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REASONS FOR JUDGMENT

INTRODUCTION

1. This case is about Imogen, aged 16 years and 8 months, and her future medical treatment. Imogen has been diagnosed with Gender Dysphoria and assessed as Gillick competent by her treating doctors. Imogen currently takes stage 1 puberty suppression medication and has expressed a consistent, persistent and insistent view that she wishes to move to stage 2 gender affirming hormone treatment. Imogen's mother disputes Imogen's diagnosis and that Imogen is Gillick competent. She says that Imogen is unable to fully and sufficiently understand the nature of the treatment proposed, lacks an understanding of and ability to assess the risks associated with stage 2 treatment and has a misplaced confidence in the positive effects of transitioning. Imogen's mother does not consent to gender affirming hormone therapy.
2. This case raises the following questions about the current law for children and adolescents presenting with Gender Dysphoria, when there is a dispute about consent or treatment:
    - Is an application to the Court mandatory?
    - Whether mandatory or not, once an application is made and if Imogen is found to be Gillick competent, can she make her own decisions about her treatment?
    - If so, what order, if any, should be made in respect of the issue of Gillick competence?
    - If Imogen's consent is not sufficient and the Court is required to make an order that is in Imogen's best interests, should that order grant Imogen "parental responsibility" to make her own decision or should an order authorising treatment be made?
3. The Attorney-General of the Commonwealth ("Attorney-General"), the Independent Children's Lawyer ("ICL") and the father on the one hand and the Australian Human Rights Commission ("AHRC") and the mother on the other, make diametrically opposed arguments as to the current state of the law about whether, absent parental consent, Imogen can make her own decision about treatment. There is otherwise disagreement about what treatment Imogen should have and the form any order should take.
4. Expert evidence was given about the efficacy of Imogen's proposed treatment. In what is currently the orthodox middle, Imogen's treating medical practitioners follow The Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents ("the Australian Standards")[1] which adopts a multi-disciplinary approach to treatment using gender affirming hormones. Advocating a more conservative approach, Dr D'Angelo the mother's adversarial expert psychiatrist suggests that psychotherapy rather than medication should be the preferred method of treatment of Gender Dysphoria. Relevant to these competing approaches, a body of research was adduced in

evidence and explored in cross examination. Adopting a less conservative approach, reference was made to the "Informed Consent Model" made available through particular general practitioners who are willing to prescribe gender affirming hormone treatment to 16 and 17 year old adolescents without knowing whether their parents or legal guardians dispute whether that treatment should be prescribed.

5. Whilst this case is heard in the context of an emerging debate about the diagnosis and treatment of Gender Dysphoria, the outcome is focused upon an assessment of Imogen's particular circumstances.

APPLICATIONS

Father

1. The father's primary application is that Imogen be granted "parental responsibility for herself for the purposes of consent to medical treatment" for Gender Dysphoria. In the alternative, the father seeks that "the court authorise the administration of stage 2 treatment for Gender Dysphoria".

Mother

1. The final orders the mother sought during the proceedings went through four iterations (as fully described in Schedule 1). All were based upon her assertion that Imogen did not have Gender Dysphoria and was not Gillick competent to make a choice to have stage 2 treatment. During final submissions, the mother continued to rely upon submissions made in her case outline.
2. The mother initially sought orders that the parties instruct the treating medical practitioners to cease both stage 1 and stage 2 treatment for Imogen. The mother's final position, at the conclusion of the evidence, was that she neither consented nor opposed Imogen commencing stage 2 treatment for Gender Dysphoria. So it remained her case that she did not consent to Imogen having stage 2 treatment for a condition which she asserted that Imogen did not have but no longer sought any mandatory injunction to stop and/or prevent that treatment.
3. At the commencement of the final hearing the mother sought an order that the father do all necessary things to facilitate Imogen attending appointments with a psychologist/ psychiatrist who specialises in treating adolescents with "Complex Post-Traumatic Stress Disorder" for the purposes of psychotherapy. The mother renewed this application at the commencement of final submissions and at no time withdrew this application. The ICL opposed that application.
4. At the commencement of final submissions the mother also sought liberty to provide the L Centre Back to school program and any mental health professional Imogen consults with a copy of the mother's expert's report. During submissions the parents agreed what could be provided was all of the expert affidavits filed in the proceedings. That order was opposed by the ICL. All of the parties agreed that a copy of these reasons for judgment was to be provided.
5. During final submissions a proposed minute of order, which was signed by the solicitors for the parents but not seen or signed by the ICL was tendered (which I have marked Exhibit 18). Orders 1 and 3 as sought were agreed to. They

required the father do all things necessary to facilitate Imogen attending the L Centre Back to school program and that the father provide the mother an update in writing with respect to Imogen on a monthly basis, including but not limited to matters concerning her health and education. The parents together sought a general order that the father do all things necessary to facilitate Imogen attending appointments with a psychotherapist/psychiatrist with a specialisation in adolescent mental health for the purposes of psychotherapy, with such regularity as recommended by the therapist. The ICL also opposed that order being made.

Independent Children's Lawyer

1. The orders which the ICL sought at the commencement of the hearing were in the alternative depending upon whether or not the Court found that Imogen is Gillick competent. If she was, then the order sought was:

The court declares that Imogen (formerly known as Thomas) born ... 2004 is competent to consent to the administration to her of Stage 2 treatment for the condition known as "Gender Dysphoria".

1. If she was not, then the order sought was that:

The proposed Stage 2 treatment of Imogen (formerly known as Thomas) born ... 2004, being the administration of oestrogen in such dose, in such manner and with such frequency as determined by her treating medical practitioners, is authorised by order of this Court.

1. In final submissions the ICL abandoned his first alternate application on the basis that he adopted the legal principles advocated by the Attorney-General.

The Attorney-General of the Commonwealth and the Australian Human Rights Commission

1. In response to a request from the Court, the Attorney-General intervened in the proceedings pursuant to s 91(1)(a) of the Family Law Act 1975 (Cth) ("the Act") to provide submissions in respect of particular questions of law. The AHRC sought leave to intervene in the proceedings at the request of the Court. Whilst the Attorney-General and the AHRC advocated different approaches, neither sought any order.

THE EVIDENCE

1. The applicant father relied on his affidavits filed 17 February 2020, 7 May 2020 and his affidavit sworn 31 July 2020 which I mark exhibit 19, as it was not filed; the affidavits of Dr C, Imogen's treating psychiatrist, filed 17 February 2020 and 8 May 2020; and an affidavit of Associate Professor J, Imogen's treating endocrinologist, filed 20 March 2020.
2. The respondent mother relied upon affidavits filed by her on 25 March 2020 and 21 May 2020 and an affidavit of Dr D Angelo, filed 12 June 2020.
3. The ICL relied upon an affidavit filed 13 July 2020 by Associate Professor Winter, an academic with a background in therapy, who primarily gave evidence relating to research relied upon by the mother's expert.
4. Each of the parties and the ICL filed case outlines; the Attorney-General and the AHRC both filed written submissions dated 17 July 2020.

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5. All witnesses gave oral evidence and in large part, the evidence of the experts was given concurrently. Dr C and Dr D'Angelo had prepared a joint statement of expert witnesses pursuant to r 15.69 Family Law Rules 2004 (Cth). Dr C and Dr D'Angelo adopt fundamentally different diagnostic frameworks, methods, and conceptualisation of the experience of Gender Dysphoria.

