Marion’s case involved an application for the sterilisation of a 14-year-old teenager with a severe intellectual disability for the purpose of “preventing pregnancy and menstruation with its psychological and behavioural consequences”. The gravamen of the decision was that if a child or young person cannot consent her/himself to a medical procedure, parental consent (which for present purposes may be equated with that of a guardian) is ineffective where the proposed intervention is:

- invasive, permanent and irreversible; and
- not for the purpose of curing a malfunction or disease.

23. The appellants contend that there are a number of features that make this case (and other similar ones) distinguishable from the facts in *Marion’s case*. In

particular, at [14] of the appellants' summary of argument in support of the appeal, the appellants submit that:

What stands out about the facts in *Marion's Case* (supra) is;

- a. The child was intellectually disabled. Therefore it was unlikely that she would ever be able to express a view about her own welfare.
 - b. The procedure to be adopted was irreversible and conclusive. The child would, if the procedure was carried out, never be able to give birth.
 - c. The Court found that there were other interests besides that of the child, which were being considered, that is, the parents' or carers interests.
 - d. The condition which was sought to be corrected by surgery was not an illness or bodily malfunction. There was a disconnect between the problem which was sought to be resolved and the means of resolving it.
 - e. The parents and other carers stood to benefit from the procedure by virtue of the fact that their task was made much more manageable.
24. The appellants contend that the procedure here is totally reversible up to the age of 16 years approximately, and if, with the passage of time, it is determined that the child should revert to their birth gender, the treatment would stop and puberty and other development would resume.
25. In relation to Ground 3, they contend that the procedure at stage two is also reversible, although the child might need to undergo a mastectomy as the application of hormonal treatment will lead to the development of breasts.
26. Secondly, the appellants contend that the condition is a diagnosed psychiatric condition which has been medically recognised with well-recognised treatment strategies. The evidence in the case confirms that the child met the "DSM IV criteria for diagnosis of Gender Identity disorder of childhood (302.6)" (appellants' written submissions, 2 September 2011, at [15], sub-paragraph (c)). This being so, the appellants contend, there is no rational basis for distinguishing treatment for a psychiatric or psychological condition from a physical ailment or impairment.
27. Thirdly, the appellants contend that there is no evidence that anyone other than the child stood to benefit directly from the treatment being undertaken. In fact, the evidence indicated that the parents were hopeful that the desire of the child to be a girl was "just a 'phase'" and that the only thing the parents sought to gain from the treatment was a "well child" (appellants' written submissions, 2 September 2011, at [15], sub-paragraph (e)).

28. Fourthly, at [16] in their written submissions, the appellants contended that the need to make an application to the Court, in circumstances where there was “no controversy” and where the procedure was “truly therapeutic”, caused the appellants and the child anxiety, stress and the expense of obtaining legal representation, and further that:

- The need to list these types of matters urgently created tension between the medical needs of this child and the court’s need to deal with other urgent cases.
- The admissible evidence necessary to enable the trial judge to make an informed decision was material that was already known to the parents and supported the treatment for which the parents sought consent.
- Parents in these circumstances should not be subjected to the vagaries of the court’s listing system.
- Considerable expense occurs for representation for the parents, independent children’s lawyer and medical practitioners who are required to provide affidavits and give evidence.

29. All this, it is contended, arose in a milieu in which the evidence given and accepted merely confirmed the existence of a psychiatric or psychological disorder and that the treatment proposed was in the best interests of the child, and should be provided.

30. It is submitted that Nicholson CJ in *Re Alex* categorised treatment for childhood gender identity disorder as falling outside treatment for a “malfunction or a disease” (at [153]), thereby requiring an order from the court authorising the parents to consent to the treatment to be administered. It is contended that his Honour’s interpretation of *Marion’s case* as limiting:

the treatments excluded from court authorisation to diseases or malfunction of organs is too narrow a construction of the High Court’s decision. This construction leaves out the whole area of psychiatry. If his Honour’s construction is correct, whenever a child suffering a psychotic episode needs to be restrained, admitted as an involuntary patient or administered drugs, permission would need to be obtained from the Family Court. Clearly that was not what the High Court intended. There is no cogent reason why psychiatric or psychological condition [sic] should be excluded from the malfunction or disease definition in *Marion’s Case* ... Conversely, there is no reason why permission needs to be sought where the treatment is for a psychiatric or psychological condition.

(appellants’ written submissions, 2 September 2011, at [19])

31. It is further submitted by the appellants at [20] of their written submissions that “there are many aspects of parental responsibility which are difficult”, such as

“[t]o give permission to turn off life support for a dying child ... There is no reason to believe that responsible parents with the support of expert medical practitioners cannot or ought not make the best decisions for their child”.

32. It was further submitted at [22] that gender identity disorder is:

a recognised and diagnosable psychiatric condition [whose] treatment is therapeutic, that is to treat a bodily malfunction or disease. Parents and guardians can and do consent to therapeutic psychiatric treatment for their minor and non-competent children without the authorisation of the Court.

33. Thus it was submitted that the court has no supervisory role here.

34. The appellants contended in oral submissions that the decision of the Nicholson CJ in *Re Alex* (and the cases that followed¹) was wrongly decided, and this court should find that to be so. In particular, it was submitted that this court should come to a different conclusion from that set out by his Honour at [195], where he said:

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.

SUBMISSIONS OF THE INDEPENDENT CHILDREN’S LAWYER

35. The independent children’s lawyer opposed the appeal and made relatively succinct submissions in relation to Ground 1, adopting, essentially, the decision of Nicholson CJ in *Re Alex* that:

a number of medical procedures have been held by the court to be procedures that are beyond parental power to authorise and require the approval of the court. The treatment of Gender Identity Disorder ... by the administration of hormonal therapies has been held to be such a procedure, the first such case being the decision of Nicholson CJ in *Re Alex* ...

(written submissions of the independent children’s lawyer, 23 September 2011, at [3])

36. The independent children’s lawyer submitted at [7] that, in accordance with *Marion’s case*:

¹ *Re Brodie (Special Medical Procedures)* [2008] FamCA 334, *Re Bernadette (Special Medical Procedure)* (2010) 43 Fam LR 467, *Re O (Special Medical Procedure)* [2010] FamCA 1153, *Re Rosie (Special Medical Procedure)* [2011] FamCA 63, *Re Jodie* [2013] FamCA 62, *Re Lucy (Gender Dysphoria)* [2013] FamCA 518.

the treatment of [gender identity disorder] is not a medical procedure for treating “a bodily malfunction or disease” as it is treatment for a psychological condition with an unknown etiology. The treatment is one where an otherwise healthy body’s functioning is altered to address a dissonance between a belief as to gender and the actual gender of the person.

37. Further, at [8]:

Nicholson CJ in *Re Alex* ... at paragraph 195 said that treatment for [gender identity disorder] is not treatment for a “malfunction” or “disease” and should be distinguished from medical treatment which seeks to address disease in, or malfunctioning of, organs.

38. The independent children’s lawyer did not take these submissions any further in oral submissions.

SUBMISSIONS OF THE PUBLIC AUTHORITY

39. The public authority opposed the appeal and made a number of submissions. First, it was submitted that:

the treatment of childhood gender identity disorder ... (stages 1 and 2) is a special medical procedure, with the consequence that consent to the treatment lies outside the scope of parental responsibility and Court authorization is required under s 67ZC of the ... Act ...

(written submissions of the public authority, 21 February 2012, at [1])

40. In particular, the public authority submitted that in *Marion’s case*, the High Court was considering “the limits to the scope of parental power to consent to medical treatment and, specifically, sterilization” (at [2]), and held, per the plurality, “that non-therapeutic sterilization lies outside the ordinary scope of parental powers and requires Court authorization to protect the interests of the child” (at [3]).

41. At [4], the public authority asserted that the principle in *Marion’s case* “has not been regarded as confined to sterilization or surgical interventions; it is of broad application.” I observe however that the footnote to this submission refers to *Re Alex*, a decision which is challenged in this appeal.

42. The public authority proposed at [5] that the test that must be applied to a medical procedure to establish whether or not it is a special medical procedure, and therefore lies outside the ordinary scope of parental authority, is whether:

- a. the medical procedure is non-therapeutic; and
- b. there is a significant risk of making a wrong decision about the child’s capacity to consent, or the child’s best interests; and
- c. the consequences of making a wrong decision are grave and [sic]

d. the child is not *Gillick* competent ...

43. Applying the test as described, the public authority submitted that stages one and two treatments for childhood gender identity disorder are non-therapeutic as they are not treatments for a malfunction or disease of the body but for a psychological condition and “will have a significant effect on a healthy physical body” (at [12]).

44. The public authority contends (at [15]) that:

there is a rational basis for distinguishing the treatment of [childhood gender identity disorder] (a mental disorder within the terms of DSM-IV) from the treatment of other psychiatric disorders. The pharmaco-therapeutic treatment sought for [childhood gender identity disorder] ‘*does not treat the psychological imperative at the heart of the condition, but alters an otherwise healthy body to accommodate to the psychological imperative.*’ Rather than address a bodily malfunction or disease, the treatment is ‘*inextricably associated with the patient’s self-identity*’ in a developmental stage when this is still forming.

