SUPREME COURT OF QUEENSLAND

CITATION:	*Re a Declaration Regarding Medical Treatment for "A"* [2020] QSC 389
FILE NO/S:	BS 13503/20
DIVISION:	Trial Division
PROCEEDING:	Originating Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED EX TEMPORE ON:	18 December 2020
DELIVERED AT:	Brisbane
HEARING DATE:	18 December 2020
JUDGE:	Lyons SJA
ORDER:	**1. Order as per draft.**
COUNSEL:	M Hickey for the Applicant
SOLICITORS:	Minter Ellison for the Applicant

HER HONOUR (delivered *ex tempore*):

1. This is an application by the mother of a child, who I shall refer to as "A", for a declaration that she can consent to Stage 1 puberty blocking medical treatment for her child without the requirement to obtain the consent of the father of the child whose whereabouts are currently unknown. "A" was born as a male and is shortly to turn 13.

2. The declaration sought is that the applicant mother can provide valid consent on behalf of her child to medical practitioners and nurses acting on behalf of the Hospital and Health Service in providing medical and nursing services to "A" to administer to "A" "medications including Lucrin and/or Spironolactone, for the purpose of blocking or supressing A's future natal puberty, and/or reducing the effect of A's natal puberty".

3. This application invokes the *parens patriae* jurisdiction of the Supreme Court and came on urgently in the applications list on the last day of the Court year.

4. I was satisfied that the matter should proceed in closed court, given the age of "A" and the sensitive personal and medical matters that the application related to. I am also satisfied that it is appropriate that there be a non-publication order of the name of the applicant, "A", any information which would disclose the identity of the clinic where "A" is being treated, the identity of any of the medical practitioners treating "A" or any other fact that could identify the child.

5. These are my reasons for the making of the orders sought which were made on the afternoon the application was heard.

Factual Background

6. In coming to my decision I have had regard to affidavits by the applicant mother as well as an affidavit of a Dr B, a child and adolescent psychiatrist with expertise in managing gender dysphoria and autism spectrum disorder. I have also had regard to an affidavit of Dr C, an endocrinologist.

7. "A" has a diagnosis of autism spectrum disorder and despite a history of school disruption, she is reportedly an above average student of around a B standard. She is currently being home schooled through the School of Distance Education. Her previous school functioning has been challenging and she has had what are described as "massive meltdowns" in the past. The material indicates that from the age of four, "A" would declare that she was something other than her male gender and began to declare she was a girl and not a boy, and had been born in the wrong body. She is uncomfortable wearing boys' clothes and prefers girls' clothing, preferably in the colour pink. When she was at school, "A" had socially transitioned to a female uniform and used her chosen female name on the school roll and on her bus pass. The state school she attended provided affirming and daily support from a guidance officer in relation to her female identity. "A"'s treating team have recommended a reversible treatment which will block her puberty as a male. The affidavit of "A"'s mother indicates that by her fourth birthday, "A" had begun to identify as a girl and uses "she/her" pronouns, although no formal name change has been undertaken.

8. "A" is currently receiving treatment and support from a multi-disciplinary team of specialists including psychologists, a psychiatrist and an endocrinologist at a specialist clinic. Dr B states that "A" has been a patient of the clinic since the 18th of May 2018. "A" was seen by a senior clinical psychologist at the clinic in May, June and December 2018 and January 2019, with follow-up treatment intervention in relation to needle phobia throughout 2019 and 2020.

9. "A" and her mother, the applicant, have been estranged from "A"'s father since May 2017, against a background of his illicit drug use and emotional, verbal and physical abuse towards both "A" and the applicant. He was at one stage forcibly removed from the family home by police and was previously the subject of a domestic violence order. He has an interstate criminal history including drugs and weapons offences. Since April 2017, the applicant has not spoken to "A"'s father or received any support from him or his family.

10. The applicant and "A" moved to regional Queensland to escape "A"'s father and lived first in a shelter, then with friends and then subsequently in a rented home and currently in a housing commission unit. "A"'s father does not know their current whereabouts, and it would seem they do not know his. The evidence indicates "A"'s father was unsupportive of "A"'s desire to be female and has said threatening and demeaning things to both "A" and her mother in this regard.

11. Against that background, the applicant asks the court to exercise its power in the *parens patriae* jurisdiction to make a declaration that the applicant may consent to

the proposed treatment and those treating "A" may act on that consent. To do so is in "A"'s best interests.

