FAMILY LAW ACT 1975

IN THE APPELLATE JURISDICTION OF THE FAMILY COURT OF AUSTRALIA AT SYDNEY

Appeal No. EA 30 of 2017

IN THE MATTER OF

FATHER
Applicant

AND

A GENDER AGENDA INC
First Intervenor

AUSTRALIAN HUMAN RIGHTS COMMISSION
Second Intervenor

SECRETARY FOR THE DEPARTMENT OF FAMILY AND COMMUNITY SERVICES
Third Intervenor

INDEPENDENT CHILDREN'S LAWYER

SUMMARY OF ARGUMENT OF AUSTRALIAN HUMAN RIGHTS COMMISSION

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1 Case stated

1. This proceeding comes before the Full Court of the Family Court of Australia as a case stated by Watts J pursuant to s 94A of the *Family Law Act 1975* (Cth) (***Family Law Act***).

2. By order of Thackray J on 5 May 2017, the Australian Human Rights Commission was granted leave to intervene in this proceeding by virtue of s 92 of the *Family Law Act*.

3. At first instance, Watts J made a finding that the child who was the subject of the proceeding, Kelvin, is *Gillick* competent[1] to consent to Stage 2 treatment for gender dysphoria.[2] His Honour adjourned the balance of the Applicant's Initiating Application for a declaration or, in the alternative, an order authorising treatment, pending the determination by the Full Court of a number of questions set out in the case stated. The Commission submits that this Court has jurisdiction to hear a case stated asking questions of law that are relevant to the issues that Watts J is required to determine.[3]

4. The first two questions in the case stated ask whether the Court 'confirms' aspects of the Full Court's decision in *Re Jamie*.[4] Question 1 puts in issue the conclusion expressed by Bryant CJ in *Re Jamie* that:

> 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.[5]

5. Question 2 puts in issue the conclusion expressed by Bryant CJ in *Re Jamie* that:

> 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.[6]

6. This Court has <u>not</u> been asked to revisit the conclusion in *Re Jamie* that if there is a dispute about whether treatment should be provided (in respect of either Stage 1 or Stage 2), and what form treatment should take, it is appropriate for that dispute to be determined by the Court.[7]

7. Questions 3 and 5 of the case stated relate to the appropriateness and jurisdictional basis, respectively, of the court granting a declaration that a child is *Gillick* competent. Questions 4 and 6 of the case stated relate to the appropriateness and jurisdictional basis,

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1 According to the test described by Lord Scarman in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (***Gillick***) at 188-189.
2 *Re: Kelvin* [2017] FamCA 78.
3 The orders sought at first instance are final, not interlocutory, orders. They are not 'prescribed orders' within the meaning of reg 15A of the *Family Law Regulations 1984* (Cth). Cf submissions of Secretary, DFCS at [2]-[6].
4 *Re Jamie* [2013] FamCAFC 110 (***Re Jamie***).
5 *Re Jamie* at [140(c)] (Bryant CJ). See also [188] (Finn J) and [195] (Strickland J).
6 *Re Jamie* at [140(e)] (Bryant CJ). See also [186] (Finn J) and [196] (Strickland J).
7 *Re Jamie* at [140(b)] (Bryant CJ), [172] (Finn J) and [194] (Strickland J). See also Applicant's submissions at [39].

respectively, of the Court making an order authorising the administration of Stage 2 treatment once a finding of *Gillick* competency has been made.

8. The facts in this case are set out in the reasons for judgment of Watts J in *Re Kelvin* [2017] FamCA 78 delivered on 16 February 2017. These facts comprise:

   8.1. background facts in relation to Kelvin, at [1]-[2], [17]-[31] and [44]-[49];

   8.2. a summary of reports by a psychologist, a psychiatrist and an endocrinologist in relation to their examination of Kelvin and their recommendations in relation to his treatment, at [32]-[39] and [50]-[53];

   8.3. evidence from Kelvin's father and treating doctors in relation to his capacity to make an informed decision about treatment, at [40]-[43].

9. The case stated contains few facts about the administration of Stage 2 treatment to children other than Kelvin.[8]

10. At the first directions hearing, the Applicant (following discussions with the other parties, including the Commission) raised with the Court the prospect of seeking leave to amend the stated case to include further facts. Justice Thackray indicated that if the parties were able to agree a statement of agreed facts, this could be provided to the Full Court. Such a statement has not been agreed and there is a dispute as to the evidence.[9] The Commission's role in this case is to assist the Court in relation to the questions of law, with specific focus on the application of human rights principles. As set out in paragraph 53 below, the Commission submits that the Court should satisfy itself of the relevant factual matters and, to the extent that it deems necessary, it should receive further expert evidence. The Commission does not seek to adduce evidence, nor to make submissions about what evidence should be put to the Court. The submissions of the Commission are not submissions of the Commonwealth.

11. In summary, the submissions of the Commission are as follows:

   11.1. The question of whether Stage 2 treatment for gender dysphoria requires court authorisation implicates a child's right to have their gender identity respected and recognised and to make decisions about their own medical treatment in accordance with their age and maturity.

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[8] There are some generalised statements about the effects of administering or withholding Stage 2 treatment at [33], [36], [37], [38], [39] and [41].

[9] The Royal Children's Hospital in Melbourne has sought leave to intervene and to adduce further evidence in the form of an affidavit affirmed by Associate Professor Michelle Telfer on 11 July 2017 (**Telfer Affidavit**). The submissions of A Gender Agenda at [9]-[16], [40]-[42], [48] and [65] rely on this affidavit to set out the factual background to this case and as a basis for submissions regarding Stage 2 treatment, and at [15]-[16] in order to challenge certain submissions of the Secretary, Department of Family and Community Services. The Secretary, in turn, objects to a significant portion of the Telfer Affidavit.

11.2. The Court should depart from the view in *Re Jamie* that Stage 2 treatment requires court authorisation if it is satisfied that:

(a) there are standard protocols for the treatment of gender dysphoria that are applied consistently in Australia; and

(b) based on the current state of knowledge about gender dysphoria there is a sufficiently low risk of making the wrong decision about Stage 2 treatment.

11.3. The Court should depart from the view that it is necessary in all cases for it to assess *Gillick* competency if it is satisfied that the risk of a wrong decision being made about competency is sufficiently low, and otherwise outweighed by the additional expense, stress and delay involved in a general requirement that all such cases come to court. This position is urged by some members of this Court based on their experience of carrying out competency assessments.[10]

11.4. In exercising the welfare jurisdiction under s 67ZC, the Court has the power to grant declaratory relief, and in particular the power to declare that the child is *Gillick* competent once a finding to that effect has been made.