(emphasis in original; footnotes omitted)

45. As to the significant risk of making a wrong decision, the public authority did not deal with the issue that the treatment was reversible, but submitted at [20] that:

The [public authority], mindful of the social model of disability, is concerned about the social consequences of treatment, including the risk of rejection by sections of the community and significant others, and the lack of longitudinal studies about the long term social consequences – what percentage of people ultimately regret the choices made and what percentage are satisfied with the outcome – to inform decision making.

SUBMISSIONS OF AHRC

46. The AHRC supported the appeal in relation to Ground 1, and submitted that absent a dispute about the proposed course of treatment, for example between the views of the child, his or her guardians and treating medical practitioners, “[o]nce a child has been diagnosed with transsexualism by appropriately qualified medical practitioners, Court authorisation should not be required for Stage 1 treatment administered in accordance with accepted treatment guidelines” (written submissions of the AHRC, 22 February 2012, at [13.4]).

47. It was submitted that court authorisation should not be required because:

13.4.1 the treatment is reversible;

13.4.2 there are no alternative treatments available;

13.4.3 withholding (or significantly delaying) treatment is likely to have significant adverse psychological and physical effects.

48. The AHRC submitted (at [13.1]) that the United Nations Convention on the Rights of the Child² should be “an interpretive aid” when considering Part VII of the Act:

The [Convention on the Rights of the Child] makes clear that it is important for children to have input into decisions that affect them, including decisions about medical treatment, and that parents have a special responsibility for assisting their children in making these decisions.

49. It was submitted that it is open to the court to consider separately whether authorisation is required for each of stage one and stage two, and that it is appropriate for a further application to be made to the court regarding stage two when a young person is approaching 16 years of age. The submission noted that:

Treatment guidelines for transsexualism recommend that Stage 2 commence at age 16 because at this age it is expected that the young person will be able to make informed mature decisions and engage in the therapy, while at the same time developing along with his or her peers.

50. The AHRC submitted (at [13.6]) that “[t]he first question to be determined by a [c]ourt when considering an application for authorisation of Stage 2 treatment is whether the young person is ‘Gillick competent’”. If the young person is not *Gillick* competent, then (at [13.8]):

in accordance with s 67ZC(2) [the court] should make an assessment about whether to authorise Stage 2, having regard to the best interests of the young person as the paramount consideration. In making this assessment, [the court] should give significant weight to views of the young person in accordance with his or her age and maturity.

51. In relation to the criteria in *Marion’s case*, the AHRC submitted at [42] that:

It is clear that it is not sufficient for a procedure to be a “special medical procedure”, such as to require Court authorisation, that the procedure is irreversible (*Marion’s case* at 250). Similarly, it is not sufficient that the consequences of carrying out or not carrying out the procedure may be grave. In *Re Baby D (No 2)*, Young J considered an application for authorisation of a procedure which involved removing and not replacing a breathing tube from an infant and possibly thereafter providing palliative care and not providing treatment to artificially prolong the life of the infant. Although this was treatment which had very grave consequences, it was held to be within the scope of parental power.

(footnotes omitted)

52. It is submitted at [43] that:

² *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

an essential element for a procedure that requires court authorisation is that there is a significant risk that a wrong decision might be made, either as to the minor's present or future capacity to consent, or about what are the best interests of a child who cannot consent.

(footnotes omitted)

53. The AHRC submitted that cases involving children with transsexualism but without intellectual disabilities have different considerations from the capacity of children to consent, either presently or at some future time, to sterilisation operations.

54. Distinguishing the cases of transsexualism from *Marion's case*, the AHRC submitted at [52] that:

There is no suggestion in the particular factual circumstances of this case [and, I would add, in these cases more generally] that the treatment proposed would be of independent benefit to Jamie's parents (other than as a result of the benefit to Jamie). Nor is there any suggestion in this case that such treatment would be sought by Jamie's parents if it was not ardently sought by her.

55. This was not the position in *Marion's case*, where the High Court identified that the question of whether a child with an intellectual disability should be sterilised may involve consideration of the "independent and possibly conflicting (though legitimate) interests of the parents and other family members" (at 251, footnote omitted).

56. The AHRC submitted in relation to conflicting interests of others that, if there was a dispute, it was appropriate for the court to hear and determine the application under s 67ZC. This was said at [54] to particularly be the case where:

54.1 there is disagreement about the proposed course of treatment between two or more of the child, his or her parents or guardians and his or her treating medical practitioners;

54.2. there is a real and genuine issue or concern in relation to a medical treatment or procedure that is to be performed on a child.

(footnotes omitted)

57. The AHRC noted that the stage one treatment was reversible, which did not meet the criteria in *Marion's case*. The AHRC submitted further that the condition is medically recognised, being a diagnosis of gender identity disorder of the transsexual type and fulfilling the diagnostic criteria for gender identity disorder as set out in DSM-IV. They submitted that regardless of the ultimate cause, there is no dispute on the evidence that it is a recognised medical condition that is able to be diagnosed. Further, they submitted that Dr G had

given evidence that there are now international consensus guidelines for the treatment of transsexualism published by the US Endocrine Society and endorsed in Australia (the “US Guidelines”). In his affidavit of 22 December 2010, Dr G deposed that:

it would be necessary to continue giving [Zoladex] to [Jamie] until she reached the age of about 16 years, when we would, according to the consensus guidelines published by the U.S. Endocrine Society, start administering oestrogen to her.

(emphasis altered)

58. As set out in the written submissions of the AHRC (at [66]):

The US Guidelines suggest that adolescents are eligible and ready for Stage 1 treatment if they:

- 66.1 fulfil DSM IV-TR or ICD-10 criteria for gender identity disorder or transsexualism;
- 66.2. have experienced puberty to at least Tanner stage 2;
- 66.3. have (early) pubertal changes that have resulted in an increase of their gender dysphoria;
- 66.4. do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment;
- 66.5. have adequate psychological and social support during treatment; and
- 66.6. demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment, cross-sex hormone treatment, and sex reassignment surgery, as well as the medical and the social risks and benefits of sex reassignment.

(footnotes omitted)

59. The AHRC submitted that it is not necessary to identify the cause of transsexualism in order for the court to find that it is a recognised medical condition with agreed procedures for treatment.

60. The AHRC submitted that there was not an issue that the condition had been properly diagnosed. In considering whether there were alternative treatments available, the AHRC noted that in *Re Bernadette (Special Medical Procedure)* (2010) 43 Fam LR 467 (“*Re Bernadette*”), heard in 2007, a divergence of views was expressed about whether treatment should commence before or after puberty. In that case, Collier J concluded at [124]:

I am satisfied there still remains grave dispute within the medical community as to the best treatment that can be offered. I am satisfied that until there is a clear cut line of authority within the medical profession, it would be difficult for parents to reach an informed conclusion in every case.

61. However, since then, as pointed out by the AHRC, the US Guidelines have been published, which has engendered a stronger consensus on treatment modalities for adolescent transsexualism, including that which arises from childhood gender identity dysphoria. As observed at first instance in this matter (at [68]), the evidence led in this case was to the effect that while:

previously some clinicians felt it was important for children to experience pubertal development of their own biological sex, so that they knew what it was really like to be for example “a boy”, before any changes were made ... at the major centres now treating such children, [this is] no longer considered necessary or appropriate in circumstances where a child has a strong and persistent conviction that they are of the opposite gender.

62. The only alternative to hormonal treatment being the withholding of treatment, it was submitted that the withholding of hormonal intervention was itself likely to have adverse psychological and physical effects. The AHRC said:

72. The primary judge referred to expert evidence that withholding treatment may lead to an increased likelihood of major mental disorder and behavioural difficulties including severe depression and anxiety disorders and risk of self-harm. Studies cited by the same expert suggested that self-harm was common among young people with severe gender dysphoria.

73. Further, if treatment was withheld it would have resulted in Jamie undergoing bodily changes that were opposite to her affirmed sex and which would be irreversible without surgery. Jamie would be likely to find such changes psychologically distressing.

63. In conclusion as to stage one treatment, the AHRC submitted at [74] that:

it appears that Stage 1 treatment may also not satisfy the second or third criteria in *Marion's case*. That is, provided that the condition of transsexualism is appropriately diagnosed and administered in accordance with accepted guidelines, it seems that the risk of making a wrong decision is low and that the consequences of making a wrong decision are not grave (particularly because the treatment is reversible). The much more significant risk appears to be that young people in Jamie's position are not able to access treatment in a timely way.

64. In oral submissions, the AHRC submitted that, as from June 2012, there is an explicit requirement under Part VII of the Act for the Convention on the Rights of the Child to be taken into account, albeit that the court has in its decisions

under Part VII long recognised the importance and relevance of the principles found in the Convention on the Rights of the Child. At s 60B(4), in listing the objects of Part VII and their underlying principles, the Act states that:

An additional object of this Part is to give effect to the Convention on the Rights of the Child done at New York on 20 November 1989.