Affidavit of Dr B dated 16 December 2020

12. Dr B states that he has personally assessed and reviewed "A" in two specialist psychiatry review appointments, first in January 2019 and most recently on 5 November 2020. Dr B indicates that "A" has been socially transitioned for several years and lives with her mother and her mother's current partner who is supporting and affirming of her female identity. "A"'s mother reports a very acrimonious relationship with the father of "A" who was significantly domestically violent. She previously had a DVO out against him which has now expired. There has been no contact with the father for more than three-and-a-half years since May 2017, and neither "A" nor her mother knows the whereabouts of the father.

13. Dr B in his affidavit sets out a history of "A"'s reports of self-mutilation and distress in relation to her genitalia. Currently, "A" reports that no one understands her, and she has no way out of her predicament of the impending onset of male puberty, as she has a needle phobia which prevents her from accessing timely Stage 1 puberty blockers to prevent life-long damaging masculinisation.

14. Dr B reports that "A" has received gender affirming care through a specialist clinic and is now hopeful of a resolution of her gender dysphoria. Dr B states that "A" is worried that if she cannot receive puberty blockers, her life is not worth living as a male if she cannot be female. She is apparently terrified of her voice deepening and her male genitalia getting bigger. She has recently experienced erections which has been distressing to her. She has previously expressed suicidal ideation in relation to her gender identity and being born in the wrong body.

15. Dr B stated that "A" is increasingly distressed and dysphoric about her body and is very concerned about stopping puberty. Early signs of puberty have been reported. It would seem that "A" wishes to start Stage 1 treatment now. Dr B stated:

> "From my review of the medical record and my own consultations with A and her mother, I have formed the view that A has been insistent, persistent and consistent in her female gender identity for six years, first disclosing to Mum at age 4 that she was a girl. She initially for some time would not wear anything other than full length clothes and did not like to reveal her body. One day they went shopping and found clothes that were more female and felt comfortable. She is socially transitioned, and her friends know her as A."

16. Dr B considers:

> "A clearly fulfils the DSM V diagnostic criteria for ASD Level 1-2 and in my opinion also meets the DSM V diagnostic criteria for Gender Dysphoria in Childhood and Adolescence (302.6, F 64.20). As a result of rigid thinking and intolerance for natal male gender she is highly anxious and resistant to discussion about natal gender

> but clear about her female identity and desire to be female through feminising surgeries and gender affirming hormone treatment in the future. At the time it was my opinion that A may require some support around this around the stages of medical treatments that are gender affirming."

17. Dr B considers that the proposed treatment with Stage 1 puberty blockers is in "A"'s best interests. He considers that the treatment with puberty blockers will reduce the risk of future mental health problems and maximise the best medical transition to a female identity. He states that puberty blockers afford a young adolescent the ability to live in their preferred gender and create an affirming lived experience that consolidates their gender identity in all social domains without the fear of their natal puberty and the emergence of secondary sexual characteristics (the basis of their body revulsion gender dysphoria and secondary anxiety and depression). It also reduces well-documented risks of deliberate self-harm and suicide in an untreated transgender adolescent.

18. Dr B stated he is concerned that if treatment is not provided to "A", the significant gender dysphoria with its associated mental health issues and significant risk of depression, anxiety, social isolation and suicide will continue, as well as potential self-harm concerning her genitalia. Dr B is concerned that "A" will develop secondary male characteristics if she does not receive Stage 1 puberty blockers as soon as possible. He does not consider there are any other possible treatments available for "A". He considers the treatment is needed and requires commencement of the administration of the medication. He does not consider that it would serve any purpose to delay the commencement.

19. Dr B considers that "A" has the capacity to understand the nature and intention of the use of reversible puberty blockers for the prevention of the advancement of her male puberty. He stated that she is well-aware of the treatment risks and complications, and has realistic expectations.

20. Dr B stated:

> "At the assessment on 5 November 2020, A satisfied me that she has the capacity to provide informed consent to the use of reversible puberty blockers at her level of maturity, and cognitive development as a young transgender female adolescent with ASD Level 1 to 2 seeking a relief from her fear of male puberty."

21. Dr B's view is that as a result of a recent family court decision, there is apt to be delay in the Family Court because of the requirement to obtain consent from both parents. Dr B states that "A" is experiencing deep concern and distress at the prospect of not being treated expeditiously.