11.5. If it is determined that a child is *Gillick* competent to consent to Stage 2 treatment, then the decision about treatment should be left to the child, and no further authorisation from the Court is required.

2 Human rights principles

12. The Commission has the function of intervening in proceedings that involve human rights issues, where the Commission considers it appropriate to do so and with the leave of the court hearing the proceeding, subject to any conditions imposed by the court.[11] Human rights issues include those arising under the *Convention on the Rights of the Child* (**CRC**).[12]

13. The Commission intervenes in this proceeding on the basis that court authorisation for Stage 2 hormone treatment of children diagnosed with gender dysphoria implicates rights under the CRC and other international human rights instruments.[13] Given the Court's experience since *Re Jamie* and the current state of medical knowledge regarding the purpose for which the treatment is provided, the nature of the treatment, and the risks

[10] For example, *Re Martin* [2015] FamCA 1189 at [35] (Bennett J); *Re Harley* [2016] FamCA 334 at [42] (Bennett J); *Re Lucas* [2016] FamCA 1129 at [68] (Tree J).

[11] *Australian Human Rights Commission Act 1986* (Cth) (**AHRC Act**), s 11(1)(o).

[12] Done at New York on 20 November 1989, [1991] ATS 4. The CRC is an international instrument relating to human rights and freedoms for the purposes of s 47 of the AHRC Act as a result of the *Human Rights and Equal Opportunity Commission Act 1986 - Declaration of the United Nations Convention on the Rights of the Child*, 22 October 1992.

[13] The proceeding also implicates rights under the *International Covenant on Civil and Political Rights*, articles 17 (privacy) and 26 (non-discrimination). Done at New York on 16 December 1966, [1980] ATS 23.

involved in undergoing, withholding or delaying treatment, the Commission considers that, on balance, and in the absence of conflict, the requirement for court authorisation has a deleterious impact on the rights of affected children.

14. One of the objects of Part VII of the *Family Law Act*[14] is to give effect to the CRC. As a result, the CRC is an 'interpretive aid' when considering the meaning of the provisions of Part VII.[15]

15. Article 3 of the CRC is firmly embedded in the *Family Law Act*. This article provides that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. When exercising the welfare jurisdiction in s 67ZC of the Family Law Act, the Court must regard the best interests of the child as the paramount consideration.[16]

16. The CRC also makes clear that it is important for children to have input into decisions that affect them (including decisions about medical treatment), that their views should be given due weight in accordance with their age and maturity, and that parents have a special responsibility for assisting their children in making these decisions.[17] Like all rights under the CRC, that right is to be afforded without discrimination of any kind.[18]

17. The Committee of the Rights of the Child has published a General Comment about adolescent health and development. This Comment notes:

> The right to express views freely and have them duly taken into account (art. 12) is also fundamental in realizing adolescents' right to heath and development. ... In order for adolescents to be able safely and properly to exercise this right, public authorities, parents and other adults working with or for children need to create an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents' participation equally including in decision-making processes.[19]

18. The Committee has also published a General Comment about the right under article 12 of children to have their views heard. This Comment makes the following observations in relation to the application of this right in health care:

> The Committee welcomes the introduction in some countries of a fixed age at which the right to consent transfers to the child, and encourages States parties to give consideration to the

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[14] *Family Law Act* s 60B(4).
[15] Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011, Replacement Explanatory Memorandum at [24].
[16] *Family Law Act* s 67ZC(2).
[17] CRC articles 5, 12 and 18.
[18] CRC, article 2(1).
[19] Committee on the Rights of the Child, *General Comment No. 4 (2003)*, "Adolescent health and development in the context of the Convention on the Rights of the Child", CRC/GC/2003/4 at [8].

introduction of such legislation. Thus, children above that age have an entitlement to give consent without the requirement for any individual professional assessment of capacity after consultation with an independent and competent expert. However, the Committee strongly recommends that States parties ensure that, where a younger child can demonstrate capacity to express an informed view on her or his treatment, this view is given due weight.[20]

19. Great weight should be given to a child's views when they are properly assessed as being able to understand fully what is proposed. If a child has this level of understanding, then he or she should ordinarily be able to consent to medical treatment for a recognised condition that is provided in accordance with treatment guidelines recommended by a relevant treatment authority.

20. Article 8 of the CRC provides that children have the right to preserve their identity. This right is significant in the context of children's gender identity. While the CRC does not specifically refer to questions of gender identity, in the interpretation of the scope of rights under the CRC, recourse may be had to supplementary means of interpretation,[21] which include the Yogyakarta Principles.[22]

21. The Yogyakarta Principles are principles on the application of international human rights law in relation to sexual orientation and gender identity. They were developed by a group of academic and UN human rights experts and adopted by these experts in 2007.[23] The experts 'agree that the Yogyakarta Principles reflect the existing state of international human rights law in relation to issues of sexual orientation and gender identity'[24] and 'affirm binding international legal standards with which all states must comply'.[25] The Yogyakarta Principles have since been referred to and relied upon by a variety of

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[20] Committee on the Rights of the Child, *General Comment No. 12 (2009)*, "The right of the child to be heard", CRC/GC/12 at [102].

[21] Such means not being limited to 'the preparatory work of the treaty and the circumstances of its conclusion', but extending to materials that 'provide a guide to the current usage of terms by the parties': *Thiel v Federal Commissioner of Taxation* (1990) 171 CLR 338 at 349-350 (Dawson J). As Kirby J observed in *De L v Director-General, Department of Community Services (NSW)* (1996) 187 CLR 640 at 676, '[e]xcept in cases of unarguably clear treaty language, courts today regularly have resort to the opinions of scholars, reports on the operation of the treaty and decisions of municipal courts addressing analogous problems'.

[22] *Principles of the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (the **Yogyakarta Principles**). At http://www.yogyakartaprinciples.org/wp/wp-content/uploads/2016/08/principles_en.pdf (viewed 19 July 2017).

[23] The Yogyakarta Principles were adopted by a group of 29 human rights experts from 25 countries representative of all geographic regions. The experts included one former UN High Commissioner for Human Rights, 13 current or former UN human rights special mechanism office holders or treaty body members (including one member of the UN Committee on the Rights of the Child), two serving judges of domestic courts and a number of academics. The process for the development of the Yogyakarta Principles is described in O'Flaherty and Fisher, 'Sexual Orientation, Gender Identity and International Human Rights Law: Contextualising the Yogyakarta Principles' (2008) 8 *Human Rights Law Review* 207 at 232-237.