GENDER DYSPHORIA AND STAGES OF TREATMENT

1. There is no issue in this case about the definition of Gender Dysphoria nor how the Australian Standards describe stages of gender affirming treatment.
2. Gender Dysphoria is a term that describes the distress experienced by a person due to incongruence between their gender identity and their gender assigned at birth. The description of Gender Dysphoria in the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-5 Fifth Edition ("DSM-5") at 302.85 is in two parts. Part A sets out six manifestations of marked incongruence, two of which must be present for at least six months. Part B requires the incongruence to be associated with clinically significant distress or impairment in social, occupational or other important areas of functioning (see also World Health Organization, ICD-10 Classification of Mental and Behavioural Disorders (ICD-10) at F64.2, a different diagnostic instrument).
3. The Australian Standards provide (at page 11) that the optimal model of care for trans and gender diverse adolescents who present to services involves a coordinated, multidiscipline team approach. This may include clinicians with experience in the disciplines of child and adolescent psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychology, gynaecology, andrology, fertility services, speech therapy, general practice and nursing.
4. The Australian Standards (at page 15) 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. In Australia, gonadotrophin releasing hormone analogues (GnRHa) are available in subcutaneous and intramuscular injectable preparations. Citing a 2017 paper[2], the Australian Standards claim that the effects of puberty suppression is reversible whilst acknowledging both that the main concern relates to the impact upon bone mineral density and that the long term impact on bone mineralisation is currently unknown.
5. The Australian Standards (at page 16 and following) describe stage 2 treatment as gender affirming hormone treatment using oestrogen and testosterone and notes some of the effects of this medication are irreversible (such as breast growth), whilst others are unknown (such as decreased sperm production).
6. The Australian Standards (at page 25) provide guidelines for surgical interventions for trans and gender diverse adolescents (also referred as stage 3 treatment).
7. In its guidelines to health professionals, the Australian Standards make an incorrect assertion about the current state of the law. At page 7, the Australian Standards state, "current law allows adolescent's clinicians to determine their capacity to provide informed consent for treatment. Court authorisation prior to

commencement of hormone treatment is no longer required". Again, whilst the guidelines say that informed consent from parents/legal guardians should be obtained in relation to puberty suppression (at page 23) and surgical interventions (at page 25), in relation to the commencement of gender affirming hormone treatment the Australian Standards say (at page 24) "...[a]lthough obtaining consent from parents/guardians for commencement of hormone treatment is ideal, parental consent is not required when the adolescent is considered to be competent to provide informed consent". The effect of the submissions of the Attorney General (and the applications of the ICL and the father) is that the Australian Standards incorrectly state the current law in relation to the need for the consent of parents/guardians to stage 2 treatment. As I shall discuss, the statements in the Australian Standards do not accurately reflect current Full Court authority which binds me, in circumstances where there is a dispute about treatment.

APPLICABLE LEGAL PRINCIPLES

Principles established so far

1. In Secretary, Department of Health and Community Services v JWB and SMB [1992] HCA 15; (1992) 175 CLR 218 ("Marion's case"), the High Court of Australia held that at common law and under the Family Law Act 1975 (Cth) a parent generally has power to consent to medical treatment of their child, but adopted the approach explained by the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority [1985] UKHL 7; [1986] AC 112, that the parental power to consent on behalf of a child diminishes as the child's capacities and maturities grow: a child is capable of giving informed consent, and a parent is no longer capable of consenting on the child's behalf, when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed (at 237 per Mason CJ, Dawson, Toohey and Gaudron JJ). This capability has become known as "Gillick competence".
2. In Marion's case, the High Court at 250-252 drew a distinction between "therapeutic" and "non-therapeutic" procedures finding that non-therapeutic medical procedures and particularly those which in combination:
    - Require invasive, irreversible and major surgery;
    - Involve a significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about the best interests of a child who cannot consent; and
    - Where the consequences of a wrong decision are particularly grave,

required court approval notwithstanding the consent of a Gillick competent child, of the child's parents and the treating medication practitioners.

1. There is a controversy in this case as to what Re Jamie [2013] FamCAFC 110; (2013) FLC 93-547 and Re Kelvin [2017] FamCAFC 258; (2017) FLC 93-809 ("Re Kelvin") have decided about cases where there is dispute about consent or treatment. However as a starting point, the following is clear.
2. The Court has jurisdiction and power to determine a dispute, disagreement or controversy about consent by making an order or declaration as to Gillick

competence under the welfare jurisdiction (s 67ZC of the Act); a parenting order (s 65D(1) and s 64B(2)(i) of the Act) or an order using the general powers conferred by s 34(1) of the Act (see Re Kelvin at [66]) including an order dismissing an application made under any of those sections. The Court has jurisdiction and power to determine a dispute, disagreement or controversy about treatment by making an order or declaration under the welfare jurisdiction or a parenting order.

3. In Re Jamie the Full Court determined:
    - Stage 1 treatment was to be regarded as therapeutic. Stage 2 treatment fell within the ambit of Marion's Case because there was significant risk of the wrong decision being made as to the child's capacity to consent to treatment and the consequences of such a wrong decision would be particularly grave (this conclusion was reversed in Re Kelvin), and
    - In respect of stage 1 treatment, if the child, the parents and the medical practitioners agree, there was no need for the Court to determine Gillick competence. A Gillick competent child can consent to stage 1 treatment and if the child is not Gillick competent, that child's parents may consent, without court intervention, and
    - In respect of stage 2 treatment, the Court is required to determine Gillick competence or otherwise authorise treatment (this was reversed in Re Kelvin).
4. In Re Kelvin, the Full Court determined that:
    - Given the current state of medical knowledge, stage 2 treatment was therapeutic and was treatment for which consent no longer lies outside the bounds of parental authority or requires the imprimatur of the court (reversing the position in Re Jamie), and
    - In respect of stage 2, if the child, the parents and the medical practitioners agree a child is Gillick competent, there was no need for the Court to determine Gillick competence (reversing the position in Re Jamie), and
    - If all agree, a Gillick competent child can consent to stage 2 treatment, and
    - If a child is not Gillick competent and the treating medical practitioners agree, the child's parents can consent to stage 2 treatment without court approval.
5. For the sake of completeness, if all agree, the law is the same for stage 3 treatment and there is no necessity for this Court to determine whether the subject child is Gillick competent before stage 3 treatment for Gender Dysphoria can proceed (see Rees J in Re Matthew [2018] FamCA 161 at [46]).

Answers to outstanding questions

1. For reasons which follow, in relation to outstanding questions raised in this case, I conclude:
    - If a parent or a medical practitioner of an adolescent disputes:
        - The Gillick competence of an adolescent; or
        - A diagnosis of gender dysphoria; or

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- Proposed treatment for gender dysphoria,

an application to this Court is mandatory;

- Whether mandatory or not, once an application is made, the court should make a finding about Gillick competence of an adolescent. If the only dispute is as to Gillick competence, the court should determine that dispute by way of a declaration, pursuant to s 34(1) of the Act, as to whether or not the adolescent is Gillick competent, without the need to make a determination based upon best interest considerations. If a declaration of Gillick competence is made, then that is determinative of the only dispute before the court and the adolescent is left to determine their treatment without court authorisation;
- Notwithstanding a finding of Gillick competence, if there is a dispute about diagnosis or treatment, the court should:
    - Determine the diagnosis;
    - Determine whether treatment is appropriate, having regard to the adolescent's best interests as the paramount consideration; and
    - Make an order authorising or not authorising treatment pursuant to s 67ZC of the Act on best interest considerations;
- If a parent or legal guardian does not consent to an adolescent's treatment for gender dysphoria, a medical practitioner, who is willing to do so, should not administer treatment to an adolescent who wishes it, without court authorisation.

If there is a dispute about consent or treatment, why is an application to the court mandatory?

1. The AHRC argue that the need to come to court to quell a dispute in relation to stage 2 treatment is no different to a range of other proposed medical procedures where court authorisation may be sought in order to provide comfort to the parties or to medical practitioners. The AHRC relied upon two vaccination cases (Mains & Redden [2011] FamCAFC 184; (2011) FLC 93-478 and Duke-Randall & Randall [2014] FamCA 126) and a cochlear ear implant case (L v B (2004) Fam LR 169), arguing that these cases came to court not because of any legal rule but because there was a dispute that had to be resolved.
2. However, as discussed below, the decision in Re Kelvin leaves important parts of what was decided in Re Jamie intact.
3. In circumstances where there is a dispute about diagnosis, consent or the nature of treatment, an application to the court is mandatory (see Re Jamie: Bryant CJ at [140](b); Finn J at [172] and Strickland J at [192]).
4. As the Attorney-General points out, there is a basis in proper medical practice for requiring an application to the court if a dispute cannot otherwise be resolved:
    - Without such a determination, a medical practitioner may run the risk of being crissminally or civilly liable in the event that, notwithstanding the practitioner's assessment that the child is Gillick competent, that is not in fact the case. That risk may be heightened in circumstances where there is a dispute between the parents as to the appropriate treatment, and one of the parents does not consent to the treatment.