65. The AHRC emphasised that it was important to bear in mind the rights set out in the Convention on the Rights of the Child, and that it should be an interpretive aid when considering the meaning of the provisions in Part VII of the Act. Drawing on three key principles, it was submitted that:
- It is important for children to have an input into decisions that affect them, including decisions about medical treatment.
 - The views of children should be given due weight in accordance with their age and maturity
 - Parents have a special responsibility to provide direction and guidance to their children in the exercise by their children of their rights.

GROUNDS OF APPEAL

Ground 1: Is childhood gender identity disorder a special medical procedure which displaces parental responsibility and requires a determination by the court?

Is Childhood Gender Identity Disorder a Bodily Malfunction or Disease as Defined in Marion’s Case?

66. The written submissions of the public authority suggested that “there is a rational basis for distinguishing the treatment of [childhood gender identity disorder] (a mental disorder within the terms of DSM-IV) from the treatment of other psychiatric disorders” (at [15]). This, it was submitted (at [15]), was because:

The pharmaco-therapeutic treatment sought for [childhood gender identity disorder] *‘does not treat the psychological imperative at the heart of the condition, but alters an otherwise healthy body to accommodate to the psychological imperative.’* Rather than address a bodily malfunction or disease, the treatment is *‘inextricably associated with the patient’s self-identity’*, in a developmental stage when this is still forming.

(emphasis in original; footnotes omitted)

67. In my view, this assertion could be fairly said to lie at the heart of the public authority’s submissions. The authority submits that the pharmaco-therapeutic treatment sought for childhood gender identity disorder does not treat the psychological imperative at the heart of the condition. However, in my view, that is exactly what it does. If the condition involves self-identity of a different

gender from the biological gender with which one is born, then the treatment can be fairly said to address the imbalance of the patient's self-identity with some, at least, of its bodily representation. In my view, it is not, as the submissions of the public authority propose, the alteration of an otherwise healthy body to accommodate a psychological imperative, but rather it is the alignment of the body with the person's self-identity.

68. The difference is a crucial one. The submission, as put, suggests a normative state which, in individual cases, cannot be a rational basis for consideration of the complex issues of transsexualism. Underlying the submission is a suggestion that to have a self-identity which departs from the normative (that is the expected physical characteristics of a particular sex) is abnormal and to treat it is a mere accommodation and not therapeutic. Once it is accepted that there is no normative state, at least not in every person, then the absolute necessity of aligning the self-identity and the physical characteristics becomes apparent. As Chisholm J identified in *In Re Kevin (Validity of marriage of transsexual)* (2001) FLC 93-087, speaking of intersexual phenomena in general and transsexualism in particular, this should be seen as an example of the diversity in human sexual formation, rather than as an aberration in or departure from the norm. Once this is accepted, it is readily understandable why people with transsexualism are concerned about the psychiatric diagnoses of gender dysphoria or gender identity disorder, as they see themselves as merely an example of diversity in human sexual formation, rather than having a psychiatric condition.³
69. However whilst understanding this discomfort, I do not need to determine whether that characterisation is correct or not for the purpose of these proceedings. Gender identity disorder is a psychological condition identified in DSM-IV (and the new DSM-5, published May 2013⁴). It may be that in time to come, transsexualism will no longer be described as a disorder, but for the time being, and for the foreseeable future, the weight of professional opinion is that it represents a particular category of pathology or mental illness.
70. As it was in *Marion's case* that the categories of medical procedures for which parents must seek court authorisation originated, it is useful to consider precisely what the majority there said.

³ See Rachael Wallbank, 'Re Kevin in Perspective' (2004) 9 *Deakin Law Review* 461.

⁴ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (5th edition, May 2013) 451: "Gender dysphoria as a general descriptive term refers to an individual's affective / cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. ... Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and / or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se."

71. First, it is important to note that in *Marion's case*, the court was dealing with the sterilisation of an intellectually disabled 14 year-old girl. The majority (Mason CJ, Dawson, Toohey & Gaudron JJ) did not consider whether treatment for a psychological condition required court authorisation. In examining the scope of parental power, their Honours said at 236-7:

The two major issues referred to at the beginning of this judgment arise more specifically at this point in an examination of parental consent as an exception to the need for personal consent to medical treatment. As noted earlier, the first issue relates to the important threshold question of consent: whether a minor with an intellectual disability is or will ever be capable of giving or refusing informed consent to sterilization on his or her own behalf. Where the answer to that question is negative the second question arises. Is sterilization, in any case, in a special category which falls outside the scope of a parent to consent to treatment? Is such a procedure a kind of intervention which is, as a general rule, excluded from the scope of parental power?

72. Under the heading "Is sterilization a special case?", the majority said at 239-40:

Where their child is incapable of giving valid consent to medical treatment, parents, as guardians, may in a wide range of circumstances consent to medical treatment of their child who is a minor. This is clear in the common law and, by implication, in the *Emergency Medical Operations Act* which creates an exception to the need for parental consent in the case of emergency treatment. ... Where this parental power exists, two principles are involved. First, the subjective consent of a parent, in the sense of a parent speaking for the child, is, ordinarily, indispensable. That authority emanates from a caring relationship. Secondly, the overriding criterion to be applied in the exercise of parental authority on behalf of a child is the welfare of the child objectively assessed. That these two principles become, for all practical purposes, one is a recognition that ordinarily a parent of a child who is not capable of giving informed consent is in the best position to act in the best interests of the child. Implicit in parental consent is understood to be the determination of what is best for the welfare of the child.

... But, the question whether it is in the best interests of the child and, thus, should be authorised is not susceptible of easy answer as in the case of an amputation on other than medical grounds. And the circumstances in which it arises may result from or involve an imperfect understanding of the issues or an incorrect assessment of the situation.

It is useful, at this point, to look at how sterilization has been treated in this regard in relevant cases. That is to say whether, and on what bases, sterilization has been treated as a special case, outside the ordinary scope of parental power to consent to medical treatment.

(footnotes omitted)

73. Under the heading “Can parents, as guardians, consent to sterilization? Conclusion”, the majority said at 249-50:

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

As a starting point, sterilization requires invasive, irreversible and major surgery. ... However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child’s present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.

74. In my view, it is clear that the majority in *Marion’s case* was dealing exclusively with the question of sterilisation, and with the sterilisation of an intellectually disabled child who could not give consent. The only member of the court to consider the application of these principles to a pathological condition or psychological disorder was Brennan J, dissenting in part, who wrote at 269:

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

Should Re Alex be followed?

75. It is accepted that it was the decision of Nicholson CJ in *Re Alex* that extended the definition of medical procedures requiring court authorisation to childhood

gender identity disorder cases. Having regard to the comments of the High Court to which I have referred, I now turn to consider the correctness of the decision of Nicholson CJ in *Re Alex*.

76. In oral submissions, counsel for the appellants said:

The difficulty which we have to confront and overcome is the line of single judge authorities commencing with his Honour, [t]he Chief Justice's decision in *Re Alex*, where his Honour concluded that the condition does not fit the description of a bodily malfunction or disease. His Honour's statement on that point is to be found at paragraph 195 of his Honour's judgment, where his Honour says:

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.

It is this paragraph and the distinction there made by his Honour which we say is a fundamental point which we have to overcome, and which we say was incorrectly decided at the time. The decision was made by his Honour in circumstances where he pointed out in paragraph 191 that there were no specific submissions by the parties in that case. His Honour then goes on to examine the evidence, which touched upon the causes of gender identity disorder, as it was before his Honour in that case. And his Honour concluded that because the cause or aetiology of the disease was not known, it could not be treated as a malfunction or disease.

So what we say, in our respectful submission, is that the definition, which his Honour limited to malfunction or disease of a physical nature, is both unjustified on the reading of *Marion's* case and also unjustified on the evidence as found in the present case by the learned trial judge.

(transcript 6 March 2012, p 4, lines 11-40)

77. In my view, it is the propositions that arise from the Chief Justice's decision in *Re Alex* that require consideration, rather than the outcome of the case. That is because his Honour was dealing with a case in which it was not a parent who was approaching the court in respect of the question of whether treatment lay within parental authority. The legal guardian for Alex, responsible for his care, was a government department, pursuant to an operative care order made by a children's court under child welfare laws. Thus, having regard to the fact that

there was no parent who was able to provide parental consent, his Honour's determination that consent to the treatment was a matter solely within the welfare power of the court may be arguably correct, whatever other bases his Honour may have had for coming to that same conclusion.