[24] Yogyakarta Principles, Introduction, p 7.

[25] Yogyakarta Principles, Introduction, p 7.

international and state bodies and courts, as reflective of existing international human rights obligations.[26]

22. Principle 3 of the Yogyakarta Principles, dealing with the right to recognition before the law, recognises that: 'Each person's self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom.'[27] Pursuant to this principle, States are required to: 'Take all necessary legislative, administrative and other measures to fully respect and legally recognise each person's self-defined gender identity.'

23. Children have the right to the enjoyment of the highest attainable standard of health and the right of access to health care services.[28] The Yogyakarta Principles describe the application of this right in relation to sexual orientation and gender identity. Under Principle 17, State are required to: 'Ensure that all persons are informed and empowered to make their own decisions regarding medical treatment and care, on the basis of genuinely informed consent, without discrimination on the basis of sexual orientation or gender identity.'

24. The application of these principles in the individual case requires an appreciation of the factual matters that inform the Court's assessment as to whether it should depart *Re Jamie* and its determination of *Gillick* competency, as outlined in paragraphs 11.1 and 11.3 above and paragraphs 51 and 60 below. That is, the assessments of the best interests of the child, children's access to health care services, the input of the child into decisions about their medical treatment and the preservation of the child's identity and bodily integrity, will be informed by factual matters regarding the maturity of the individual, the purpose for which the treatment is provided, the nature of the treatment, and the risks involved in undergoing, withholding or delaying treatment.

3 Reconsidering *Re Jamie*

25. In order to answer the first two questions in the case stated, it is first necessary to understand the High Court's decision in *Marion's case*, the nature of 'special medical procedures', and the Full Court's judgment in *Re Jamie*, including the nature of findings in that case about whether treatment is 'therapeutic'.

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[26] O'Flaherty 'The Yogyakarta Principles at Ten' (2015) 33(4) *Nordic Journal of Human Rights* 280 at 287-294.

[27] Similarly, the right to respect for one's private life (Article 8 of the European Convention on Human Rights) has been held to include the physical integrity of a person and extends to a person's sexual gender identity and the right to personal development: *Goodwin v United Kingdom* (European Court of Human Rights, Grand Chamber, Application No 28957/95, 22 July 2002), [90]; *Schlumpf v Switzerland* (European Court of Human Rights, Application No 29002/06, 5 June 2009), [100], [114], [116].

[28] CRC, article 24(1).

3.1 Marion's case

26. *Marion's case* involved the proposed sterilization of a girl with an intellectual disability. The High Court identified two major issues in the case.[29] The first was a 'threshold question' of whether a child (whether with an intellectual disability or not) is capable of consenting to medical treatment on his or her own behalf. The Court answered this question by reference to the judgment of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*, which was said to reflect the common law in Australia.[30] The second issue arose if the child was incapable of consenting to treatment and was whether sterilization was a procedure that fell outside the scope of parental authority to consent.

27. The High Court analysed four first instance decisions in Australia and a number of decisions from other common law countries in relation to proposed sterilizations. In the key Australian case of *Re Jane*,[31] Nicholson CJ held that the consent of the court is necessary in order to perform a medical procedure on a child or a person with an intellectual disability if the procedure involves interference with a basic human right and if its principal purpose is non-therapeutic. However, his Honour noted the difficulties in drawing a line between therapeutic and non-therapeutic procedures.[32]

28. The majority in *Marion's case* held that there were a number of factors involved in the decision to authorise a sterilization procedure which meant that it should not come within the ordinary scope of parental power to consent. The Court limited itself to consideration of procedures other than those where sterilization was 'a by-product of surgery appropriately carried out to treat some malfunction or disease'. In this context, the majority said: '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.'

29. The relevant factors identified by the majority which led to the conclusion that sterilization was a 'special case' that required court authorisation were that: (a) the procedure requires invasive, irreversible and major surgery; (b) there is a significant risk of making a wrong decision (either as to the child's present or future capacity to consent, or about what are

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[29] *Secretary, Department of Health and Community Services v JWB and SMR* (1992) 175 CLR 218 (***Marion's case***) at 231-232 (Mason CJ, Dawson, Toohey and Gaudron JJ).

[30] *Marion's case* at 237-238 (Mason CJ, Dawson, Toohey and Gaudron JJ).

[31] *Re Jane* (1988) 85 ALR 409 (later followed in *Re Elizabeth* (1989) 13 Fam LR 47 and the first instance judgment of *Marion's case*: *Re Marion* (1990) 14 Fam LR 427 at 448).

[32] *Re Jane* (1988) 85 ALR 409 at 439-440.

the best interests of a child who cannot consent); and (c) the consequences of making a wrong decision are particularly grave.[33]

30. The factors outlined by the majority which contribute to the significant risk of a wrong decision being made,[34] present both points of distinction from, and an analogy with, Stage 2 treatment for gender dysphoria. The factors involved in a decision to authorise sterilization of another person indicated to the Court that, in order to ensure the best protection of the interests of the child, such a decision should not come within the ordinary scope of parental power to consent to medical treatment. In that regard, Court authorisation acted as a 'procedural safeguard'.[35] While the question of consent arises both in the case of a proposed sterilization of an intellectually disabled person and in the case of Stage 2 treatment of gender dysphoria, it is perhaps more complex in the case of sterilization of an intellectually disabled person. Similarly, the question of independent and possible conflicting interests of other family members is more problematic in the context of the sterilization of an intellectually disabled person. Moreover, whereas the procedure of sterilization appears antithetical to the right to procreate[36] and bodily inviolability, thereby calling for a procedural safeguard by means of court authorisation,[37] by contrast the fundamental right of the child to preserve their self-defined gender identity speaks in favour of recognition of the child's views and the parents' participation in that decision-making process.

31. On the other hand, the gravity of the consequences of a wrong decision presents an analogy with the decision to authorise sterilization in terms of the prospect of 'social and psychological implications concerning the person's sense of identity, social place and self-esteem'.[38] Like the decision to sterilize, the decision to undertake Stage 2 'involves serious questions of a person's "social and biological identity"'.