Affidavit of Dr C dated 16 December 2020

22. In her affidavit, Dr C states that she first met "A" in April 2019 and that she agrees with Dr B's diagnosis that "A" fulfilled the criteria for gender dysphoria under DMS V. She also considered that "A" presented with autism spectrum disorder and anxiety, particularly when discussing gender, which caused her obvious distress. She considered that "A"'s history was normal and the physical

examination was consistent with a normal male in early puberty. She considered that it was unlikely that there was an endocrine or genetic reason to explain "A"'s gender dysphoria.

23. Dr C stated that the proposed treatment is Stage 1 treatment and it is consistent with the Australian Standards of Care and Treatment Guidelines for supporting Trans and Gender Diverse Children and Adolescents.[1] The proposed Stage 1 treatment is intra-muscular injections of Lucrin every three months. If Lucrin cannot be administered due to a needle phobia, "A" may be treated with Spironolactone orally on a daily basis. Dr C states that the treatment is reversible and it will prevent the physical progression of puberty and may cause the testes to shrink in size.

24. Dr C states that the likely long-term physical effect on "A" if the proposed treatment is not provided is that "A" would proceed through male puberty and experience considerable distress. She indicates that "A" has already become extremely distressed with the early changes of male puberty and wishes to proceed to Stage 2 immediately to prevent further development as soon as possible. She notes that there are some risks of sub-optimal bone mineral accrual which improves on cessation of treatment and a risk of impaired fertility, as well as other side effects of risk of low blood pressure and elevated blood potassium levels. Dr C states however that the proposed treatment is recommended because it is the only treatment for male to female gender dysphoria that meets the best practice guidelines. She states she does not believe it would serve any purpose to delay treatment until "A" is 18, and that delay in the treatment would increase the risks of major depressive disorder and self-harm.

25. Dr C notes the definition of capacity in the *Guardianship and Administration Act* 2000 (Qld) and the definition of *Gillick* competency and whilst she believes "A" has the capacity to understand the information provided around the proposed treatment, she does not believe that "A" fully understands what is proposed and is not persuaded that she is currently *Gillick* competent. Dr C notes however that "A" is anxious to commence the treatment and wishes to prevent further progression of puberty. She states that she has met with "A"'s mother who is supportive of the commencement of Stage 1 treatment and understands the risks and effects of the proposed treatment.

26. Dr C states that she understands that there has been no contact with "A"'s father since the parents' separation three-and-a-half years ago and is reported to be non-affirming of "A"'s gender, which has been the source of family conflict. She states that the gender service has not been in contact with the father due to concerns about the safety of both "A" and her mother, due to a history of reported domestic violence.

Does this Court have Jurisdiction to Grant the Relief Sought?

27. This application is bought in the *parens patriae* jurisdiction of this Court. There is no doubt that the jurisdiction is exercised to protect children who are unable to look after their own interests and the court is placed in a position to act as a parent

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1 Verdan 1.3, September 2017.

of the children. It must exercise its jurisdiction in the manner in which a wise, affectionate and careful parent would act for the welfare of a child.

28. Children and minors are incapable of giving informed consent until they achieve sufficient understanding and intelligence to enable them to understand fully what is proposed. Until that time, a parent generally has power to consent to treatment on a minor's behalf. The *parens patriae* jurisdiction permits the court to make orders contrary to the wishes of a child's parents if it is satisfied it is in the best interests of the child to do so. That was clearly expressed by Chesterman J in the *State of Queensland v Nolan*.[2] His Honour observed:[3]

> "The jurisdiction appealed to is that which was formally vested in the Sovereign but was transferred in centuries past to the Lord Chancellor and from him personally to the Courts of Chancery and then to those courts which, like the Supreme Court, exercise the jurisdiction of that court. It is exercised to protect the person and property of subjects, particularly children who are unable to look to their own interests. The court has a wide power in relation to the welfare of infants. The dominant factor in the exercise of the jurisdiction is always what is in the best interests of the child in question. In a passage approved by Brennan J. in *Marion's Case* it was described by Lord Esher M.R. in *R. v. Gyngall*:
>
> > 'The Court is placed in a position by reason of the prerogative of the Crown to act as supreme parent of children, and must exercise that jurisdiction in the manner in which a wise, affectionate, and careful parent would act for the welfare of the child.'
>
> The power is to be exercised for the protection of those whose plight enlivens it. See also *Fountain v. Alexander.*"