78. The case is arguably distinguishable on this basis, but Nicholson CJ relied upon a number of other matters to justify the requirement for the court's oversight. It is necessary to examine these matters.
79. Nicholson CJ observed (at [180]) that the application before him "would seem a novel one and [he] was not referred to any Australian or overseas authority with similar fact characteristics". As his Honour noted, "no surgical intervention [was] sought or indeed contemplated by any of the parties or witnesses while Alex [was] under the age of at least 18 years" (at [3]).⁵ His Honour described the matter before him as "whether [he] should authorise medical treatment involving the administration of hormonal therapies that will begin what is colloquially described as a 'sex change' process" (at [4]). His Honour, at [178], considered whether *Marion's case* should be read as "confining the reasons for authorisation to surgical interventions only", and concluded that it is not surgical interventions alone that fall outside the scope of parental power to consent to medical procedures on behalf of a child. Having regard to the proposed sterilisation that was before the court in *Marion's case*, his Honour posited that the same principles as in *Marion's case* would apply "if authorisation [was] sought for an alternative intervention of **similarly irreversible** effect for the same purpose, for example the use of radiation or pharmaceuticals" (at [178]) (emphasis added).
80. His Honour considered whether the administration of stage one hormones, as a reversible medical treatment, in fact required the court's authorisation. He noted the contrast between stage one treatment – the administration of a combination of oestrogen and progestogen – and stage two, which would have, according to the expert evidence, irreversible consequences.
81. In this instance, his Honour was not being asked to make orders in relation to the second stage. However, his Honour was asked not to view the reversible first stage in isolation from the second stage, which could have irreversible consequences. According to his Honour, it was regarded as common ground that what was before him for determination was a "staged clinical program [that] should be seen as part of a single package" (at [186]). His Honour observed that it had been put to the court, "on the basis of the expert evidence", that "to authorise the first stage of treatment but leave the subsequent stages for future application and determination by this Court would be destructive and anxiety-provoking" for Alex (at [186]). Given that all parties sought an order

⁵ Note that Alex did at 16 return to the Family Court seeking permission for a bilateral mastectomy. The Court made orders that the operation proceed. See *Re: Alex* (2009) 42 Fam LR 645.

authorising both stages of treatment, his Honour accepted that he should treat the stages of treatment as a single treatment plan, and did so.

82. The parties in this appeal approached the matter somewhat differently. First, the decision by Dessau J treated stages one and two separately, permitting only stage one treatment. The appellants themselves focussed their main argument on the assertion that treatment (stages one and two) for the medical condition of childhood gender identity disorder is not a special medical procedure attracting the jurisdiction of the Family Court under s 67ZC of the Act. By this argument, the parents of Jamie would not require permission from the court at all to authorise such treatment. Alternatively, they argued that if unsuccessful on their primary submission, then stages one and two should be considered together.
83. The position of the AHRC was clear. They submitted that stage two treatment should continue to be regarded as “a special medical procedure that requires authorisation” (transcript 6 March 2012, p 42, lines 9-10). In relation to stage two treatment, they submitted that before determining whether or not to authorise stage two treatment, the threshold question for the court is whether the child has the competency to authorise such treatment on his or her behalf. That is a matter to which I will return later.
84. The AHRC made it clear that they were not seeking to submit that a child should be able to consent to a sterilisation procedure, and that their submissions were limited to treatment mechanisms for childhood gender identity disorder in young people.
85. At [153], Nicholson CJ summarised *Marion’s case* thus:
- The gravamen of the decision was that if a child or young person cannot consent her/himself to a medical procedure, parental consent (which for present purposes may be equated with that of a guardian) is ineffective where the proposed intervention is:
- invasive, permanent and irreversible; and
 - not for the purpose of curing a malfunction or disease.
86. In applying those criteria to *Re Alex*, Nicholson CJ found that: “the evidence does not establish that Alex has the capacity to decide for himself whether to consent to the proposed treatment” (at [168]). As to the question of whether the proposed treatment was invasive, permanent and irreversible, his Honour treated both stages together and satisfied himself that the second stage, in particular, would have irreversible consequences.
87. I cannot be certain, however, his Honour would have come to the same conclusion had he considered only stage one. At [185], his Honour said:

I was asked not to view the **reversible** first stage in isolation from the second stage of hormonal therapy which would have **irreversible** consequences and may involve injections or an implant.

(emphasis added)

88. In my view, the evidence is clear that stage one is a reversible process, and therefore, unlike his Honour, I do not think that it can be described as “invasive, permanent and irreversible” (at [153]).
89. In relation to whether the treatment was for the purpose of curing a malfunction or disease, Nicholson CJ pointed out that there were no specific submissions before him in this regard, and that the High Court’s definition in *Marion’s case* was framed in the context of an application for a sterilisation that was not, in the strict sense, medically required.
90. At first instance in this matter, Dessau J set out at [82] the evidence before the court:

Dr G saw no problems in carrying out the first stage of treatment. It is fully reversible. It has no side-effects. As he said, “Endocrinologists have been prescribing it for years in children much younger than [Jamie], to arrest precocious puberty”. It would enable Jamie’s mental development to proceed “normally”, without the “terrible impediment” of gender dysphoria. Dr G cited that blocking puberty at an early age has been shown in other centres to be beneficial, and is recommended in clinical guidelines published in 2009 by the US Endocrine Society.

91. Hence there was no debate at first instance that stage one, which I am here considering, was fully reversible. Unlike Nicholson CJ in *Re Alex*, Dessau J did not examine in detail the aetiology of Jamie’s condition. I do not suggest that it was essential to do so. As I have indicated, in considering whether the treatment is a response to a “malfunction or disease”, if that is the focus of the enquiry, it is sufficient that the condition is a psychiatric or psychological condition as defined by DSM-5 (or DSM-IV, as it stood at the time of hearing), and that the evidence is confirmatory.
92. At [47], Dessau J wrote:

On 12 January 2011, [Dr N] prepared a report in relation to Jamie. ... The diagnostic conclusion was that Jamie “meets DSM-IV Criteria for the diagnosis of Gender Identity Disorder of childhood ...”.

93. Although Dr C did not in his written report specifically address it, a number of academic papers attached to his affidavit discuss the aetiology of gender identity disorder and the current inability to conclusively explain the phenomenon. For example:

In summary, neither biological nor psychological studies provide a satisfactory explanation for the intriguing phenomenon of [gender identity

disorder (“GIDs”)]. In both disciplines, studies have been able to correlate certain findings to GIDs, but the findings are not robust and cannot be generalized to the whole population.⁶

94. Further:

The development and maintenance of gender identity disorders is held to be a multifactorial pathological process, in which individual psychological factors exert their effects in concert with biological, familial and sociocultural ones. From the point of view of developmental psychology, it would be wrong to imagine that patients with GID constitute a homogeneous group with a uniform pathogenesis. Different theoretical conceptions imply different – complementary, not necessarily contradictory – notions of the possible causes of GID. In view of the still unsatisfactory state of the data, any generalizations should be made with caution.

Neurobiological genetic research has not yet convincingly shown any predominant role for genetic or hormonal factors in the etiology of GID.

...

On the other hand, studies of gender identity in patients with various types of intersex syndrome (e.g. complete versus partial androgen receptor defects) have led to the formulation of a biological hypothesis for the etiology of gender identity disorders, in which these are caused by hormone resistance restricted to the brain. In addition, neuroanatomical findings in the dichotomous brain nuclei of transsexual patients provide further evidence for a biological component in the complex etiology of GID. Contrary to earlier assumptions, gender identity cannot be changed by external influences alone, i.e., attempts at so-called “re-education,” even when these attempts are begun as early as first year of life; this implies an early somatic determination of gender identity. Moreover, because bodily and genital sensations exert a major effect on psychosexual and gender-identity development, one must assume that the overall process involves an interaction of biological and psychosocial factors. Etiological and pathological influences should thus be sought in both areas.

...

The diagnosis and treatment of gender identity disorders in childhood and adolescence falls within the expertise of child and adolescent psychiatrists, who should, however, regularly call upon the expertise of colleagues in sexual medicine and paediatric endocrinology.⁷

(footnotes omitted)

⁶ Wylie C Hembree et al, ‘Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline’ (2009) 94(9) *Journal of Clinical Endocrinology & Metabolism* 3132.

⁷ Alexander Korte et al, ‘Gender Identity Disorders in Childhood and Adolescence: Currently Debated Concepts and Treatment Strategies’ (2008) 105(48) *Deutsches Arzteblatt International* 834, 835, 837, 839.

95. The point, I think, is that despite the inability to identify conclusively the aetiology of gender identity disorder, it has been identified as a disorder in DSM-IV and in its recently published successor, DSM-5.

96. At [195], Nicholson CJ in *Re Alex* stated that:

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.

As his Honour said, later in that paragraph, “[t]he present case does not lend itself to such a comparison”.

97. It is undoubtedly the case that the majority in *Marion’s case* were speaking of medical treatment seeking to address disease or malfunctioning of organs. It is conceivable, therefore, that the majority did not have in contemplation at all that a psychiatric disorder would fall within a group of cases in which the court’s authorisation for treatment would be required. However I see no reason to limit their observations to a physical disease, particularly as Brennan J directly addressed the application of the principle to psychiatric disorders and considered it therapeutic provided the treatment is appropriate for and proportionate to the purpose for which it is administered.

98. Thus where the question is whether the treatment relates to a disease or malfunctioning of organs, including psychological or psychiatric disorders, then, in my view, if the treatment is in response to a disorder, even a psychological or psychiatric one, it is administered for therapeutic purposes. For that reason alone, in my view, the treatment at stage one for gender identity disorder would not fall within the category of cases which the High Court was considering in *Marion’s case*.