- Without such a determination, a medical practitioner may run the risk of effectively giving preference to one parent's view over that of the other in circumstances where, if the child is not Gillick competent, each parent with parental responsibility has power to consent (or not consent) on behalf of the child (s 61C of the Act). If parents disagree, it is invidious for medical practitioners to be required to give preference to the views of one parent rather than the other.

How should a dispute only about Gillick competence be determined?

1. The Attorney-General (supported by the ICL) submits the nature of a dispute may come to the court in different forms; the court might be only asked to make a finding or a declaration as to whether or not an adolescent is Gillick competent; if once that decision had been made there was no issue about the treatment, the adolescent could provide consent and that would be the end of the controversy and it would be inappropriate for the court to generate a controversy of its own by going on to consider authorisation of treatment on best interests principles.
2. The question arises as to whether a finding of Gillick competence is sufficient, or should a declaration be made pursuant to s 34(1) of the Act. Following Re Jamie, in circumstances where there was no controversy about treatment and a finding of Gillick competence, there was debate about whether the Full Court (Bryant CJ at [139], Finn J at [188] and Strickland J at [192]) had meant that the application should be dismissed or alternatively a declaration of Gillick competence be made (see Re Jacinta [2015] FamCA 1196 at [25]- [26]; Re Logan [2016] FamCA 87; Re Jason [2016] FamCA 772 at [24]- [25]; Re Kelvin [2017] FamCA 78 at [9]- [16]). Questions 3 to 6 asked of the Full Court in the stated case in Re Kelvin were aimed at providing an answer to that debate but because of the answers given by the Full Court to questions 1 and 2, the Full Court held that it was unnecessary to answer those further questions.
3. In Re Matthew (decided after Re Kelvin), Rees J dealt with the issue of whether the authorisation of stage 3 for treatment for Gender Dysphoria was necessary, where there was no controversy about Gillick competence or treatment. Her Honour chose to make a declaratory order pursuant to s 34(1) of the Act about Gillick competence rather than an order dismissing the application after a finding of Gillick competence. Her Honour explained at [49]:

Whilst it might be argued that strictly a declaration must create or testify to a right, I am conscious that this issue is of concern to a wider audience and that parents and treating practitioners look to the Court's orders for guidance in these matters.

1. I do not interpret Bryant CJ at [140](f) in Re Jamie suggesting that a dispute as to Gillick competence must be determined on best interest considerations. That determination is based upon factual findings and can be undertaken without recourse to the parens patriae jurisdiction and without regard to best interest principles if a declaration is made pursuant to s 34(1) of the Act. In the context of this contested case, had a finding of Gillick competence been sufficient for me to put my pen down, I would have adopted the approach taken by Rees J in Re

Matthew and made that declaration without reference to best interest principles, pursuant to s 34(1) of the Act.

Why is the finding of Gillick competence of an adolescent not determinative, if parents do not agree about treatment?

1. The Attorney-General (supported by the ICL and the father, although the father seeks a different form of order) argues that current Full Court authorities provide that, if the Court is called upon (by way of mandatory application or one that was not mandatory) to determine a controversy about treatment, the Court should not merely resolve that controversy by making a finding or determination about Gillick competence, but go on to make an order to authorise treatment having regard to the best interests of the child as the paramount consideration (including taking into account but not being bound by the child's consent). That argument is based upon a reading of the relevant passages from Re Jamie and Re Kelvin.
2. In Re Jamie, Bryant CJ said at [140]:

...

(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.

...

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

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

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

(Emphasis added)

1. In Re Jamie, Finn J at [172] and [188] said that:
    1. 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.

...

1. 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.
2. In Re Jamie, Strickland J at [192] said he generally agreed with the reasons of both Bryant CJ and Finn J. At [195] his Honour indicated that court authorisation would not be required "where the child is able to give consent to the proposed treatment".
3. In Re Elliott [2017] FamCA 1008, Tree J expressed the view that the approaches of Bryant CJ at [140](f) and Finn J at [188] were not consistent. I accept the submission by the Attorney-General that consistency can be found by understanding what Finn J said at [188] was in a context of circumstances where there was no dispute about treatment. Her Honour at [188] is simply saying that in circumstances where there was no disagreement, there would be no need to authorise treatment in circumstances where a finding or declaration of Gillick competence would be sufficient to enable stage 2 treatment to proceed. Similarly, the words of Strickland J at [195] should be read in the same context.
4. In Re Kelvin, the plurality (Thackray, Strickland and Murphy JJ) said at [116], [124] and [167]:
    1. We think it important to emphasise that the Court in this case is concerned to examine, within the confines of the questions stated, whether there is any role for the Family Court in cases where there is no dispute between parents of a child who has been diagnosed with Gender Dysphoria, and where there is also no dispute between the parents and the medical experts who propose the child undertake treatment for that dysphoria.

...

1. Any court authorisation for that treatment is a departure from the exercise of a right and responsibility ordinarily vested in parents. Of course, routine treatments for everyday medical conditions embrace that parental right and responsibility and do not require court authorisation. However, other circumstances may dictate the need for court intervention. For example disputes between parents or experimental or novel treatment or treatment for unusual or novel conditions can present difficulties; those circumstances may require a determination by a court of the best interests of the relevant child, in other words by a source other than those who would usually be regarded as being "in the best position to act in the best interests of the child".

...

1. We note though that in answering that question we are not saying anything ... about the need for court authorisation where there is a genuine dispute or

controversy as to whether the treatment should be administered; e.g., if the parents, or the medical professionals are unable to agree. There is no doubt that the Court has the jurisdiction and the power to address issues such as those.

(Emphasis added)

1. The minority (Ainslie-Wallace and Ryan JJ) said at [189] and [200]:
    1. Marion's case was central to the approach adopted in Re Jamie and is important for what it does and does not say. Marion's case does not stand for the proposition that consent to a therapeutic procedure which has grave or irreversible consequences is outside the scope of parental power or outside the consent of a competent child. Nor does it erect a freestanding obligation to obtain a court finding that a child is Gillick competent before his or her consent can be given effect. In our view the principles that emerge from Marion's case when applied to Re Jamie should have resulted in the conclusion that in relation to stage 2 treatment for Gender Dysphoria the court has no role to play unless there is a dispute about consent or treatment.

...

1. Marion's case does not:

...

- Support court intervention in relation to therapeutic procedures to which a legally competent person can consent.

(Emphasis added)

1. The statement at [200] by the minority needs to be read in the context of the caveat contained in the final words of [188].
2. The AHRC (supported by the mother) disagreed with the Attorney-General, arguing that parents may come to court with issues in relation to either consent or treatment but the court may resolve the question in relation to consent, by finding a child is Gillick competent, and if it does, the court does not need to separately go to the question of whether to authorise treatment on the basis of best interests. Only if the court finds that the child is not Gillick competent, would it be necessary to go on and make a determination about the authorisation of treatment.
3. The AHRC submitted, by way of example, that if a child who was of any age but assessed as Gillick competent consented to a cochlear ear implant, the court may quell a dispute about whether the child was Gillick competent but not make any determination under s 67ZC or s 65D(1) of the Act in accordance with the child's best interests.
4. The AHRC does not dispute the power of a court to make an order against the wishes of a Gillick competent child pursuant to the parens patriae power (s 67ZC). In X and Others v The Sydney Children's Hospital Network [2013] NSWCA 320; (2013) 85 NSWLR 294, Basten JA (with whom Beazley P and Tobias AJA agreed), amongst other things, discussed the history and width of the parens patriae jurisdiction. In that case the New South Wales Court of Appeal overruled the wishes of a competent 17 year old Jehovah Witness who wanted to

refuse blood products which were potentially lifesaving. The AHRC points to Beazley P's note at [2] that whilst the court's jurisdiction under parens patriae power was a broad one it should act cautiously when exercising it.