3.2 Special medical procedures

32. The majority in *Marion's case* described sterilization procedures as a 'special case'.[39] Since *Marion's case*, the Family Court of Australia has considered a number of cases in which it has been argued that other medical procedures were also beyond the scope of parental authority to consent. These procedures are often referred to as 'special medical

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33 *Marion's case* at 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
34 *Marion's case* at 250-253 (Mason CJ, Dawson, Toohey and Gaudron JJ).
35 *Marion's case* at 249 (Mason CJ, Dawson, Toohey and Gaudron JJ).
36 The Commission notes that the impact of Stage 2 treatment on fertility is a matter that may have bearing on the question of court authorization for treatment (see submissions of Secretary, DFCS at [38], ICL at [74]-[75], AGA at [40(1)]); and the Telfer Affidavit at [27]-[30]), and is properly the subject of expert evidence.
37 *Marion's case* at 249 (Mason CJ, Dawson, Toohey and Gaudron JJ).
38 *Marion's case* at 252 (Mason CJ, Dawson, Toohey and Gaudron JJ).
39 *Marion's case* at 239 (Mason CJ, Dawson, Toohey and Gaudron JJ).

procedures'.[40] The categories of medical procedures that may be deemed a 'special case' or a 'special medical procedure' are not closed.[41]

33. The Court's jurisdiction to hear such cases is found in the 'welfare jurisdiction' conferred by s 67ZC of the *Family Law Act*.[42] The Court has jurisdiction under s 67ZC to hear and determine applications for authorisation of medical procedures, even where the procedure in question is ultimately determined not to be a 'special case' or a 'special medical procedure'.[43] In respect of those special cases, however, court authorisation is necessary and is, in essence, a procedural safeguard for the performance of medical interventions, particularly where issues in conflict with the best interests of the child may exist and may be a matter of real concern.[44]

34. Pursuant to this jurisdiction, the court has heard cases dealing with: (a) sterilization of children; (b) hormonal and surgical procedures performed on children with gender dysphoria; (c) hormonal and surgical procedures performed on children with a number of different intersex variations;[45] (d) proposed bone marrow transplants from a healthy child to a sick relative;[46] (e) experimental, potentially life-saving treatment on an infant;[47] (f) withdrawal of medical treatment from infants with very serious disabilities;[48] and (g) performance of cardiac surgery on a child when parental consent was refused.[49]

35. In exercising this jurisdiction, the Court has been required to determine whether a particular medical procedure requires court authorisation in cases that are not analogous with *Marion's case*. Along with this Court, the High Court in *Marion's case* has called for legislative guidance in relation to this issue.[50]

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[40] Justice Finn in *Re Jamie* preferred the term 'medical procedure which requires court authorisation' (at [150]-[153]). This is consistent with usage of the term by Nicholson CJ in *Re Alex* (2004) 31 Fam LR 503. The Commission has used the term 'special medical procedure' in these submissions as a shorthand for that concept.

[41] *Re Baby D (No 2)* [2011] FamCA 176 at [224]; *Re Alex* (2004) 31 Fam LR 503 at 537 [198].

[42] *Re Alex* (2004) 31 Fam LR 503 at 506 [6]; *Re GWW and CMW* (1997) 21 Fam LR 612 at 614-615 (referring with approval to submissions by the Commonwealth Attorney-General. Note that this case was heard prior to relevant State referrals of power to the Commonwealth in relation to children and so refers only to children 'of a marriage'). See also *Marion's case* at 254-257 (Mason CJ, Dawson, Toohey and Gaudron JJ); Applicant's submissions at [53].

[43] For example, *Re Baby D (No 2)* [2011] FamCA 176 at [224].

[44] *Re Baby D (No 2)* [2011] FamCA 176 at [234].

[45] *Re A* (1993) 16 Fam LR 715; *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226; *Re Sally (Special Medical Procedure)* [2010] FamCA 237; *Re Sean and Russell (Special Medical Procedure)* [2010] FamCA 948; *Re Sarah* [2014] FamCA 208; *Re Dylan* [2014] FamCA 969; *Re Carla (Medical Procedure)* [2016] FamCA 7.

[46] *Re GWW and CMW* (1997) 21 Fam LR 612; *Re Inaya (Special Medical Procedure)* [2007] FamCA 658.

[47] *Re Baby A* [2008] FamCA 417.

[48] *Re Baby D (No 2)* [2011] FamCA 176; *Re Baby R (Life Support)* [2015] FamCA 449.

[49] *Re Michael* (1994) FLC ¶92-471; *Re Michael (No 2)* (1994) FLC ¶92-486.

[50] *Marion's case* at 253 (Mason CJ, Dawson, Toohey and Gaudron JJ). See also the Hon Justice Steven Strickland, 'To Treat Or Not To Treat: Legal Responses to Transgender Young People Revisited' Association of Family and Conciliation Courts Australian Chapter Conference, Sydney, Australia, 14-15 August 2015, pp 30-31.

3.3 Re Jamie

36. The first case in which the Court considered whether hormonal treatment for gender dysphoria was a 'special medical procedure' was *Re Alex*.[51] In that case, Nicholson CJ determined that the procedure required court authorisation on the basis that: (a) the evidence suggested that the treatment was not for the purpose of curing a disease or correcting some malfunction; and (b) Stage 2 had 'irreversible consequences' and that '[t]here are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the court is not asked to authorise surgery'.[52]

37. After *Re Alex*, and prior to *Re Jamie*, the position was that court authorisation was required for both Stage 1 and Stage 2. As a result of the Full Court's decision in *Re Jamie*:

    37.1. court authorisation is no longer required for Stage 1 treatment;

    37.2. children seeking authorisation for treatment for gender dysphoria only need to approach the Court once, prior to the time that Stage 2 treatment is anticipated to commence and at an age when they are typically able to make their own decisions about medical treatment;

    37.3. the first question that that Court will ask is whether the child is capable of consenting to Stage 2 treatment him or herself and, if so, authorisation by the Court is not necessary.