99. It also appears that the novelty of the condition described by Nicholson CJ is no longer supportable. The cases since *Re Alex* (see footnote 1 above) would indicate that the condition is not as unusual as it presented itself in 2003 when *Re Alex* was decided. The cases referred to above followed the approach taken by Nicholson CJ in *Re Alex*. This may be simply because it was not until *Re Bernadette* that the issue of whether it was in fact necessary for the court to determine whether treatment should be provided was raised.

100. Before leaving this ground, I need to address the submission of the public authority that stage one falls within *Marion’s case* because there is a significant risk of making the wrong decision where the treatment is invasive, permanent and irreversible.

101. The public authority submitted that the specific factors contributing to the significant risk of making the wrong decision are (at [23]):
- a. the aetiology of the disorder is not understood;
 - b. the procedures to treat it/ respond to it are experimental;
 - c. the procedures are ethically complex and contentious;
 - d. the procedures will commence or continue a gender change process, a major life-altering decision; and
 - e. there are differing professional opinions as to how a child or adolescent should be treated for gender identity disorder.

(footnotes omitted)

102. I note, however, in relation to these submissions that the evidence in this case was overwhelmingly indicative of the treatment being a common treatment:

Zoladex, a GnRH analogue, [used] to block puberty ... was described by Dr G as routinely used in the hospital to treat children with precocious puberty, as well as patients with gender identity disorder. He described it as almost always effective in suppressing pituitary gonadotrophins, which then shut off testosterone production by the testes for as long as treatment is continued. In Dr G's experience, it has never caused any unwanted side-effects.

(first instance judgment at [55])

103. The public authority submitted at [24] that:

The specific factors arising that may contribute to a significant risk of a wrong decision and the gravity of the consequences arising from a wrong decision need to be considered in a systematic and holistic way for the purposes of establishing whether or not a procedure is a special medical procedure. A limited focus on whether a procedure is invasive or reversible does not address the potential factors arising out of various domains that may contribute to a medical procedure being special as required by the special medical procedure test.

(footnotes omitted)

104. The public authority further submitted that stages one and two are part of one treatment plan and the special medical procedure test needed to be applied to the treatment plan as a whole.

105. However, many conditions result in different views about what treatment should be given – for example, whether a condition might be treated with medication or surgery, and which medications might be more effective than others. The possibility of different treatments, provided they are not invasive,

permanent and irreversible, would not render the treatment as requiring the court's approval on that ground alone. Counsel further submitted that it was necessary to emphasise the complexity of the issues involved and the evolving nature of the therapy, and to identify the attendant risks. Counsel said:

And so one might say that there are certain conditions which will always or just about always require court authorisation. There may well be other conditions which will commonly or sometimes require court authorisation. It will depend. It will depend on the facts coming out in the case, and also the evolving state of medical knowledge and similar.

(transcript 6 March 2012, p 33, lines 12-16)

106. While I agree that there may be cases when issues present themselves as requiring the court's authorisation due to the evolving state of medical knowledge, the question is whether the treatment at stage one involves such a condition. In my view it does not for the reasons explained.
107. It is also important in these cases to identify that, unlike *Marion's case*, it is unlikely that the parental interests would be anything other than the welfare of the child (as opposed to having a collateral interest in having the treatment carried out). Accordingly, I agree with Ground 1 of the grounds of appeal, to the extent that it is confined to stage one of the treatment, so that, contrary to the view expressed by the trial judge, stage one of the treatment of the condition described as "childhood gender identity disorder", with which Jamie has been diagnosed, is not a special medical procedure that displaces the parental responsibility of the appellants to decide upon the appropriate treatment for their child. Properly advised and informed, parents are in a position to make such decisions.
108. In summary, I conclude that stage one treatment of childhood gender identity disorder is reversible, is not attended by grave risk if a wrong decision is made, and is for the treatment of a malfunction or disease, being a psychological rather than physiological disease. As such, and absent controversy, it falls within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.
109. Having so concluded, I now turn to Ground 3.

Ground 3: Did the trial judge err in law and in the exercise of discretion by concluding that stage two treatment for childhood gender identity disorder should be the subject of a further application to the court prior to its commencement?

110. As this ground is couched in the alternative, it could potentially be disposed of on the basis that the appellants have been successful in relation to Ground 1. However there is implicit in the ground an assumption that stages one and two should be dealt with together. Thus Ground 3 is not really in the alternative but

is an adjunct to Ground 1; that is, whatever finding the court makes, stages one and two should be treated together.

111. It will be obvious from what I have said about the aspects of stage one which distinguish it from stage two that I think there is a relevant distinction. The complete reversibility, with few, if any, side effects, of stage one is a significant issue. Stage two is acknowledged to be different. Her Honour concluded at [127] of her reasons that the treatment at stage two was “irreversible in nature” and found at [60] and [84] that:

60. Oestrogen treatment brings about feminisation of the body. It also stimulates a marked increase on bone mineral density, which is beneficial. It has effects on growth plates in the long bones, promoting the eventual closure of the growth plates, but in the doses Jamie would receive, the effect would be slow. Growth velocity may be stimulated in the first year of oestrogen administration, but would slow after one to two years. Jamie’s height would be less, by three to four centimetres, than if male puberty had been completed.

...

84. The part of the stage two treatment that warrants particular consideration is that the introduction of oestrogen will cause breast growth. If Jamie were thereafter to choose to live as a man, the breasts could only be removed by surgical intervention.

112. In addition, her Honour was also aware of the possibility that things might change, writing at [128]:

Although Dr C talked about it being likely that Jamie’s trajectory is reasonably predictable, in the sense that her gender identity dysphoria has existed since early childhood, and she has now lived entirely as a girl for several years, it is impossible to predict how life will unfold for a 10-year-old child by the time she is a young person of around 16 years’ of age. Although one hopes that her life will go from strength to strength, there are all sorts of vagaries and potential factors that may intervene. There is her own health, the health of her parents or brother, the relationship of her parents, her relationship with her parents, her relationships generally, her schooling, and/or advances in medical science, to name some obvious ones.

113. In deciding not to treat stages one and two together, her Honour said, “I simply cannot determine in 2011, when Jamie is still only 10, what is likely to be in her best interests in 2016 or 2017 when she is aged sixteen” (at [130]).
114. As the appellants’ case was that stages one and two should be dealt with together, their written submissions did not address the issue of whether there might be another reason not to treat them together – that is, the question of the child’s capacity to consent to stage two treatment. That is, is the child *Gillick* competent?

115. In *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, it was said by Lord Scarman at 88-90:

In the light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child, or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent: but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parent's consent.

116. In oral submissions, the appellants addressed this issue:

This case needs to be distinguished again from the facts in *Marion's* case because there the High Court were dealing with a child who was never going to be Gillick competent on the view as it stood at the time when the hearing took place. No such conclusion can be drawn here and indeed her Honour is already almost at, but not quite prepared to say because of the child's young age, that the child is totally Gillick competent to give a decision. That finding, your Honour, can't be criticised and it can't be argued against but it does have consequences and the consequences are that when we come to appeal ground 3 the possibility of Jamie being Gillick competent when she turns 16 and when the stage 2 treatment is to commence is very strong and what we will be saying when we return to ground 3 is that her Honour completely overlooked that as a possibility when concluding that the stage 2 treatment should be subject of a separate application.

(transcript 6 March 2012, p 9, lines 13-24)

117. As to who should determine *Gillick* competence, the appellants proposed that:

in the first instance it is the doctors who would need to satisfy themselves ... whether Jamie is Gillick competent and if they couldn't satisfy themselves of that fact then ... the parents would top up, as it were, whatever other analysis and decision-making is needed to ensure that full consent can be given but principally Gillick competence is a matter for the clinician and only in cases where there is doubt the court becomes involved and again they would fall into the band of cases that we would say contain a controversy.