5. X and Others v The Sydney Children's Hospital Network [2013] NSWCA 320; (2013) 85 NSWLR 294 is the only case that has been identified where a court has overruled the views of a Gillick competent child to impose treatment. Other cases involving anorexia nervosa and treatment for drug rehabilitation involved children who were not Gillick competent (Director General, Department of Community Services v Y [1999] NSWSC 644; Director General, Department of Community Services v Thomas [2009] NSWSC 217; (2009) 41 Fam LR 220).
6. The AHRC argues that it would only be in an extraordinary case that a court would decide not to exercise its parens patriae jurisdiction to authorise treatment where a child was Gillick competent and consented to treatment that has found not to be a special medical procedure and, in respect of which, recognised treatment guidelines exist. No case was identified where a court had refused to authorise therapeutic treatment where a Gillick competent child had consented.
7. The AHRC pointed to the changed understanding about the nature of treatment and argues that any statement made in Re Jamie needs to be viewed in light of the difference in the state of medical knowledge between 2011, when Re Jamie was decided at trial and when Re Kelvin was decided in 2017. A logical extension of that argument however, would require a consideration of the volume of evidence in this case which demonstrates a proliferation of academic and other writings since Re Kelvin and the emergence of alternate thinking about treatment and questions arising from the state of knowledge in respect of the long-term implications of current medical treatment for Gender Dysphoria.
8. Cleary J in Re Ryan [2019] FamCA 112 made a declaration that Ryan was competent to consent to the administration to himself of stage 3 treatment ("top surgery" or "bilateral mastectomy with nipple reconstruction surgery") for the condition gender dysphoria in a case where his father opposed the authorisation of surgery. In doing so, her Honour did not make clear what power was being exercised but it is reasonable to assume that it was s 67ZC of the Act, given that her Honour discussed various best interest considerations. Her Honour did not specifically refer to the statement of Bryant CJ at [140](f) of Re Jamie. I acknowledge the approach I have taken differs from Cleary J's in that I interpret Bryant CJ's words as requiring an assessment as to whether to authorise treatment not merely making a declaration that a child is competent to consent to the treatment.
9. In this case, there is dispute about treatment and the form it should take. Whilst it is true that what was said in Re Jamie was strictly obiter dicta, it was well considered and it has been expressly left untouched in Re Kelvin. I conclude that I should follow the conclusions of Bryant CJ in Re Jamie at [140], in respect of the approach to be taken when treatment is disputed. Given there is a dispute about what form treatment should take, this court should determine that dispute pursuant to s 67ZC (Re Jamie, per Bryant CJ at [140](b)). In doing so the court

should have regard to the best interests of the child as the paramount consideration and give significant weight to Imogen's views in accordance with her maturity and level of understanding (Re Jamie, per Bryant CJ at [140](f)).

Should a medical practitioner administer stage 2 treatment without parental consent or alternatively court authorisation?

1. Dr C gave evidence that "the Informed Consent Model" of care in Gender Dysphoria is being adopted by an increasing number of medical practitioners. This model sees general practitioners proceeding with the prescription of gender affirming hormone therapy to adolescents over 16 years of age who express the desire to do so and who are assessed by the general practitioner as being able to give informed consent to the treatment, without the general practitioner making any inquiry as to whether or not the parents or legal guardians of the adolescents give their consent. Dr C opines that there is confusion in respect of the legality of the Informed Consent Model.
2. Attached to Dr C's affidavit filed 8 May 2020, is a letter he wrote to the father's solicitor on 1 May 2020 in which he draws attention to the fact that now that Imogen is 16 years of age, she "may attend the practice of a number of medical practitioners who have stated a willingness to accept a patient's self-identified gender without mental health professional evaluation, and who will prescribe gender affirming hormone therapy at the patient's request if, in the opinion of that doctor, the patient is able to give informed consent to the treatment". Dr C says these doctors practice under what is known as the "informed consent model". ACON Health Limited ("ACON") has essentially condoned this model and sets 16 years of age as being the threshold for autonomous consent to hormone treatment, overriding any parental objections or misgivings. Dr C expresses concerns about the clinical wisdom and legal standing of this approach, and does not recommend it for any patients who are under the age of 18, including Imogen. Dr C says a listing of some of the doctors who are practising according to the ACON version of the informed consent model is published on the Transhub website. Dr C made reference to this website during his oral evidence.
3. On the other hand, Dr D'Angelo gives the following evidence:

Some clinics, particularly in the USA have moved to an informed consent model. Generally, this means that there is no mental health assessment: the patient signs a waiver and is given the gender-affirming hormones that they request. I am not aware of any clinics in Australia that operate under this model. Some GPs may practice this way, however, the medico legal implications of his form of work are not clear. I am aware of some GPs in the UK who have been disciplined or sanctioned by their registration bodies for prescribing hormones to transgender people. I have not seen any evidence that "informed consent" is becoming a widely accepted model of treatment.

1. This judgment confirms the existing law is 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 a child's parents or legal guardians consent to the proposed treatment. Absent any dispute by the child, the parents and the medical practitioner, it is a matter of the medical professional

bodies to regulate what standards should apply to medical treatment. If there is a dispute about consent or treatment, a doctor should not administer stage 1, 2 or 3 treatment without court authorisation.

Is the delay in the filing of the application until after Imogen's 16th birthday relevant?

1. In this case, although the father signed his application and his first affidavit in support in December 2019, as did Imogen's treating psychiatrist, the application was not filed until after Imogen's 16th birthday, thereby avoiding a potentially difficult issue. As the plurality in Re Kelvin suggested at [84], stage 2 treatment might be a "special medical treatment" as defined in s 175(5)(a) of the Child and Young Persons (Care and Protection) Act 1998 (NSW). Section 175(1) creates an indictable offence for any person to carry out a special medical procedure on a child under the age of 16. There may be a reasonable likelihood (although not inevitable effect) that stage 2 treatment would render Imogen permanently infertile. There would be an argument under s 175(5) of the Child and Young Persons (Care and Protection) Act that that effect would be "an unwanted consequence" and if it was, the section would not apply. If stage 2 was a special medical treatment for the purposes of s 175, then I accept the Attorney-General's submission that a constitutional question may arise as to whether or not an order of this court authorising stage 2 treatment for a child under 16 would protect a medical practitioner from criminal liability under s 175(1) of the Child and Young Persons (Care and Protection) Act. As the Attorney-General argues, the resolution of such a question would require notice under s 78B of the Judiciary Act 1903 (Cth) and consideration of the High Court of Australia's decision in P v P [1994] HCA 20; (1994) 181 CLR 583. Since Imogen was 16 at the time of the filing of the application, s 175 of the Child and Young Persons (Care and Protection) Act does not require further consideration in this case.

RELEVANT BACKGROUND

1. The father was born in 1959 overseas. The mother was born in 1971 overseas.
2. At some point in time between 1994 and 1996 the parties commenced cohabitation overseas. In 1996 the parents moved to Australia.
3. In September 2003 the parents were married in Australia.
4. Imogen, was born as a natal male Thomas in Australia on ... 2004 and is currently 16 years and 8 months.
5. As a child Imogen dressed as a male and played with toys that were usually targeted for boys.
6. On ... 2008 the parents second-child Olivia was born in Australia and is currently 12 and a half years old.
7. Imogen says she felt she was female from when she was about six or seven years old and pushed these thoughts away, engaging in pursuits that could be seen as "masculine".
8. During 2012 the parents and the two children travelled around Australia for seven months. During this time Imogen was home-schooled.
9. In 2016 Imogen started secondary school at M High School in Suburb N.

10. In October 2016 the mother attended a secondment for work, leaving the children in the father's care for around six weeks.
11. On 12 March 2017 Imogen's parents finally separated when the mother left the matrimonial home with Olivia. Imogen initially remained in the family home with the father but subsequently went to live with her mother and Olivia.
12. In May 2017 the mother and the children commence counselling with an agency.
13. In July 2017 the father moved into a one bedroom apartment with two day beds in the living area and the children started spending alternate weekends with the father.
14. In November 2017 Olivia was diagnosed with complex trauma by Dr O, a psychiatrist, and was prescribed medication to manage her anxiety. Around the same time Imogen started to display symptoms of anxiety such as nail biting, and concern about security.
15. In April 2018 the mother and children holidayed in Adelaide initially with the maternal grandparents. Leading up to the return home of the grandparents, Imogen pressed her mother to be able to return with them. The mother formed the view that that was because Imogen wanted unfettered time to use her gaming device. Around this time Imogen started to game excessively, quit after-school activities and started to refuse to go to school.
16. In May 2018 Imogen's school refusal increased. Imogen was difficult to get out of bed in the morning, cried under the sheets and told her mother that she is lonely and depressed.
17. In July 2018 Imogen saw Dr P, who is a general practitioner, and was prescribed anti-depressants. The mother and the children were also seeing psychologists at Q Centre.
18. By August 2018 Imogen was no longer attending school. The mother took Imogen to Dr O who increased the dosage of Imogen's anti-depressant medication (Zoloft). Around this time the mother's relationship with Imogen started to deteriorate. The mother says that conflict with Imogen increased when the mother tried to impose rules regulating Imogen's use of her phone and gaming device. Imogen became aggressive and defiant towards her mother.
19. On 17 September 2018 Imogen attended an appointment with Dr O. Dr O noted that Imogen presented with major depressive illness associated with anxiety and panic but with no suicidal ideation. Dr O recommended increasing sertraline and a trial with quetiapine as well as continuing with psychologist appointments.
20. Following the appointment with Imogen, Dr O wrote a letter on 19 September 2018 to Dr P, noting family violence as described by Imogen (then Thomas).
21. On 29 September 2018 there was an altercation between the mother and Imogen, which involved violence and is described below.
22. From 2 October to 5 October 2018 the mother, Imogen and Olivia attended a residential stay at Q Centre with the main focus of that stay being Olivia's behaviour. Imogen actively participated in this stay and the family returned with strategies to manage Olivia's behaviour.