38. A consideration of the rights of children under the CRC and, in particular, their evolving capacity to make decisions about their own medical treatment was significant in reaching these conclusions.[53]

39. In *Re Jamie*, the appellant parents argued that hormonal treatment for gender dysphoria was not a special medical procedure requiring court authorisation. This argument was raised for the first time on appeal.[54] Because it had not been argued at first instance, the evidence before the Court did not directly address this issue. Nevertheless, the Full Court had the benefit of expert reports from Jamie's treating doctors, namely a paediatric endocrinologist and two child psychiatrists.[55] The report from the paediatric endocrinologist annexed what were referred to as 'consensus guidelines' on treatment for gender

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[51] *Re Alex* (2004) 31 Fam LR 503.
[52] *Re Alex* (2004) 31 Fam LR 503 at 534 [183] and 537 [196].
[53] See, for example, *Re Jamie* at [122], [128]-[130] (Bryant CJ).
[54] *Re Jamie* at [4] (Bryant CJ).
[55] *Re Jamie (special medical procedure)* [2011] FamCA 248 at [29].

dysphoria published by the US Endocrine Society 18 months earlier.[56] It also annexed and discussed relevant academic literature on gender dysphoria.[57]

40. The factual material before the Full Court in *Re Jamie* reflected the state of knowledge as at the time of the first instance hearing in March 2011.[58] The decision on appeal was made 'at a particular point in time and at a particular stage in the development of legal principle and medical science'.[59] At the time the appeal in *Re Jamie* was heard, there had been eight first instance judgments dealing with gender dysphoria.[60] The Applicant has indicated that since *Re Jamie*, there has been a significant increase in the number of children approaching the court for authorisation for hormonal treatment for gender dysphoria.[61] Furthermore, a number of judgments since *Re Jamie* have referred to the application of treatment guidelines published by US Endocrine Society,[62] and the World Professional Association for Transgender Health.[63]

41. In *Re Jamie*, the Chief Justice acknowledged that court authorisation may be initially required for a procedure because of the 'evolving state of medical knowledge', but may not be required later.[64] Similarly, in recognising the factual basis of the assessment of the requirement for court authorisation, Finn J observed that an appreciation of 'the effects, particularly the physical effects, on the child of the two stages of the proposed treatment ... is necessary in order to understand the very significant issues raised' in the appeal.[65] This proceeding is not an appeal from the Court's decision in *Re Jamie*. For the reasons set out in paragraph 13 above, this Court may depart from its decision in *Re Jamie*, without concluding that *Re Jamie* was wrongly decided, because the factual position is now different from that before the Court in *Re Jamie*.[66]

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56 *Re Jamie (special medical procedure)* [2011] FamCA 248 at [59] and [82]. The guidelines were published by the US Endocrine Society, 'Endocrine Treatment of Transsexual Persons' (2009) 94(9) *Journal of Clinical Endocrinology & Metabolism* 3132.

57 *Re Jamie* at [93] (Bryant CJ).

58 *Re Jamie (special medical procedure)* [2011] FamCA 248.

59 The Hon Justice Steven Strickland, 'To treat or not to treat: legal responses to transgender young people' Association of Family and Conciliation Courts 51st annual conference, Toronto, Canada, 28-31 May 2014, p 72.

60 See the cases listed at footnote 1 to paragraph 34 in *Re Jamie* (Bryant CJ).

61 Applicant's submissions at [30].

62 See, eg *Re Sam and Terry (Gender Dysphoria)* [2013] FamCA 563 at [25], referring to evidence that the treatment in that case was based on the US Endocrine Society guidelines 'which has been adopted by the Australasian Paediatric Endocrine Group' and was 'similar to treatment approaches in other centres in Australia'; *Re Shane (Gender Dysphoria)* [2013] FamCA 864 at [32], referring to evidence that the treatment in that case was in accordance with the US Endocrine Society guidelines and was 'similar to the practice adopted in other Australian hospitals'.

63 See, eg *Re Quinn* [2016] FamCA 617 at [4] and *Re Lincoln (No 2)* [2016] FamCA 1071 at [28], each dealing with the question of competency to consent to Stage 3 surgical interventions for gender dysphoria, and each referring to the WPATH guidelines as setting out 'generally accepted interventions' comprising three stages of treatment for gender dysphoria.

64 *Re Jamie* at [106] (Bryant CJ).

65 *Re Jamie* at [161] (Finn J).

66 This is expressly acknowledged in the conclusion of Bryant CJ at [140(c)]. Cf Submissions of A Gender Agenda at F-2, [44]-[51], which assess the decision in *Re Jamie* by reference to material not before the court in that case.

3.4 Whether the treatment is 'therapeutic'

42. The Court in *Re Jamie* referred with approval to the distinction drawn by Brennan J in *Marion's case* between therapeutic and non-therapeutic treatment.[67] Justice Brennan said (with emphasis added):

> 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.[68]

43. The reasoning of majority in *Marion's case* suggested that a procedure resulting in sterilization would be 'therapeutic' if it was 'appropriately carried out' to treat some malfunction or disease.[69]

44. The Court in *Re Jamie* found that Stage 1 treatment is administered for therapeutic purposes.[70] Because the treatment is reversible, is not attended by a grave risk if the wrong decision is made, and is for the treatment of a recognised condition,[71] absent controversy, decisions about Stage 1 treatment fell within the ambit of parental responsibility.[72]

45. Justice Finn considered that the irreversibility of Stage 2 treatment remained an important consideration, 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'.[73] Her Honour said that:

> 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 treatment would bring about for the child.[74]

46. Strickland J agreed that the therapeutic benefits of the treatment need to be weighed against the risks involved and the consequences which arise out of treatment being

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67 *Re Jamie* at [74] and [97] (Bryant CJ), [177], [180] and [182] (Finn J), [195] (Strickland J).
68 *Marion's case* at 269 (Brennan J).
69 *Marion's case* at 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
70 *Re Jamie* at [98] (Bryant CJ), [179] (Finn J), [193] (Strickland J).
71 *Re Jamie* at [66]-[69] and [97]-[98] (Bryant CJ).
72 *Re Jamie* at [108] (Bryant CJ), [179] (Finn J), [193] (Strickland J).
73 *Re Jamie* at [180].
74 *Re Jamie* at [182].

irreversible.[75] His Honour subsequently expanded on this proposition in extra-curial comments, saying:

> When deciding whether or not authorisation is required, the principle of proportionality should be invoked, such that the therapeutic benefit of the proposed procedure should be weighed against the risk of making the wrong decision and the consequences of that decision.[76]

47. In examining the therapeutic benefit of the treatment, and whether the treatment was appropriate for and proportionate to the purpose for which it is administered, the Court in *Re Jamie* addressed the following factual issues:

    47.1. The treatment proposed is aimed at 'the alignment of the body with the person's self-identity'.[77] This is relevant when considering the right of children to the preservation of their identity under article 8 of the CRC and the 'integral' nature of a person's gender identity 'to their personality and [their] self-determination, dignity and freedom' pursuant to Principle 3 of the Yogyakarta Principles.

    47.2. There were no alternative treatments available, meaning that the only alternative to providing treatment was withholding treatment.[78] This (and the following issue) is relevant when considering the right of the child to the enjoyment of the highest attainable standard of health, including the right of access to health care services, in accordance with article 24(1) of the CRC and Principle 17 of the Yogyakarta Principles.