(transcript 6 March 2012, p 13, lines 8-15)

118. I understand the submission here to be meaning that it is for the clinicians to decide whether the child is *Gillick* competent, but if the child is not, or if there is doubt, the court would become involved and an application would be necessary. I observe that the orders made by her Honour related to enabling the parents to authorise stage one treatment, and the application was otherwise dismissed. Her Honour did not deal, in the orders at least, with the question of whether there should be a return to court when stage two is pending. But that is hardly surprising, and her Honour canvassed various possibilities, including that Jamie may not wish to continue with the treatment. At [131], her Honour did give some indication of her views about whether there would need to be a further application, and seemed to consider that it would be necessary.
119. However, I also note that the question of *Gillick* competence in relation to stage two was not really put to her Honour. The matter was though squarely raised in the appeal.
120. The AHRC emphasised that the Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities⁸ provide for a number of rights that are engaged by these proceedings. In particular, it was submitted that the Convention on the Rights of the Child should be an interpretive aid when contemplating the meaning of the provisions in Part VII of the Act and, further, that even prior to the amendment to s 60B coming into effect, s 67ZC implements relevant parts of Australia's obligations under the Convention on the Rights of the Child. In particular, the principal legislation is to be construed so as to give effect to, and not to breach, Australia's international obligations. Where a construction that is consistent with international law is open, that construction is to be preferred over a construction that is inconsistent with international law (*Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273). As the Act and the Convention on the Rights of the Child share an underlying common purpose or object, namely a concern that decisions are made in a child's best interests, in an application under s 67ZC, it is appropriate for the court to have regard to the relevant provisions of the Convention on the Rights of the Child. This is the more so since the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) received Royal Assent on 7 December 2011. From 7 June 2012, s 60B(4) provides that: "An additional object of this Part is to give effect to the Convention on the Rights of the Child done at New York on 20 November 1989". The provision, however, is not equivalent to incorporating the Convention on the Rights of the Child into domestic law.
121. In particular, in addition to the best interests test, Articles 5 and 12 of the Convention on the Rights of the Child are apposite to the question of *Gillick*

⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2525 UNTS 3 (entered into force 3 May 2008).

competence, in my view. As described by the AHRC in their written submissions:

10. ... this proceeding engages a number of rights under the [Convention on the Rights of the Child, including:]

10.3. respect for the responsibilities, rights and duties of parents, legal guardians or other persons legally responsible for children, to provide, in a manner consistent with the evolving capacities of the children, appropriate direction and guidance in the exercise by the children of their rights (Article 5);

10.4. assurance to children who are capable of forming their own views the right to express those views freely in all matters affecting them, the views of children being given due weight in accordance with their age and maturity (Article 12(1));

10.5. in particular, children shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting them, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law (Article 12(2)); ...

...

122. I agree with the submission of the AHRC that the Convention on the Rights of the Child makes it clear that it is important that children have input into decisions that affect them and that parents have special responsibility for assisting their children in making these decisions:

Children are rights bearers and not merely objects of protection. Further, there is a strong presumption that the realisation of children's rights will occur in the context of the family unit in a manner which accommodates a child's evolving capacities.

(written submissions of the AHRC, 22 February 2012, at [26]) (footnotes omitted)

123. The AHRC submitted that that it was open to the court to consider separately whether authorisation was required for each of stages one and two, and that stage one could be distinguished from stage two on the basis that the first question was whether the child was competent to make a decision (that is, *Gillick* competent) to authorise the treatment.

124. The public authority submitted that where a child is *Gillick* competent, the child has the authority to make the decision. The public authority submitted at [49] of their written submissions:

the correct approach is that set out in *Marion's Case* and as described by Bryant CJ in *Re Alex* (2009), that is, if the child is *Gillick* competent court

authorization of the special medical procedure is not necessary. However, it is up to the Court to decide whether the child is *Gillick* competent or not.

(footnote omitted)

125. The public authority then addressed squarely the question of what should happen if a child is *Gillick* competent, posing the question: “[D]oes that mean the court does not have jurisdiction in respect of the treatment for childhood gender identity disorder or a range of other conditions?” (transcript 6 March 2012, p 30, lines 15-18).

126. The public authority then responded to the question posed:

A hardline position could even be, though, your Honour, if a child is consenting and able to consent, even if there is a controversy, the court doesn’t have jurisdiction. Next along the spectrum is, if a child is *Gillick* competent and there is a controversy, then the court has jurisdiction. And the next along the spectrum, and one for which the [public authority] has some attachment, is that regardless of the capacity of a child given the fundamental nature of treatment for a condition of this kind or comparable special medical procedures, it should be the court which authorises the provision of treatment.

(transcript 6 March 2012, p 30, lines 22-30)

127. That argument is synthesised into the following submission:

The orientation of the [public authority] and I’m choosing the words carefully – is to prise the jurisdiction of this court as a monitoring, oversighting check and balance, and therefore to tentatively urge upon the court that regardless of the child’s attitude or capacity, more particularly, in terms of *Gillick* competence, this court should retain and exercise its role as an oversighting body.

(transcript 6 March 2012, p 20, lines 38-43)

128. The public authority confirmed that its position was that the threshold question, “Is the child *Gillick* competent?” has to be determined by the court. The submissions indicate that there are two questions, and I deal with each in turn below.

129. The first is whether, if the child is *Gillick* competent, there remains any role for the court at all. In my view, there does not. The Convention on the Rights of the Child, in particular, mean that it is essential, by art 12.1, to “assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child”. Further, by art 5, there is to be:

respect [for] the responsibilities, rights and duties of parents, ... members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of [their] rights ...

130. It is also important to note that the treatment guidelines for transsexualism recommend that stage two commence at about age 16. Whilst every case has to be considered according to the level of maturity and understanding of the particular child, 16 is an age at which children are regarded, for some purposes, as persons capable of autonomous decision-making. While legislation provides that the age of majority in all states and territories of Australia is 18 years, there are many jurisdictions in which the legislation allows a child over 16 to be autonomous in deciding about their medical treatment.
131. For example, in South Australia, “[a] person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult” (*Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6).⁹
132. In New Zealand, pursuant to s 36(1) the *Care of Children Act 2004* (NZ), a child of age 16 years or over can give consent as if of “full age” to the following types of medical intervention:
- (a) any donation of blood by the child:
 - (b) any medical, surgical, or dental treatment or procedure (including a blood transfusion ...) to be carried out on the child for the child’s benefit by a person professionally qualified to carry it out.
133. In the United Kingdom, s 8 of the *Family Law Reform Act 1969* (UK) presumes young people aged over 16 years or over to be capable of giving effective consent to any surgical, medical or dental treatment. The section reads:
- (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.
 - (2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration

⁹ See also the *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 174, 175 and the *Minors (Property and Contracts) Act 1970* (NSW) s 49.

of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

- (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

134. In my view, it would be contrary to the Convention on the Rights of the Child, and to the autonomous decision-making to which a *Gillick* competent child is entitled, to hold that there is a particular class of treatment, namely stage two treatment for childhood gender identity disorder, that disentitles autonomous decision-making by the child, whereas no other medical procedure does. The High Court in *Marion's case*, adopting the formulation in *Gillick*, held at 237 that a child is capable of giving informed consent when he or she “achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed”.
135. I see no basis for reading this down because the treatment is for childhood gender identity disorder. Indeed, one might think that, of all the medical treatments that might arise, treatment for something as personal and essential as the perception of one's gender and sexuality would be the very exemplar of when the rights of the *Gillick*-competent child should be given full effect.
136. The second and more vexing question posed is who should determine the question of *Gillick* competence. Is it the medical doctors, or is it necessary for an application to the court to be made for an assessment as to whether the child is competent to give informed consent to the procedure?
137. With some reluctance I conclude that the nature of the treatment at stage two requires that the court determine *Gillick* competence. In *Marion's case*, the majority held that court authorisation was required first because of the significant risk of making the wrong decision as to a child's capacity to consent, and secondly because the consequences of a wrong decision are particularly grave.
138. It seems harsh to require parents to be subject to the expense of making application to the court with the attendant expense, stress and possible delay when the doctors and parents are in agreement but I consider myself to be bound by what the High Court said in *Marion's case*.
139. That application however would only need to address the question of *Gillick* competence and once established the court would have no further role. The material in support of such an application, whilst needing to address the proposed treatment and its effects, and the child's capacity to make an informed decision, would not need to be as extensive as an application for the court to authorise treatment and I can see no reason why any other party need be

involved, absent some controversy. It would be an issue of fact to be determined by the court on the material presented.

CONCLUSION

140. 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.

141. Accordingly, I conclude that Order 1 of the orders made on 28 March 2011 should not have been made and should be set aside. The decision to continue the treatment ordered by her Honour is within the proper limits of parental responsibility.

COSTS

142. At the conclusion of the appeal, we were informed that no party would seek an order for costs.

FINN J

INTRODUCTION

143. On 10 January 2011 the parents of a child who was born a male in 2000, but who had been diagnosed in 2007 with gender identity disorder, filed an application in the Family Court of Australia seeking, by way of final orders, that they be authorised to obtain the following special medical procedures on behalf of the child:
- (a) The administration of puberty suppressant hormones, such as implants of Zoladex (a GnRH agonist) at intervals and at a dosage as may be determined as necessary to achieve suppression of Gonadotrophins and testosterone to pre-pubertal levels under the guidance of the child's treating medical practitioners including but not limited to Dr G (Endocrinologist) and Dr C (Psychiatrist);
 - (b) Additional treatment of oestrogen as may be considered appropriate by the child's treating Endocrinologist, currently being Dr G (Endocrinologist) and in consultation with and on the written advice of the child's treating Psychiatrist, currently being Dr C (Psychiatrist).
144. That application was heard by Dessau J on 28 March 2011. On that day her Honour made an order (Order 1) authorising the parents:
- to consent to treatment on behalf of their child ... under the guidance of the child's treating medical practitioners including but not limited to his endocrinologist Dr G and his psychiatrist Dr C, for the administration of Zoladex (a GnRH agonist) and cyproterone acetate in such dose, in such manner and with such frequency as determined in consultation with the treating medical practitioners to achieve suppression of gonadotrophins and testosterone to pre-pubertal levels.
145. Her Honour also ordered (Order 4) that:
- all existing applications shall be adjourned for Reasons for Judgment and further orders on a date to be advised to the parties.
146. On 6 April 2011 her Honour made a further order (Order 1):
- That the parents' application filed 10 January 2011 shall be otherwise dismissed.
147. Her Honour's Order 1 of 28 March 2011 and her Order 1 of 6 April 2011 are the subject of this appeal by the parents of the child.
148. On 6 April 2011 her Honour published reasons for judgment in relation to her orders of 28 March and 6 April 2011.