29. There is no doubt that the dominant consideration is always the best interests of the child, and whilst they relate to medical best interests, they also cover emotional and other welfare issues as well. Whilst it is relevant to obtain the view of the child or the child's parent or guardian, it is the child's best interests which are the primary consideration. The issue in this case is that whilst "A", the applicant and the multi-disciplinary treating team all consider that the treatment should commence without delay, the views of the father have not been able to be obtained. Recent Family Court authority has indicated that treatment should not commence without a court order unless there is consent from both parents. In the recent decision of *Re Imogen*,[4] it was held that any treating medical practitioner seeing an adolescent under the age of 18 is not at liberty to initiate Stage 1, 2 or 3 treatment without first ascertaining whether or not the child's parents or legal guardians consent to the proposed treatment. Absent any dispute between the child, the parents and the medical practitioner, it is a matter for the medical professional bodies to regulate what standards should apply to medical treatment.

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2 [2002] 1 Qd R 454 at [8].
3 At [7] (citations omitted).
4 (2020) 61 Fam LR 344.

If there is a dispute about consent or treatment, a doctor should not administer Stage 1, 2 or 3 treatment without court authorisation.[5]

30. The Family Court of Australia has significant expertise and has a considerable body of jurisprudence in relation to consent to medical treatment in this area of the law. That Court has jurisdiction in relation to the custody and guardianship of children of a family. I also note that s 3 of the *Commonwealth Powers (Family Law – Children) Act* 1990 (Qld) specifically gives legislative power to the Commonwealth in relation to custody and guardianship of and access to children.

31. There are a number of authoritative decisions of the Family Court of Australia in this area of the law and that Court has significant expertise and jurisprudence in this field. The recent single judge decision by Watts J in *Re Imogen*[6] contains a very convenient discussion of some of the issues and relevant considerations. That decision outlined that the term Gender Dysphoria describes "the distress experienced by a person due to incongruence between their gender identity and their gender assigned at birth".[7] In diagnosing Gender Dysphoria, the American Psychiatric Association[8] recognises that there are six manifestations of marked incongruence (two of which must be present for at least six months); and that the incongruence must be associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.[9] It was recognised[10] that in accordance with the Australian Standards,[11] the optimal model of care for trans and gender diverse adolescents who present to services, involves a coordinated, multidiscipline team approach (including but not limited to the involvement of clinicians with experience in the disciplines of child and adolescent psychiatry, paediatrics, adolescent medicine and paediatric endocrinology).

32. I also note that The Australian Standards describe Stage 1 treatment as 'puberty suppression' which typically relieves distress for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females. This treatment involves the injection of gonadotrophin releasing hormone analogues (GnRHa). Its effects are reversible, however the main concern with such treatment relates to the impact upon bone mineral density and that the long-term impact on bone mineralisation is currently unknown. Stage 2 is gender affirming treatment using oestrogen and testosterone. Some Stage 2 treatments are irreversible whilst the reversibility of others are unknown. Stage 3 generally involves surgical intervention.

33. In the 2017 decision if *Re Kelvin*,[12] the full Court of the Family Court held that in non-controversial cases, transgender children and their families are no longer required to seek authorisation from the Court to undertake Stage 2 hormone treatment. However, it was held that where the decision to access treatment was

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5 At [35] and [63].
6 (2020) 61 Fam LR 344.
7 At [22].
8 The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-5* Fifth Edition ("DSM-5") at 302.85.
9 See also World Health Organization, *ICD-10 Classification of Mental and Behavioural Disorders* (ICD-10) at F64.2.
10 At [23].
11 At page 11.
12 (2017) 351 ALR 329.

not supported by one or both of those parents, as well as for children in state care, a court order is still required.

34. It was therefore considered that as a result of that decision, Family Court authorisation was no longer required for a young person where the young person consents to treatment, the treating team agree that the person is *Gillick* competent and the young person's parents do not object to treatment. However, it was considered that Family Court authorisation would still be required in the following situations:

    a. the young person is **not** considered *Gillick* competent by their treating medical practitioners; and/or
    b. the young person's medical practitioners do not propose treatment; and/or
    c. one or both of the young person's parents object to the treatment.