    47.3. Withholding (or significantly delaying) treatment was likely to have significant adverse psychological and physical effects.[79]

48. The Commission intervened in *Re Jamie* and, based on the evidence that was before the Court at that time, submitted that court authorisation for Stage 2 remained appropriate on the basis that:[80]

    48.1. consensus guidelines in relation to treatment for gender dysphoria had only recently been adopted in Australia;

    48.2. there were still uncertainties about the long term effects of the treatment proposed;

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[75] *Re Jamie* at [195].
[76] The Hon Justice S Strickland, 'To treat or not to treat: legal responses to transgender young people' Association of Family and Conciliation Courts 51st annual conference, Toronto, Canada, 28-31 May 2014, pp 46 and 75.
[77] *Re Jamie* at [67]-[68] (Bryant CJ). See also *Re Kelvin* [2017] FamCA 78 at [34]-[35]; ICL's submissions at [54].
[78] *Re Jamie* at [62] (Bryant CJ).
[79] *Re Jamie* at [62] (Bryant CJ). See also *Re Kelvin* [2017] FamCA 78 at [37] and [39].
[80] Submissions of the Australian Human Rights Commission in *Re Jamie* at [96]-[117]. At https://www.humanrights.gov.au/sites/default/files/Submissions%20of%20AHRC%20Re%20Jamie.pdf (viewed 15 July 2017). These submissions have been anonymised in accordance with orders made in that proceeding. The names of the parties and other people involved in the proceeding, along with other material that may identify them, has been redacted.

48.3. there were no longitudinal studies available dealing with patients' satisfaction with treatment, including whether people going through treatment later regretted doing so;

48.4. as a result, it was difficult to evaluate the risk of making a wrong decision about what was in the best interests of a child who was not *Gillick* competent to consent to treatment; and

48.5. there were grave consequences if a wrong decision were made.

49. The Commission's submissions recognised that the Court's role may change based on evidence of increased experience and familiarity with the treatment guidelines,[81] and a better understanding of: (i) the nature of the potential risks involved in the treatment; and (ii) patients' satisfaction with the treatment. As noted in paragraph 13 above, given the Court's experience since *Re Jamie* and the current state of medical knowledge, the Commission considers that, on balance, and in the absence of conflict, the requirement for Court authorisation has a deleterious impact on the rights of affected children.

50. **Question 1** in the case stated asks:

> Does the Full Court confirm its decision in *Re Jamie* ... to the effect that Stage 2 treatment of a child for the condition of Gender Dysphoria in Adolescents and Adults as classified in ... DSM-5 ... , requires the court's authorisation pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ... , unless the child was *Gillick* competent to give informed consent to the treatment?

51. In answer to question 1, the Commission submits that the Court should depart from the view in *Re Jamie* that Stage 2 treatment requires court authorisation if it is satisfied that:

51.1. there are standard protocols for the treatment of gender dysphoria that are applied consistently in Australia; and

51.2. based on the current state of knowledge about gender dysphoria there is a sufficiently low risk of making the wrong decision about Stage 2 treatment, taking into account:

(a) the purpose for which the treatment is provided;

(b) the lack of alternative treatments;

(c) the risks if treatment is withheld or delayed;

(d) the potential future health impacts if treatment is provided; and

(e) evidence of patients' satisfaction with the treatment.

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[81] See paragraph 40 above.

52. In those circumstances, there would no longer be a basis for removal of the decision as to Stage 2 treatment from the ambit of parental responsibility.

53. The Commission submits that the Court can be satisfied that there are current guidelines in place,[82] and that there is a reasonable basis upon which to be satisfied of: (a) the (therapeutic) purpose for which the treatment is provided; (b) the lack of alternative treatments; and (c) the adverse consequences if treatment is withheld or delayed.[83] To the extent that the Court deems it necessary to rely on further evidence regarding: (d) the potential future health impacts if treatment is provided; and (e) patients' satisfaction with the treatment,[84] the Commission supports the Secretary's proposal for an independent joint expert.[85]

4 Determination of *Gillick* competency

54. If the Court decides that hormonal treatment for Stage 2 is no longer a medical procedure requiring court authorisation, then question 2 does not arise. In that case, and barring a dispute, the Court would not have any role in relation to this treatment, and therefore would not need to assess whether the child was *Gillick* competent. Question 2 only arises if the Court decides that Stage 2 should continue to be subject to court authorisation.

55. In that context, there is a threshold question as to whether the child is capable of consenting to the treatment.[86]

56. In *Re Jamie*, the Full Court held that: (a) Court authorisation for Stage 2 remains appropriate unless the child concerned is *Gillick* competent; (b) if the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy; (c) 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.[87]

57. In *Re Jamie*, with some reluctance, the Court held that it was necessary for it to determine *Gillick* competency in all cases relating to Stage 2 treatment for gender dysphoria.[88] The Court acknowledged the additional expense, stress and possible delay involved in a

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[82] See the Telfer Affidavit at [13], [15]-[21] and [51]-[52]. The Commission understands that these paragraphs of the Telfer Affidavit are not objected to by any party.

[83] As to **(a)** see *Re Kelvin* at [33] and [36] and the Telfer Affidavit at [15], [16], [18], [20] and [22]; as to **(b)** and **(c)** see *Re Kelvin* at [37]-[39] and the Telfer Affidavit at [25], [26], [40] and [41]. The Commission understands that the paragraphs of the Telfer Affidavit referred to in this footnote are not objected to by any party.

[84] As to **(d)** see *Re Kelvin* at [41] and the Telfer Affidavit at [21] and [48]; as to **(e)** see the Telfer Affidavit at [23], [58], [59] and the article referred to in Note 1. The Commission understands that the paragraphs of the Telfer Affidavit referred to in this footnote are not objected to by any party.

[85] Letter of 1 August 2017 from [redacted], Senior Solicitor for Crown Solicitor on behalf of the Secretary, DFCS, to the parties and intervenors.

[86] *Marion's case* at 231-232 (Mason CJ, Dawson, Toohey and Gaudron JJ).

[87] *Re Jamie* at [140(c) to (e)] (Bryant CJ), [184]-[186] (Finn J), [196] (Strickland J).

[88] *Re Jamie* at [137] (Bryant CJ), at [185] (Finn J).

requirement to come to court and sought to weigh these factors against the risk of a wrong decision being made about whether or not the child was competent to consent to treatment.