149. In her reasons for judgment her Honour referred to the child in question as “Jamie”, and she referred to the treatment to which the parents had sought to be able to consent in sub-paragraph (a) of paragraph 1 of their initiating application as “stage one” treatment and to the treatment referred to in sub-paragraph (b) of paragraph 1 of their application as “stage two” treatment. The name “Jamie” and the references to “stage one” treatment and “stage two” treatment have continued to be used in the proceedings before this court.
150. The expression “special medical procedures” (or “special medical procedure”) was also used in her Honour’s reasons (as it had been in the parents’ initiating application). This is not an expression found in the *Family Law Act 1975* (Cth) (“the Act”).
151. However, as her Honour explained at [33], the authorities refer to certain procedures as “special medical procedures”, being procedures which, in her Honour’s words, “fall beyond [the bounds of a parent’s responsibility to be able to consent to medical treatment for and on behalf of their child,] and require determination by the court, as part of the court’s *parens patriae* or welfare jurisdiction”. Her Honour cited the High Court decision in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (“*Marion’s case*”) in support of this proposition.
152. It is to be noted, however, that the expression “special medical procedures” does not appear in that High Court decision, nor in Nicholson CJ’s later decision at first instance in that case (*In Re Marion (No 2)* (1994) FLC 92-448). The expression would seem to have first appeared in the unreported *ex tempore* decision of Gun J in *Telfer & Telfer* (Unreported, Family Court of Australia, Gun J, 11 July 1994), and has been used frequently since.
153. I have reservations concerning the usefulness of the expression “special medical procedure”. I consider that it would be preferable to refer to a “medical procedure which requires court authorisation”.
154. I note that the expression “Medical Procedure” appears in Part 4.2 of the *Family Law Rules 2004* (Cth) (“the Rules”) which is the part of the Rules concerned with “Specific Applications” and the procedure for making such applications. The Dictionary for the Rules then contains the following definition of “Medical Procedure Application”:

Medical Procedure Application means an Initiating Application (Family Law) seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease.

Example

An example of a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease is a procedure for sterilising or removing the child’s reproductive organs.

155. I also have some reservations, as will emerge from my later reference to passages from the judgments of members of the High Court in *Marion's case*, about the use of the word “bodily” in the definition (whatever that word may be intended to mean) and about the precision of the language in the example given in the Rules.
156. Having explained the expression “special medical procedures”, Dessau J observed at [33] that there “was no dispute in this case that the procedures proposed fall within the definition of special medical procedures”.
157. After reviewing in depth the expert evidence which was before her concerning the child’s condition and wishes as well as the nature of the treatment proposed and the risks to the child if the treatment was not undertaken, her Honour concluded at [119] that stage one of the treatment (which she had earlier found at [58] to be reversible) was in the child’s best interests and that it needed to commence as a matter of urgency.
158. In relation to stage two of the treatment, it was the position of the child’s parents, supported by the child’s doctors, that her Honour should authorise them to approve stage two treatment at the same time as she authorised the approval of stage one, leaving them and the child to decide at the appropriate time whether or not it should occur (at [126]). Her Honour was satisfied in line with previous decisions of her own and of other single judges, that the two stages of treatment can be viewed as one treatment plan, but she was equally satisfied that whether the two stages of the one treatment plan should be approved at the same time depends on all the circumstances of the case (at [123]).
159. The issue in this case, as explained by her Honour at [127] of her reasons, was whether the court could “comfortably determine this 10-year-old child’s best interests, and therefore approve a particular procedure or treatment, irreversible in nature, not due for six years.” Her Honour determined (at [130]) that she should not do so, and thus apart from having made the order in relation to the stage one treatment, she otherwise dismissed the parents’ application. The practical result of her Honour’s dismissal of the balance of that application is that the parents would have to make a further application to the court for authority to consent to stage two treatment once it was required.
160. Before turning to the grounds of appeal and the issues which they raise, it is important to note that in her reasons for judgment, Dessau J recorded at [49] that no-one “has taken issue with the diagnosis” of gender identity disorder made in relation to the subject child. No issue has been taken on this appeal regarding that diagnosis.
161. I would also explain that the evidence concerning the effects, particularly the physical effects, on the child of the two stages of the proposed treatment were well explained by her Honour in her reasons. Because an appreciation of these

effects is necessary in order to understand the very significant issues raised by this appeal, I will here set out her Honour's principal findings concerning the effects of the two stages of treatment.

162. In relation to the effects of stage one treatment her Honour concluded:

57. According to Dr G, Zoladex will slow the process of maturation and the growth plates of the long bones. Sperm production in the testes will also be arrested. Penile erections ... will cease during the Zoladex treatment. Bone mineral density will increase during treatment.

58. The effects of Zoladex and the suppression of puberty last only while it is being given. The effects are reversible.

...

82. Dr G saw no problems in carrying out the first stage of treatment. It is fully reversible. It has no side-effects. As he said, "Endocrinologists have been prescribing it for years in children much younger than Jamie, to arrest precocious puberty". It would enable Jamie's mental development to proceed "normally", without the "terrible impediment" of gender dysphoria. Dr G cited that blocking puberty at an early age has been shown in other centres to be beneficial, and is recommended in clinical guidelines published in 2009 by the US Endocrine Society.

...

104. ... as the stage one procedure is fully reversible, without long-term effects on fertility, the child will be free to change her mind at a later date ...

163. In relation to stage two which involves oestrogen treatment and which her Honour concluded at [127] of her reasons was "irreversible in nature", she made the following additional findings:

60. Oestrogen treatment brings about feminisation of the body. It also stimulates a marked increase in bone mineral density, which is beneficial. It has effects on the growth plates in the long bones, promoting the eventual closure of the growth plates, but in the doses Jamie would receive, the effect would be slow. Growth velocity may be stimulated in the first year of oestrogen administration, but would slow after one to two years. Jamie's final height would be less, by three to four centimetres, than if male puberty had been completed.

...

84. The part of the stage two treatment that warrants particular consideration is that the introduction of oestrogen will cause breast growth. If Jamie were thereafter to choose to live as a man, the breasts could only be removed by surgical intervention.

...

105. ... stage two of the treatment ... would entail irreversible physiological feminisation

164. Again, none of these findings by Dessau J were challenged on the appeal.

THE GROUNDS OF APPEAL

165. The grounds of appeal contained in the parents' amended notice of appeal (filed on 24 June 2011) directed to the orders which authorised the parents to consent to stage one treatment and which dismissed the balance of their application, were as follows:

1. That, contrary to the view expressed by the learned trial Judge, treatment of the condition described as "childhood gender identity disorder" with which "Jamie" was diagnosed is not a special medical procedure which displaces the parental responsibility of the appellants to decide upon the appropriate treatment for their child.
2. That Ground 1 be considered and allowed notwithstanding that no such submission was made to the learned trial Judge, and her Honour proceeded on the basis that:- "There was no dispute in this case that the procedures proposed fell within the definition of special medical procedures" (Judgment [at first instance] paragraph 33).
3. Further and in the alternative to Ground 1, once the diagnosis of childhood gender identity disorder was established and accepted and the treatment approved, the learned trial Judge erred in law and the exercise of discretion in concluding that the treatment for the disorder should be the subject of a further application to the Court when the "stage 2" is about to commence.

166. In their amended notice of appeal the parents sought from this court a declaration that:

1. ...
 - a. the treatment for the medical condition known as CHILDHOOD GENDER IDENTITY DISORDER is not a special medical procedure which attracts the jurisdiction of the Family Court of Australia under s. 67ZC of the Family Law Act; and

- b. the parents of “Jamie” do not require permission from the Family Court of Australia, or any other Court of competent jurisdiction to authorise such treatment for their child as they may be advised is appropriate.
167. In the alternative to such a declaration, the parents sought an order to the effect that they be authorised to consent to both stage one and stage two of the treatment.
168. Both the Australian Human Rights Commission (“AHRC”) and the public authority were permitted to intervene in the proceedings before this court. The independent children’s lawyer also appeared. The position taken on the appeal by each of these parties is more fully explained in the reasons of the Chief Justice. But, in summary, the public authority and the independent children’s lawyer opposed the appeal, as did the AHRC (at least in relation to the assertion by the appellants that court authorisation is not necessary for stage two of the treatment).
169. There was, however, no opposition by any party to the parents being permitted, as they were, to argue their first ground of appeal, being in essence that in the circumstances of this case, it was unnecessary to obtain court approval for either stage of the treatment proposed for the child, notwithstanding that this point of law had not been taken below.