35. Accordingly, in that decision, the Court recognised that where the diagnosis results from a proper assessment, the proposed treatment aligns with best practice guidelines, and parents and doctors are in agreement, this is an issue more appropriately determined in the medical realm. The impact of the considerable cost and delay associated with court processes on young transgender people and their families was of itself, "*a significant pointer to this court holding that there is no role for courts in the process, absent a dispute between parents or between parents and doctors*".[13] The Court also stressed the importance of differentiating between therapeutic and non-therapeutic treatment, and acknowledged that this characterisation of treatment depends on the state of the science. The Court held:[14]

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

36. However in the recent decision of *Re Imogen*,[15] it was held that if a parent or a medical practitioner of an adolescent disputes the *Gillick* competence of an adolescent; a diagnosis of gender dysphoria; or proposed treatment for gender dysphoria, an application to the Family Court is mandatory.[16] Whilst there is *no dispute* in this case as to diagnosis or treatment, there is *no consent* from "A"'s father. Accordingly, medical practitioners have concerns as to whether they can

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13 At [119] (emphasis added).
14 At [47].
15 (2020) 61 Fam LR 344.
16 At [35], and at [38] citing *Re Jamie* (2013) 50 Fam LR 36 per Bryant CJ at [140](b), Finn J at [172] and Strickland J at [192].

commence treatment which is urgently required without the specific consent of "A"'s father – hence this application to the court.

37. On the evidence before me, I am satisfied of the following matters:

(a) "A" has a confirmed diagnosis of gender dysphoria. Dr B, a specialist psychiatrist in this area, has considered that "A" meets the criteria for that diagnosis under DMS V as does Dr C;
(b) What is proposed is Stage 1 treatment which is puberty blocking treatment which is considered to be therapeutic and reversible;
(c) "A" and her mother both consent to the treatment. "A"'s experienced multi-disciplinary team support the diagnosis of gender dysphoria;
(d) The proposed treatment is the national and international best practice and is in accordance with the current Guidelines;
(e) The applicant and the expert treating team all consider that it is in "A"'s best interests that treatment should occur without delay;
(f) Whilst Dr B considers "A" is *Gillick* competent, there is uncertainty as to whether that is endorsed by the entire treatment team;
(g) Contact details of the father are not known and he has not been in contact with the family since May 2017;
(h) There will be considerable delay in ascertaining the views of the father in relation to the proposed treatment; and
(i) Delaying treatment to seek and obtain "A"'s father's consent is not in the best interests of "A".

38. I am satisfied that orders should be made in the terms sought as it is clearly in the best interests of "A" that treatment should commence without delay. This order for the declaration was made given the time of year and those concerns about delay. However, I consider that in relation to any future proposals about Stage 2 treatment, the Family Court of Australia would be the most appropriate forum given its expertise in matters of this nature, and as the same matters of urgency which necessitated this application would not be operative.

Orders

39. Accordingly, I make orders in the terms of the draft provided by the applicant, which are effectively in the following terms:

1. The minor who is the subject of this application is not to be referred to by name in these proceedings but by the reference "A".

2. The identity of "A" is suppressed such that the full name of the child, the child's family members and their occupations, the child's medical practitioners and other clinical staff, any hospital, health service, clinic or medical practices where the child may obtain the treatment, and any other fact or matter that may identify the child must not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the parties' real names) shall be released by the Court to non-parties without further contrary Order of the Court (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).

3. Subject to any contrary order of the Court, the Court file must not be made available for search or review by any person who is not a party to the proceeding or a party's legal representative in the proceeding.

4. The affidavits, exhibits, written submissions and parties' correspondence with the Court within this proceeding are to be placed in a sealed envelope and may only be opened by further order of the Court (with the sealed envelope to be so marked).

5. The audio recording of these proceedings not be published or made available except to Auscript for the purpose of making a transcript, or to the Court.

6. Any transcript of the proceedings be made available only to a party to the proceeding or a party's legal representative in the proceeding, or to the Court.

7. The Court declares that:

   (a) the applicant may give valid and lawful consent to the administration of medication(s), including Lucrin and/or Spironolactone, to "A", for the purpose of blocking or suppressing "A"'s future natal puberty, and/or reducing the effect of "A"'s natal puberty (**the Treatment**), without the need for seeking or obtaining the consent of "A"'s father to the Treatment (**the Applicant's Consent**);

   (b) the persons/practitioners named in the draft orders provided by the applicant may validly and lawfully act upon the Applicant's Consent, if given, for the purposes of providing medical and nursing services to A and/or for the purposes of administering the Treatment.