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23. From 6 October to 12 October 2018 the children went on a holiday with the father and his then partner, Ms R. Ms R was doing research on Gender minorities and their access to medical treatment.
24. Once Imogen returned from the holiday on 12 October 2018, she told her mother that she wanted to be a girl. The mother noticed that Imogen had shaved her body hair. The mother's evidence was that initially she was supportive and offered money for clothes, ear piercing and nails as well as purchasing the girls school uniform to encourage Imogen to return to school. At some point the mother came to believe that the timing of Imogen "coming out" was heavily influenced by conversations she presumed Ms R had with Imogen.
25. On 15 October 2018, while Imogen was residing with the father, the mother received a text message from the father advising her that Imogen has chosen a female name and prefers the female pronouns.
26. During October 2018 Imogen has a number of appointments with Ms S, a psychologist, as well as an appointment with Dr O. On 17 October 2018 Dr O referred Imogen to the F Clinic.
27. On 25 October 2018 Imogen stopped residing with the mother.
28. Imogen commenced counselling with Ms T, a psychologist, at the U Centre in late October 2018.
29. In late November 2018, Imogen and her father attended the mother's home at a time they knew the mother was out to collect Imogen's gaming equipment. Alerted by her partner, the mother returned home and when she arrived, she saw the father on the street. She says he shouted "Imogen has a right to her possessions". The mother saw Imogen carrying a handful of keyboards. Olivia tried to intervene saying, "This isn't right". This is the last time Imogen and the mother have seen one another.
30. In December 2018 Imogen started attending the F Clinic and was supported by the father. Imogen was seen by a Dr V, psychiatrist and Ms W, psychologist, who did not diagnose Imogen as having Gender Dysphoria at that time.
31. In early 2019 the mother remarried.
32. In February 2019 Dr V and Ms W diagnosed Imogen with Gender Dysphoria. Dr H, a paediatric endocrinologist associated with the F Clinic, telephoned the mother to inform her of that diagnosis.
33. On 12 February 2019 Imogen was assessed for admission to the L Centre Back to school readiness program, but was deemed unsuitable due to low motivation to return to school.
34. In March 2019 Imogen commenced distance education, but her participation was inconsistent and low.
35. On 9 March 2019 Imogen started seeing Dr C. He remains her current treating psychiatrist.
36. On 21 March 2019 the father reported that Olivia was self-harming. When Olivia returned to the mother's home she reported that Imogen and the father had been fighting. Olivia said she felt helpless and started to self-harm.

37. Imogen attended the K Fertility Clinic at the end of March 2019 and undertook sperm cryopreservation.
38. On 16 April 2019 Imogen commence stage 1 treatment under the care of Dr H at the F Clinic.
39. On 11 May 2019 Imogen attends an interview with Dr C. At this appointment he took a systemic history to determine if she met the DSM-5 diagnostic criteria for Gender Dysphoria.
40. The mother made applications to Victims Support for herself and the children. The father, as the alleged perpetrator, had no notice of the application. On 3 June 2019 those applications were determined.
41. In August 2019 the mother sent text messages to the father in the following terms about Imogen's inheritance: "Totally cut off... will be changing wills and getting mum and dad to do same" and "So all will got [sic] to Olivia...speaking to lawyer on Monday...cut off...given every chance". The mother states that these messages were sent out of frustration. The father shared these messages with Imogen.
42. On 7 September 2019 Imogen commenced taking a daily 2mg dose of Progynova (oestrogen) as prescribed by Professor J. This dose was aimed at ameliorating an effect of stage 1 treatment and was not the commencement of stage 2 treatment.
43. During late August and throughout September 2019, tensions escalate between the mother and Imogen. The maternal grandparents visit from the United Kingdom but Imogen did not want to see them or the mother. The mother sent messages attempting to arrange for the maternal grandparents to meet with Imogen. In some text message exchanges the mother refers to Imogen as "Thomas" and uses the male pronoun.
44. On 12 October 2019 the father informed the mother that Imogen is now taking progynova. The father told the mother in a text message "Imogen has commenced stage 2 Treatment, from the 7th September, taking 2mg Progynova daily" (As per the original). The assertion that stage 2 treatment had commenced was incorrect.
45. On 5 November 2019 the mother had a telephone conference with Associate Professor J, Imogen's endocrinologist, and met with him on 7 November 2019. In the telephone conference, Associate Professor J told the mother that Imogen had been prescribed oestrogen by him. On 7 November he told the mother that he would no longer treat Imogen until the court made an order. After those discussions with Associate Professor J, the mother maintained the belief that stage 2 treatment had commenced.
46. On 13 November 2019 the mother was sent a letter from Dr C informing her that the dose of oestrogen was not enough to be considered "phase 2" therapy.
47. Towards the end of the second day of the hearing, the mother and the Court learnt from Dr C that Imogen has been sourcing progynova (oestrogen) from on the internet since December 2019. Imogen and her father believed this drug to be identical to that which had been previously prescribed by Associate Professor J.

The father administers a 2mg dose of the un-prescribed drug to Imogen each day for the purposes of dealing with side effects of stage 1 treatment. The evidence from the father is that Imogen is not using the drug to attempt to commence stage 2 treatment.

48. On 17 February 2020 the father filed his initiating application.
49. On 6 March 2020 the father informed the mother that Imogen had changed her medication and was now taking fluoxetine instead of Zoloft.
50. In mid- March 2020 Imogen was assessed for the Back to school program again.
51. On 25 March 2020 the mother filed her response.
52. On 26 March 2020 Imogen purchased more progynova from overseas.
53. On 30 March 2020 Imogen and her father had a telephone interview with Dr Y, psychiatrist, during which she was told about the purchase of overseas medication. In a letter dated 22 April 2020 addressed to Dr P and copied to Dr C (amongst others), Dr Y informed them that Imogen was sourcing her own medication.
54. The parents and Imogen attend appointments with Dr D'Angelo pursuant to orders made by this Court (Re Imogen (No. 3) [2020] FamCA 395) between 22 and 26 May 2020.
55. On 11 June 2020, Imogen made a third purchase from overseas for progynova.