58. It is significant that in the vast majority of cases that have been decided after *Re Jamie*, the Court has found that the child was competent to make his or her own decision about treatment.[89] This circumstance distinguishes the practice of court authorisation of sterilization of children with intellectual disabilities, and may provide some comfort to the Court regarding the risk of making the wrong decision about competency. In addition, some members of the Court have questioned whether the current process provides any additional safeguard because there is rarely a contradictor, and the Court is likely to make a finding of *Gillick* competency based on the advice of the child's treating doctors.[90] The Commission is not aware of any cases where the Court has formed a different view from a child's doctors about the question of competency, or has formed a different view about whether treatment should be carried out in circumstances where the child and his or her parents and doctors were in agreement.

59. **Question 2** in the case stated asks: 'Does the Full Court confirm that the Family Court of Australia and not the child's treating professionals should determine whether a child is Gillick competent to give consent to the treatment ... ?'

60. The Commission submits that the Court should depart from the view that it is necessary in all cases for it to assess *Gillick* competency if it is satisfied that the risk of a wrong decision being made about competency is sufficiently low, and otherwise outweighed by the additional expense, stress and delay involved in a general requirement that all such cases come to court.

61. This assessment is likely to be influenced by the range of factors that the Commission has identified for consideration in paragraph 51 above in relation to question 1.

62. The Commission submits that (as held in *Re Jamie*) if the Court is required to make an assessment of competency and determines that the child is *Gillick* competent, then there is no need for the Court to authorise treatment.[91]

63. The question of *Gillick* competency in relation to Kelvin has been determined. This proceeding is not an appeal from that decision. The case stated does not call into question

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[89] Children were found not to be *Gillick* competent in *Re Shane (Gender Dysphoria)* [2013] FamCA 864; *Re Jordan* [2015] FamCA 175; *Re Karsen* [2015] FamCA 733 and *Re Marley* [2015] FamCA 878, including in circumstances where the expert evidence suggested that no child would be competent to make such a decision.

[90] For example, *Re Martin* [2015] FamCA 1189 at [35] (Bennett J); *Re Harley* [2016] FamCA 334 at [42] (Bennett J); *Re Lucas* [2016] FamCA 1129 at [68] (Tree J).

[91] *Re Jamie* at [140(d)] (Bryant CJ), [188] (Finn J) and [196] (Strickland J). Cf submissions of Secretary, DFCS at [15], [46]-[48].

the propriety of the assessment of *Gillick* competency in this proceeding.[92] Furthermore, s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) does not displace or limit the Court's welfare jurisdiction.[93] The provision does not confer on the minor a right to consent, nor does it alter the common law position in relation to the determination of *Gillick* competency.[94]

5 Availability of declaratory relief

64. **Question 3** proceeds on the basis that Stage 2 treatment requires court authorisation (see question 1), and that it is a matter for the Court to determine *Gillick* competency as a threshold question (see question 2). In that context, it asks: 'if a finding is made that the child was *Gillick* competent to give informed consent to the treatment, should any application for a declaration that the child is *Gillick* competent to give consent to the treatment, be dismissed?' The Commission submits that the answer to this question is: 'No'. It would be appropriate for a declaration to be made.

65. **Question 5** asks whether the jurisdiction and power of the Court is enlivened, pursuant to s 67ZC of the Act, to make a declaration that the child is *Gillick* competent to give informed consent to the treatment. The Commission submits that the Court has jurisdiction to hear cases relating to special medical procedures in any individual case pursuant to the particular provisions of Part VII of the *Family Law Act* that confer the relevant rights or impose the relevant obligations, combined with its general welfare jurisdiction under s 67ZC of the *Family Law Act*.[95]

66. The constitutional basis for this jurisdiction is found in s 51(xxi), (xxii) and (xxxix) in relation to children of a marriage, and s 51(xxxvii) and (xxxix) in relation to ex nuptial children in respect of whom a relevant referral to the Commonwealth has been made.[96]

67. The Family Court of Australia is a statutory court. In exercising the jurisdiction conferred on it by the *Family Law Act*, the Court may exercise the powers that are conferred on it by that Act either expressly or by implication. The Court may also exercise such powers as are incidental and necessary to the exercise of the jurisdiction so conferred on it.[97]

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92 Cf submissions of A Gender Agenda at [1], G-3 [72]-[80].

93 *K v Minister for Youth & Community Services* [1982] 1 NSWLR 311 at 321 (Helsham CJ in Eq); *X v Sydney Children's Hospitals Network* [2013] NSWCA 320 at [28]-[30] (Basten JA).

94 Cf submissions of A Gender Agenda at [53]-[54], [74]ff.

95 *Re Alex* (2004) 31 Fam LR 503 at [6]; *Re GWW and CMW* (1997) 21 Fam LR 612 at 614-615; *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 at [13], [22]-[23]; *Re Lucy (Gender Dysphoria)* [2013] FamCA 518 at [30]. See also *Marion's case* at 254-257 (Mason CJ, Dawson, Toohey and Gaudron JJ); Applicant's submissions at [53].

96 *Re Lucy (Gender Dysphoria)* [2013] FamCA 518 esp at [35]; *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 at [41], [74], [139]. Cf ICL's submissions at [19]-[34]. See Notice of A Constitutional Matter under section 78B of the *Judiciary Act 1903* (Cth), filed 31 July 2017, Ground B.

97 *DJL v Central Authority* (2000) 201 CLR 226 at 241 [25] (Gleeson CJ, Gaudron, McHugh, Gummow and Hayne JJ).

68. Unlike the Federal Court of Australia, the Family Court of Australia does not have a general express statutory power to grant declaratory relief.[98] That, however, is not dispositive of the matter. Section 34 of the *Family Law Act* is relevantly identical to s 23 of the *Federal Court of Australia Act 1976* (Cth), which gives the Court the power to make orders and issue writs of such kinds as it considers appropriate in relation to matters in which it has jurisdiction. That power is very wide.[99]

69. Furthermore, the question arises as to whether in the particular exercise of its welfare jurisdiction under Part VII of the *Family Law Act*, the Court has the power to grant declaratory relief by implication from the conferral of that jurisdiction, or otherwise as incidental and necessary to the exercise of that jurisdiction.[100] The majority of the High Court in *Marion's case* noted that the welfare jurisdiction of the Family Court is similar to the *parens patriae* jurisdiction and that its scope is 'very wide';[101] it is 'impossible to say what are the limits of that jurisdiction'.[102] In *AMS v AIF*, Gaudron J said: 'If there is a risk to the welfare of a child, the *parens patriae* jurisdiction will support a great variety of orders and orders of great width'.[103] However, the orders must be necessary for the welfare of a child or appropriate and adapted to avert a risk to the child's wellbeing.[104]

70. The Commission does not consider that the observation of Carew J in *Re Jaden,* that the reference to 'orders' in s 67ZC does not include orders in the nature of a declaration,[105] and the authorities relied upon by her Honour to support that conclusion,[106] deny the breadth of the Court's powers under s 34 of the *Family Law Act*, nor the existence of implied powers flowing from the conferral of jurisdiction, to make a declaration of *Gillick* competency.