ISSUES RAISED BY THIS APPEAL

170. The primary issue raised by this appeal is whether it is within the scope of the parental authority conferred on parents by s 61C of the Act to consent to treatment of the type proposed for the child in this case to treat the condition known as gender identity disorder, or whether it is necessary for there to be court authorisation of the treatment under s 67ZC of the Act (the so called “welfare” or “*parens patriae*” power). As already indicated, the proceedings before Dessau J were conducted on the basis that such court authorisation was necessary with the issue now before us not being raised before her Honour.
171. A subsidiary issue raised by the appeal is whether, if court authorisation is required for both stages of the treatment, Dessau J erred by authorising only stage one of the treatment and refusing court authorisation for stage two until that stage of the treatment was necessary. I can dispose of this subsidiary issue at this point by saying that I agree with her Honour that whether the two stages of the treatment should be approved by the court at the same time (assuming, of course, that such approval is necessary for both stages) will depend on all the circumstances of the case, and I do not consider that her Honour erred in the exercise of her discretion, in refusing to authorise stage two of the treatment at the time when the matter was before her, having regard to the reasons which she gave for that refusal.

172. In relation then to the primary issue in this appeal, being whether court authorisation is necessary for stage one and/or stage two of the treatment in question, there cannot, of course, be any question that in circumstances where there is a disagreement in relation to proposed treatment between the parents and/or their child or with the child's treating doctors, an application to the court will be necessary. However, in this appeal, we are concerned solely with cases where there is no disagreement between the child, the parents and the treating doctors.
173. This is also not a case which involves a child who is under the legal guardianship of a government department or official. Special considerations may well apply in such a case.
174. In *Marion's case* the High Court determined (by majority) that court authorisation was necessary for the sterilization of a fourteen year old intellectually disabled girl. In explaining their reasons for this decision Mason CJ, Dawson, Toohey and Gaudron JJ said (at 249-50):

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

As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child's present or 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.

175. Although in *Marion's case* the High Court was concerned with the sterilization of a disabled child, the principles contained in the second paragraph of the passage just cited have subsequently been applied in a number of cases where other serious forms of medical treatment were proposed for a child (see the

examples provided by Nicholson CJ in *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175, [175]). In the present appeal there was particular emphasis on those principles in the submissions of both the public authority and the AHRC; indeed, it was submitted by senior counsel for the public authority that this court is bound by the decision in *Marion's case*. (transcript 6 March 2012, p 4, lines 1-2) I will return to the principles contained in the second paragraph of the above-cited passage after making some reference to what is said in the first paragraph of that passage.

176. In that first paragraph their Honours considered it necessary to draw a distinction between a therapeutic and a non-therapeutic procedure, although they considered the distinction could be uncertain and they did not further discuss it. Relevantly, however, for present purposes there is nothing in their Honour's observations which can, in my view, be taken as limiting their observations to only a physical, as opposed to a psychiatric or psychological, malfunction or disease.
177. Brennan J, in his reasons in *Marion's case*, was able to explain the therapeutic – non-therapeutic distinction (including, it should be noted, particularly for present purposes, in relation to psychiatric disorders) in the following way (at 269):

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

178. In his oral submissions to us (transcript 6 March 2012, p. 22, lines 31-34) senior counsel for the public authority endeavoured to distinguish Brennan J's definitions of therapeutic and non-therapeutic treatments from the views "of the plurality". But I am not persuaded that Brennan J's definitions should not provide some assistance in considering the difficult issues raised by this case.

CONCLUSION IN RELATION TO STAGE ONE TREATMENT

179. Given the evidence before Dessau J of the child's condition and the risks faced by her if she did not receive stage one of the treatment, that stage of the treatment can be seen as therapeutic. Furthermore, given that stage one of the treatment is reversible, the concerns of the High Court majority in relation to the risks of a wrong decision and resulting grave consequences do not arise. There is also no dispute between the child, her parents, or her doctors that the

stage one treatment should be undertaken. I am therefore satisfied that that stage of the treatment did not require court authorisation. I thus agree with the conclusion reached by the Chief Justice that:

[108] ... stage one treatment of childhood gender identity disorder is reversible, is not attended by grave risk if a wrong decision is made, and is for the treatment of a malfunction or disease, being a psychological rather than physiological disease. As such, and absent controversy, it falls within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.

DISCUSSION AND CONCLUSION IN RELATION TO STAGE TWO TREATMENT

180. Stage two of the proposed treatment presents greater problems if only because it is, as found by Dessau J at [127] of her reasons, “irreversible in nature” (at least not without surgery as was recognised at [84] of her Honour’s reasons). This consideration must, in my view, remain important, even when it is accepted that the treatment can be categorised as therapeutic, and in this regard the concept of proportionality referred to by Brennan J must come into play.
181. In the passage cited above from the majority judgment in *Marion’s case*, it was recognised that some forms of medical treatment are irreversible and yet do not require court authorisation. However, their Honours proceeded to hold that such authorisation was required at least for sterilization “because of the significant risk of making the wrong decision, either as to a child’s present or future capacity to consent or about what are the best interests of a child who cannot consent”, and also because of the “particularly grave” consequences of a wrong decision.
182. Such risks of a wrong decision and the grave consequences of a wrong decision must similarly exist in relation to stage two of the proposed treatment in this case when regard is had to the effects of that treatment as explained by Dessau J in the passages from her Honour’s reasons earlier set out. Thus, in my view, in a case such as this, the therapeutic benefits of the treatment would have to be weighed or balanced against the risks involved and the consequences which arise out of the treatment being irreversible, and this would seem to be a task appropriate for a court, given the nature of the changes that stage two of the treatment would bring about for the child.
183. However, there is in this case, or at least there will be in time, a significant difference from *Marion’s case*, and that is that the subject child may be able to give consent to the proposed treatment. In this case stage two of the treatment would commence when Jamie is about 16 years of age, and at that time she may well have the capacity to consent to her own medical treatment in

accordance with the principles in the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. (That decision was recognised as part of the common law of this country by Mason CJ, Dawson, Toohey & Gaudron JJ in *Marion's case* (at 237).)

184. The question thus becomes in this case, whether the determination as to whether Jamie in fact has “Gillick competence” to fully understand and give informed consent to stage two of the treatment at the time it is to commence, is to be left to her doctors and parents to decide, or whether the court should make that decision, at least as a threshold issue. It was strongly submitted on behalf of both the public authority and the AHRC that it is the court that should make that decision, and that this was required because of what the High Court majority said in *Marion's case* in relation to the risk of a wrong decision being made regarding the child's capacity to consent to treatment that is irreversible and also in relation to the particularly grave consequences of a wrong decision.
185. I am extremely reluctant to impose upon the child and her parents the costs and stress of further court proceedings, particularly when the court may ultimately reach the same decision which the child and her parents had already reached with the child's doctors.
186. Nevertheless, I have concluded that at least the question of a child's capacity to consent to treatment which has the irreversible effects of stage two treatment must remain a question for the court. I have reached this conclusion because of the requirement by the High Court majority in *Marion's case* for court authorisation for irreversible medical treatment in circumstances where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment and where the consequences of such a wrong decision are particularly grave, as they would be in this case.
187. In reaching this conclusion I have also taken into account the persuasive submissions made on behalf of the AHRC and the public authority which support continued court involvement in decisions concerning stage two treatment.
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.

WHAT ORDERS SHOULD THIS COURT MAKE?

189. All members of this court have concluded that Jamie's parents did not require court authorisation for stage one of the proposed treatment. The appropriate course would therefore be to allow the appeal against the order providing for such authorisation and to discharge that order. I stress that this course does not

reflect any error on the part of Dessau J, but rather it is necessary because of the point of law argued on the appeal and not before her Honour. As is said by the Chief Justice, the decision for that treatment to continue will be a matter for Jamie's parents exercising their parental responsibility.

190. In my view, it would not be in accord with the reasons of this court, or indeed within any power contained in the Act, for it to make the declaration sought by the parents in their amended notice of appeal. Nor would the order which they seek in the alternative to the declaration be in accord with the reasons of any member of this court.
191. No party sought an order for costs in relation to the appeal, and thus there will be no order for costs.

STRICKLAND J

192. I have had the advantage of reading the draft reasons for judgment of the Chief Justice and of Justice Finn. I agree with the outcomes proposed by both of my colleagues and generally for the reasons set out by each of them.
193. In summary, I agree that on the evidence before the trial judge stage one of the treatment can be described as therapeutic. Further, because the stage one treatment is reversible, none of the concerns expressed by the High Court in *Marion's case* as to the risks of a wrong decision and any resulting grave consequences arise.
194. Thus, given there is no dispute between the child, her parents or her doctors that the stage one treatment should be undertaken, that treatment did not require court authorisation. It falls within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decision about medical treatment.
195. 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.
196. 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.

I certify that the preceding one hundred and ninety-six (196) paragraphs are a true copy of the reasons for judgment of the Honourable Full Court (Bryant CJ, Finn & Strickland JJ) delivered on 31 July 2013.

Associates:

Date: 31 July 2013