FAMILY VIOLENCE

1. Dr D'Angelo relies upon the history of family violence and Imogen's sister's mental health issues as part of the basis upon which he diagnosed Imogen as having complex post-traumatic stress disorder. Dr D'Angelo opines that Imogen has not received therapy to address the trauma associated with being exposed to family violence, parental conflict and Olivia's behaviour.
2. My confidence in accepting the father's version in respect of family violence in preference to the mother's is significantly affected by the deceit of the father in failing in the opportunities he had in two affidavits and in his oral evidence to disclose that Imogen was sourcing unprescribed medication from overseas. I find that the history of family violence in Imogen's family is as described by the mother. The mother's version is also consistent with particular independent contemporaneous records.
3. The mother has alleged that the father was physically abusive from an early stage in the relationship and says the violence commenced in early 1995. The mother reports that the violent incidents did not happen often and they were still able to have many happy memories as a family but the father was short-tempered and angry. One of the more serious incidences of violence occurred in September 1996 before the children were born, while the mother and father were camping in a country town. They had a fight about a past relationship and the father broke the mother's mirror as well as punched her in the face causing her nose to bleed a significant amount, as a result the mother had to throw out her pillow. The father admits this incident occurred.
4. The father has denied all other allegations of family violence made by the mother. In his oral evidence the father says he did not do anything to the children other

than discipline them in the usual course of parenting. There are however, reports that the father has been violent not only to the mother but also to Olivia. Dr O records Imogen telling her in 2018 that the father would "shout, swear and hit them, mostly [her] mother and sister but on a few occasions [she] had tried to intervene and got hit as well" (Letter from Dr O to Dr P dated 19 September 2018). The father gave evidence that he had a conversation with Imogen on the weekend before the hearing about what Imogen had said to Dr O. In his affidavit affirmed 31 July 2020, the Friday, before the hearing, he says, "I spoke to Imogen about this and she denies making those comments". I prefer to rely upon Dr O's contemporaneous record as being accurate. Olivia also reported her father's abuse to the Department of Family and Community Services.

5. In October 2016 the mother went on a secondment for work for six weeks and the children were left in the sole care of the father. During that time the father was verbally and physically aggressive towards Olivia with Imogen being hit by the father if Imogen tried to intervene. Imogen was very distressed during this period. The mother likens returning home to returning to a "War zone" in which the children and the father were screaming at each other. When the mother returned Olivia was completely withdrawn and regressed to urinating on the bed. Olivia reported to the mother that the father hurt her. It was from this time Olivia commenced to exhibit troubling behaviour as detailed below. The mother describes that toward the end of the marriage there was constant shouting and swearing amongst the family and that the father had started to track her phone.
6. On 11 March 2017, the day before the final separation, the mother says the father accosted her in the kitchen and "performed lewd sexual gestures". The mother asserts, "I felt terrified and took a knife from the drawer as I feared he would attack me. He backed away and left the house". The father seemed to accept there was an incident between himself and the mother in the kitchen on the night before the mother left the matrimonial home. He denied he made a lewd sexual gesture to the mother or threatened the mother in any way. He said he didn't see the mother holding a knife and he doesn't remember backing away or leaving the house. Whilst it is clearly not acceptable behaviour for the mother to have taken up a knife, I accept her evidence about what happened during this incident.
7. The father has not been charged as a result of him perpetrating family violence.
8. On 25 February 2018 the mother made three application for Victims' support for herself and the children, primarily to assist in paying for therapy. On 3 June 2019 these applications were determined in the mother's favour. A decision under the Victims Rights and Support Act 2013 is no more than evidence of complaint, assessment and compensation and is not of itself probative of any of the alleged allegations underpinning the application.
9. On 29 September 2018 there was an incident between the mother and Imogen which the mother conceded constituted family violence. Imogen was gaming in her bedroom and to stop her, the mother physically pulled Imogen onto her bed. She placed her hands either side of Imogen's head and "wriggled her head".

Imogen called the police. The mother and Olivia left the home and went to a friend's house. The police attended the home but did not charge the mother.

10. The mother also admitted that at times she yelled at the children and smacked them but she says that that was in the context of normal parental discipline.
11. Imogen has told Dr C that she currently feels safe living with the father. I accept the ICL's submission that there is currently no risk to Imogen of family violence in her father's household. The mother says that "lately" Olivia is contented when she returns from her time with her father.

IMOGEN'S SISTER'S MENTAL HEALTH

1. There is significant evidence before the Court regarding the troubling behaviour of Imogen's younger sister Olivia.
2. As indicated, when the mother returned from her secondment in October 2016 Olivia, then aged eight, had become withdrawn. She had urinated on the bed and told the mother that the father had hurt her.
3. During 2017 Olivia's behaviour significantly regressed. The mother deposes that Olivia exhibited certain behaviours such as hiding in boxes; becoming non-verbal; starting to behave like a cat; being petrified by loud noises; having severe phobias including a phobia of grass; struggling with emotional regulation; having daily psychosomatic symptoms including an upset tummy and hot flushes; running away from home and regressing to baby behaviour such as sucking dummies.
4. Olivia 's behaviour was not restricted to when she was at home. Annexed to the mother's affidavit was a report from Olivia 's school noting that Olivia would hide under the desk and behaved like a cat or a baby and at times would hit her head on furniture. Olivia was defiant at school and unable to accept responsibility for her behaviour which also included being violent to other students.
5. Olivia was diagnosed by Dr O as having complex trauma which manifested in generalised anxiety, panic episodes and oppositional defiant disorder. In a letter from Dr O to Dr P dated 19 September 2018, she observed

... some challenging family dynamics and [Olivia 's] presentation severely impacts upon [Imogen's given name at birth] and [Olivia 's] anxiety has taken the form of oppositionality. This often interferes with the family spending time together and [Olivia] clearly competes with [Imogen] for [the mother's] attention...

1. Dr O reported Imogen avoided discussing her sister during therapy.

THE CURRENT RESEARCH INTO THE DIAGNOSIS AND TREATMENT OF GENDER DYSPHORIA

1. Relevant to the issues raised by the experts in this case, are their different views about the state of the current research into the diagnosis and treatment of Gender Dysphoria.
2. As indicated, a significant volume of recent research was adduced in evidence and additionally a large number of publications and writings were referred to in footnotes to the written evidence given by Dr D'Angelo and Associate Professor Winter. Research literature in transgender health has expanded rapidly in the last decade and particularly since Re Kelvin was decided. For example, Associate

Professor Winter states that his search for “transgender” and “health” yielded 5,681 results with 1,135 of them being published in 2019 compared to 94 in 2009.

3. Some of the issues raised by a review of the research by Dr D’Angelo and Associate Professor Winter are:
    - Why has there been an exponential rise in gender dysphoria cases in the past decade?
    - Why has there been a surge in adolescent transgender identification without a reported history of childhood gender-nonconforming behaviours?
    - What is the research base for the gender-affirmative care model?
    - What is the state of the research in respect of later regret and detransitioning?

Rise in cases

1. The experts in this case agree that there has been an exponential rise in adolescent referral to gender clinics in the last decade.
2. Dr D’Angelo opines there is “concern that the current surge in adolescent transgender identification represents a new manifestation of maladaptive coping with various developmental issues, exacerbated by underlying mental health comorbidities” and a “degree [of] social contagion”.
3. Associate Professor Winter opines that the rise in referrals may be largely due to developments in society and in medicine, leading to greater awareness and understanding, and lessening of stigma associated with gender issues and of trans identity. An additional factor of note in his view is the increased availability of appropriate and accessible services. Furthermore, he believes adolescents may be able to exert greater agency than children in securing a referral and this may go some way to accounting for the more dramatic rise in referral numbers for adolescents.
4. Associate Professor Winter also opines that there is a co-occurrence in a number of gender dysphoria cases with Autism Spectrum Disorder which itself is an increasingly prevalent diagnosis, consequently providing a pathway to gender clinic referral.

Lack of reported childhood history

1. Dr D’Angelo identifies a recent study by Littman[3] which claimed to identify “Rapid Onset Gender Dysphoria” (“ROGD”):

A recent study suggests that transgender ideation in this new cohort can manifest after intense online exposure to transgender topics, and that often groups of friends come out as trans simultaneously.[4]

1. Dr D’Angelo says that this descriptive study raises the concern that the sudden surge in adolescent transgender identification represents a new manifestation of maladaptive coping with various developmental issues, exacerbated by underlying mental health comorbidity and that some have also raised concerns about the degree to which social contagion is involved. Dr D’Angelo asserts that the study concludes that much additional research is needed.