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[98] See discussion in *Re Jaden* [2017] FamCA 269 at [23]-[24]. Submissions of Applicant at [49]; Secretary, DFCS at [12]; ICL at [93].

[99] *R v Ross-Jones; Ex parte Beaumont* (1979) 141 CLR 504 at 509 (Gibbs J); *Smith and Smith (No 2)* (1985) FLC 91-604 at 79,894–79,895 (Evatt CJ); *Valceski v Valceski* (2007) 70 NSWLR 36 at [52] (Brereton J).

[100] For one example of the Family Court recognising a power to make orders incidental to the conferral of jurisdiction, see *Norton & Locke* (2013) FLC 93-567; [2013] FamCAFC 202, where the power to grant interlocutory injunctive relief was said to be incidental to the Court's 'jurisdiction to determine if it has jurisdiction': see esp [43]; see also the cases cited at [33]-[41].

[101] *Marion's case* at 258 and 261 (Mason CJ, Dawson, Toohey and Gaudron JJ).

[102] *Marion's case* at 258 (Mason CJ, Dawson, Toohey and Gaudron JJ), citing *Wellesley v Wellesley* (1828), 2 Bli. N.S. 124 at 131.

[103] *AMS v AIF* (1999) 199 CLR 160 at 189 [86] (which was concerned with orders made by the Family Court of Western Australia).

[104] *AMS v AIF* (1999) 199 CLR 160 at 190 [88]. However, the Court does not have jurisdiction to make orders binding on third parties whenever it would advance the welfare of a child to do so: *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 at 390 [52] (Gleeson CJ and McHugh J); see also at 434 [204] (Callinan J).

[105] *Re Jaden* [2017] FamCA 269 at [29]. See *Knight v FP Special Assets Ltd* (1992) 174 CLR 178 at 205, where Gaudron J observed that it was contrary to long-established principle and wholly inappropriate that the grant of a power to a court (including the conferral of jurisdiction) should be construed as subject to a limitation not appearing in the words of that grant, and that the necessity for the power to be exercised judicially tended in favour of the most liberal construction.

[106] *Re Jaden* [2017] FamCA 269 at [22]-[28].

71. Once the Court's jurisdiction is engaged in relation to any application for Stage 2 treatment on a minor, the first question is whether the child is relevantly competent to consent to treatment. If not, the second question is whether it is in the best interests of the child for the treatment to be authorised.

72. The preferable view is that the determination of competency is a 'threshold question' once the Court's jurisdiction has been engaged, rather than incompetence being a 'jurisdictional fact' necessary for the establishment of jurisdiction.[107] The determination of legal capacity depends on the individual circumstances of the case, and is part of a process of determining whether or not to make orders under s 67ZC(2). The determination varies 'according to the gravity of the particular matter and the maturity and understanding of the particular young person'.[108] The Court has jurisdiction whether or not it ultimately finds that the child is *Gillick* competent, or that it is in the best interests of the child for the procedure to be authorised.

73. Finally, the Commission considers that there may be a benefit to the child in a declaration of *Gillick* competency once a finding to that effect has been made, including by way of formal recognition of the child's right to express views and have them duly taken into account (article 12 of the CRC), and a formal acknowledgment that they are informed and empowered to make their own decisions regarding medical treatment, without discrimination on the basis of sexual orientation or gender identity (Principle 17 of the Yogyakarta Principles). A declaratory judgment is, after all, a 'formal statement by a court pronouncing upon the existence ... of a legal state of affairs';[109] it may not create rights, but it 'indicate[s] what they have always been'.[110] The Commission submits that such a pronouncement may be of value to an individual child who is seeking to have affirmed what he or she has always known to be true.

6 Whether to dismiss an application for authorisation once a finding of *Gillick* competency is made

74. The Commission submits that the answer to **Question 4** is 'yes'. A child who is mature enough to make decisions about his or her own medical treatment should be entitled to do so and no further authorisation from the court is necessary. This is consistent with article

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[107] This submission is consistent with the approach of the New South Wales Court of Appeal in *X v The Sydney Children's Hospitals Network* [2013] NSWCA 320 at [32]-[45], [66]. Cf *Re Logan* [2016] FamCA 87 at [14]; ICL's submissions at [92]; Applicant's submissions at [52]. The fact that *Gillick* competence (or incompetence) is a highly evaluative and fact-sensitive matter strongly tells against it being a jurisdictional fact; to be 'jurisdictional', a fact must have an 'objective existence': see *Timbarra Protection Coalition Inc v Ross Mining NL* (1999) 46 NSWLR 55 at 64 (Spigelman CJ); M Aronson, M Groves and G Weeks, *Judicial Review of Administrative Action and Government Liability* (6th ed, 2017) at [4.530].

[108] *Marion's case* at 293 (Deane J).

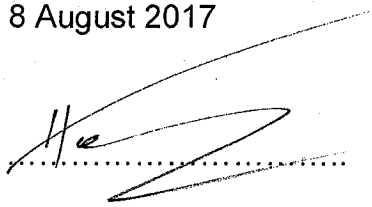
[109] J Woolf, *Zamir & Woolf: The Declaratory Judgment* (3rd ed, 2000) at [1.02].

[110] P W Young, *Declaratory Orders* (2nd ed, 1984).

12(1) of the CRC which requires States Parties to assure to children who are capable of forming their own views the right to express those views freely in all matters affecting them and to give those views due weight in accordance with the age and maturity of the child.

75. **Question 6** proceeds on the basis that the child (or someone with parental responsibility for the child) has sought an order authorising the administration of the treatment and the Court, although finding that the child is *Gillick* competent to consent to Stage 2 treatment, has decided not to dismiss the application. Consistently with its answer to question 5, the Commission submits that a finding of *Gillick* competency does not deprive the Court of its jurisdiction under s 67ZC to make an order authorising the administration of the treatment. Nevertheless, the Commission submits that the better course is for the Court to dismiss the application for authorisation and allow the child to make his or her own decision about treatment.

8 August 2017



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