2. Associate Professor Winter comments upon the Littman study and refers to a paper by Restar (2020)[5] which makes a number of criticisms of the Littman study. Associate Professor Winter finds the most compelling criticisms to be firstly the way parents were recruited for the study, namely, through websites prominent for their critical stance towards contemporary transition health care, as practised with adolescents; secondly the failure of the author to share potentially important findings and thirdly, the fact that there is no attempt whatsoever to collect any data from the adolescents themselves. Associate Professor Winter cautions against interpreting Littman's results and opines that puberty (and the physical transformations it brings), changes in gender demands of school and home, increased knowledge, understanding and self reflection and other factors more commonly play a part in promoting late-onset trans youth to access services. Both the World Professional Association for Transgender Health ("WPATH") and the Australian Professional Association for Trans Health ("AusPATH") have released statements urging caution in regard to the research on ROGD.
3. Associate Professor Winter opines that what Littman refers to as "rapid onset gender dysphoria" is not actually all that rapid. He opines that "the absence of a documented history does not inevitably mean absence of earlier gender incongruence or dysphoria". He then extracts the following statement from WPATH SOC-7[6]:

... many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender-nonconforming behaviors [sic]...Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

1. Associate Professor Winter also observes:

The gender issues may indeed develop with the approach or arrival of adolescence. But in some cases a sense of gender unease or uncertainty, a feeling of not fitting in, or indeed discomfort and distress, may have been present for some time. The young person may have lacked an awareness or language to enable them to pinpoint what they face. They may have been hiding their emerging sense of self for years, for fear of negative reaction from others, including peer and family rejection, bullying, harassment and stigmatisation. They may have even overcompensated, throwing themselves into activities that are stereotypically masculine or feminine, in each case in line with the sex assigned at birth. They may even come into contact with health professionals on account of other issues, such as poor peer relationships, social anxiety or difficult behaviour. The professionals concerned may fail to ascertain the role gender issues might play in the young person's circumstances.

Research base for gender-affirmative care model

1. Imogen seeks to embrace the gender-affirmative care model. This is a model promoted both in Australia and worldwide.
2. Associate Professor Winter records that in Australia, AusPATH is the peak national organisation actively promoting communication and collaboration amongst professionals across all disciplines engaged in health care, rights and wellbeing of trans people. He opines that its membership represents a substantial

percentage of those working on a daily basis in health care with trans individuals in Australia. AusPATH has published the Australian Standards, Worldwide, the corresponding organisation is WPATH. WPATH publishes the Standards of Care for the Health of Transexual, Transgender and Gender-Nonconforming People, now in version 7 (Soc-7),[7] enclosed as annexure H to Associate Professor Winter's affidavit. Both offer detailed guidelines for clinicians; the former runs to 51 pages; the latter to 67 pages. The organisations are independent of one another.

3. Dr D'Angelo asserts that the gender affirming treatment model is based on the "Dutch protocol" described in de Vries et al.[8]. Dr D'Angelo criticises the small sample size, the strict inclusion criteria limit, the lack of assessment of physical health outcomes, the lack of any longitudinal aspect to the study and the lack of a control group. Associate Professor Winter concedes that the current Australian model supports social transition to an extent that was not a feature of the 'Dutch protocol'.[9]
4. Dr D'Angelo expresses concern about the lack of adequate study into the physical and psychological long-term effects of hormonal and surgical interventions. Dr D'Angelo points to one 2019 study[10] showing more than three times the incidence of venous thromboembolism for biological males.
5. Whilst Associate Professor Winter acknowledges that the research base is small, he notes a growing body of evidence on the effects of transition healthcare. He refers to a report by Cornell University in which 55 individual studies were reviewed with 51 reporting "gender transition improves overall well-being of transgender people"[11]. The report concluded that "the greater the availability of medical and social support for gender transition contributes to better quality of life for those who identify as transgender".
6. Both the Australian Standards and Associate Professor Winter acknowledge that further research is warranted into the long term outcomes of current treatments under the gender affirmative model. Whilst the Australian standards assert that they are based upon available empirical evidence and clinical consensus there is also an acknowledgement on page 1 that not only is future research warranted, it is likely to influence future recommendations.
7. Dr D'Angelo challenged the notion, promoted by those who have developed the Australian Standards, that suicidality was reduced by treatment. Dr D'Angelo claimed that a Swedish study[12] showed that compared with aged-matched controls, there was a 19 times higher hazard rate of completed suicide after transgender surgery. Dr D'Angelo was challenged in relation to that claim during cross examination by the AHRC. I was satisfied that Dr D'Angelo had not properly analysed the table in the report upon which he based his claim.
8. Dr D'Angelo also raises the spectre of there being vested interests at play in the development of the WPATH standard of care, claiming that there are ties between the guideline authors (including paid consultancies) and pharmaceutical

companies producing hormones. I am unable to place any weight on that speculation.

Regret and detransitioning

1. Dr D'Angelo claims in his report at paragraph 80:

It is generally asserted that the rate of regret following medical and surgical transition is extremely low, in the order of 2-3%. I have argued in a previous publication that this figure may in fact be substantially larger. Most adult follow-up studies have very large lost-to-follow up rates, in the order of 30% or more. This is very large when compared to the usual lost-to-follow up rates in most studies. Many have expressed concern that this 30% of patients may consist of people who regret their transition or who have had an adverse outcome.

1. I accept Associate Professor Winter's evidence that there are many reasons why trans patients are lost to follow up including patients change their documentation, move locations, start a new life and lose contact with social groups and family and that "one should be cautious in drawing conclusions about detransitioners from looking at lost-to-follow up figures".
2. The AHRC challenged Dr D'Angelo's 30% lost to follow up claim. I reject Dr D'Angelo's original claim that the 30% loss to follow up may consist of people who regret their transition. Dr D'Angelo subsequently modified that claim to say that the studies with such a loss to follow up rate cannot be regarded as statistically valid.
3. Associate Professor Winter states that he is familiar with research on children who desist. There is a small group of studies which have suggested "desistance is the most common outcome for young trans children, and that it is a minority whose gender incongruence...goes beyond a phase persisting into adolescence or adulthood". Most of this research is through "follow up" methodology.

The Royal Australian College of Physicians' letter of 5 March 2020

1. In August 2019 the Federal Minister for Health wrote to The Royal Australian College of Physicians (RACP) seeking advice on the treatment of Gender Dysphoria in children and adolescents in Australia. The RACP responded on 5 March 2020.
2. In that response, the RACP noted that trans and gender diverse children and adolescents are a very vulnerable population, experiencing stigma and extremely high rates of depression, self-harm, attempted suicide and completed suicide. Importantly, the RACP described treatment for Gender Dysphoria as an emerging area of healthcare where existing evidence on health and wellbeing outcomes of clinical care is limited due to the relatively small number of studies, the small size of study populations, the absence of long-term follow up and the ethical challenges of robust evaluation when control (no treatment) is not acceptable. The College relevantly observes that similar limitations on the existing evidence of healthcare apply to other conditions which affect small segments of the population, such as rare cancers. The College expressed the view that addressing gaps in the evidence base is important, although notes that further scientific evidence may take a considerable period of time to produce.

3. In the meantime, the College supported the principles underlying the Australian Guidelines, and specifically the emphasis on the multidisciplinary approach to providing person-centred care which priorities the best interests, preferences and goals of the child or adolescent. The College recommends that treatment should be holistic, developmentally informed, child centred and individualised. In order to facilitate a higher level of informed consent, the College recommends that patients and families must be provided with information about the limitations of the available evidence regarding Gender Dysphoria and there should be informed discussion of the burdens and benefits of treatment and options in a way each child or adolescent can understand. The College points to differences across Australia in the access, funding and delivery of care and treatment for Gender Dysphoria. It recommends the development of a national framework for service provision and outcomes monitoring and believes that that is the best way to ensure consistency in the outcome of data collection across jurisdictions.
4. The College strongly advised the Australian Government against a suggestion that a national inquiry be undertaken into Gender Dysphoria on the basis that it would not increase scientific evidence available regarding Gender Dysphoria but would further harm vulnerable patients and their families through increased media and public attention.

ISSUES TO BE DETERMINED

1. The following issues are to be determined:
    - Apart from a consideration of Gender Dysphoria, what are Imogen's other mental health conditions?
    - Does Imogen have Gender Dysphoria as described in the DSM-5?
    - Is Imogen Gillick competent?
    - What future treatment is in Imogen's best interests?
    - In what form should the order be made?

APART FROM A CONSIDERATION OF GENDER DYSPHORIA, WHAT ARE IMOGEN'S OTHER MENTAL HEALTH CONDITIONS?

1. Imogen has no known general medical health conditions.
2. Both Dr C and Dr D'Angelo agree that Imogen has widespread and complex co-existing mental health difficulties.
3. Dr C lists the following diagnosis with reference to descriptions in the DSM-5:
    - Major Depressive Disorder in remission (296.26);
    - Social Anxiety Disorder (300.23) with Panic Attacks, resulting in school refusal;
    - Suspected Unspecified Communication Disorder (307.9) falling one criteria short of a diagnosis of Autism Spectrum Disorder, level 1;
    - Probable Internet Gaming Disorder, in remission (this is not yet an official DSM-5 diagnosis and therefore does not have an ascribed diagnostic code;
    - Social Exclusion or Reaction (V 62.4), past (by age peers);

- Parent-child Relational Problem (V 61.20), predisposed to by the impact of her mother's untreated post-natal depression on the early attachment relationship;
- Sibling Relational Problem (V 61.8), in remission;
- Possible ongoing effects of an alleged past exposure to family dysfunction and domestic violence (not a DSM-5 listed diagnosis);
- Disruption of Family by Separation or Divorce (V 61.03); and
- Child Neglect (995.52) – being the deprivation of necessary medical care (being gender affirming hormone therapy) resulting in psychological harm.

4. Dr D'Angelo lists the following diagnosis:
   - Complex Post-Traumatic Stress Disorder (309.81);
   - Major Depressive Disorder, in partial remission (296.26); and
   - Other specified Gender Dysphoria (and he noted that Imogen's clinically significant distress and impaired school and social functioning were more likely to be due to difficulties other than Gender Dysphoria).
5. In Dr D'Angelo's view, Imogen's difficulties can be accounted for by a diagnosis of complex post-traumatic stress disorder which would account for social withdrawal, school refusal, identity disturbance, poor self-concept, defensiveness and hypervigilance, anxiety and depression, and inter-personal difficulties. He opines that what Imogen has described in relation to her school attendance and social contact can be a form of avoidance because social contact triggers "re-experiencing of traumatic affects".

DOES IMOGEN HAVE GENDER DYSPHORIA AS DESCRIBED IN THE DSM-5?

1. A central focus during this hearing, is the diagnostic criteria for Gender Dysphoria in Adolescents and Adults contained in the DSM-5 at 302.85 and it is useful to set it out in full:
   - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six month's duration, as manifested by at least two of the following:
     1. A marked incongruence between one's experience/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
     2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adults, a desire to prevent the development of the anticipated secondary sex characteristics).
     3. A strong desire for primary and/or secondary sex characteristics of the other gender.
     4. A strong desire to be of the other gender (or some alternate gender different from one's assigned gender).
     5. A strong desire to be treated as the other gender (or some alternative gender difference from one's assigned gender).

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6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2. Both Dr C and Dr D'Angelo agree that Imogen's condition fulfils the DMS-5 criteria in Part A, Dr C saying that Imogen has all the manifestations described; Dr D'Angelo saying that she meets descriptions 2 and 3.
3. Dr C, Imogen's treating psychiatrist, diagnoses Imogen as meeting the part B criteria for Gender Dysphoria and is consequently of the opinion that her condition fulfils the criteria for Gender Dysphoria as described by the DSM-5. That diagnosis had earlier been confirmed at the A Hospital who did not rush that diagnosis. He opines that that diagnosis does not exclude the co-existence of other psychiatric disorders and mental health-related problems. Imogen has made consistent, persistent and insistent statements about the source of her distress, indicating that it is associated with her Gender Dysphoria. Dr C accepts Imogen's contention that, while she has other mental health and social issues, a significant proportion of her personal suffering and social withdrawal (manifesting as her inability to attend school, her reluctance to seek paid part-time casual work and her retreat into the relative safety of a largely online social existence) is attributable to her disgust with her body, anxieties about being able to present convincingly as a female adolescent in public and her consequent dread of being misgendered as male or "outed" by others as a trans female without her consent. In Dr C's view, it is only Imogen who can know and describe her subjective experience. Dr C's primary position relies upon the stated self-experience and the history given by Imogen above any theoretical constructions, unless there is a good reason to doubt her narrative.
4. Dr D'Angelo however does not agree that Imogen meets the DSM-5 criteria in section B. He believes that Imogen's distress and social and occupational impairment is mostly due to a post-traumatic mental health condition, rather than her sense of gender incongruence. Dr D'Angelo opines that given that the consequences of exposure to developmental trauma, especially violence, can be severe and ongoing, it is impossible to ascertain whether Imogen's sense of gender incongruence is causing clinically significant distress. Dr D'Angelo believes the history of family dysfunction and domestic violence, which he opines is serious, is highly significant in this case. He opines that young people may focus on bodily discomfort (which he points out is exceedingly common in adolescents) and their gender as an explanation for their distress, with the hope, often unrealistic in his view, that transition will resolve their distress. In his experience, traumatised and troubled teens often mistakenly attribute their distress to their body/gender when in fact it is being generated by other factors. He is critical of Dr C's approach on the basis that one of the pillars of psychotherapy and psychodynamic psychiatry is that people are not always aware of the sources of their distress. Dr D'Angelo opines that Imogen has

retreated into the safety of a largely online experience which involves a level of social contagion. That is, Imogen's beliefs have been conditioned by material she has accessed or inactions Imogen has had on the internet, and I accept that to some degree that is likely to be correct.

5. Dr D'Angelo criticises Dr C for the "reification" of gender identity as a concrete thing to be accepted at face value rather than understanding that gender dysphoria emerges within a context including the adolescent's developmental history, current and past family functioning, school relationships and experience, her current relational context and other influences including social media and the current political climate as it relates to sex-roles and transgender concepts.
6. I accept the ICL's submission that the mother's expert does not provide an adequate explanation as to why he would remove from the mix the possibility that problems of school attendance, social functioning and discomfort with her own body might not be associated with gender dysphoria. Whilst there might be other contributing factors, it was unexplained as to why Imogen's dysphoria was not part of the mix in explaining her distress, anxiety and reluctance.
7. The ICL submitted that Dr D'Angelo displayed a rigid unwillingness to countenance discomfort with her body as being a driver for her anxiety by saying that discomfort or distress could be due to other matters or that the discomfort or distress was not clinically significant.
8. I accept Dr C's opinion that Imogen's comments about showering in the dark and insisting there be no full-length mirrors in the house spoke eloquently of Imogen's distress around issues relating to her own body.
9. The ICL referred to the fact that the report from Dr V of 25 February 2019 recorded that Imogen had told Dr V that she felt like her genitalia was not really part of her.
10. Ms T, Imogen's psychologist, provided a report dated 14 February 2019 (Exhibit 10). This report records work that she did with Imogen between October 2018 and February 2019. Ms T records Imogen becoming noticeably withdrawn and that withdrawal being linked to concerns about being judged by others and particularly not being read as a teenager girl. Imogen reported that she gets caught up in the thought that nothing is happening and she describes that 50 per cent of her mental health challenges are due to gender and the process of seeking support to affirm her gender, and the remaining 50 per cent are due to the inter-relationship of gender and other comorbid psychological difficulties. Ms T assessed Imogen as meeting the criteria for Gender Dysphoria and recommended a multidisciplinary approach to Imogen's treatment. Ms T also records Imogen has having considerable knowledge around Gender Dysphoria pathways acquired through internet searches and her advice to Imogen to confirm all such information with appropriate treating practitioners.
11. Dr D'Angelo said that it could not be established that Imogen's distress or impairment was "primarily caused" by the marked incongruence in her gender. It is Dr C's position that no causative factors are either presumed or required. Part B of the definition does not require Part A manifestations of incongruence to be

"primarily caused by" but rather "associated with" the significant stress or impairment.

12. I take into account that Dr C is Imogen's treating psychiatrist and has assessed her in a significant number of interviews since 9 March 2019. Dr D'Angelo has had two online interviews with Imogen which he describes in detail, providing a contemporaneous transcript. I find that Dr C has had a significantly greater opportunity to assess Imogen's self-experience over a longer period of time, including her awareness of the sources of her distress. Dr C basis his diagnostic formulation on the DSM-5, which no longer holds to a hierarchical model whereby treatment of one condition is believed to address the patient's other "lesser" or presumed "derivative" condition. He describes this approach as being "aetiologically agnostic" in circumstances where the causation of Imogen's problem is not yet known in an empirically proven manner. Dr C's diagnosis is not entirely limited to DSM-5 descriptions and he acknowledges the history of past traumatic experiences that Imogen has had. I accept Dr C's diagnosis that Imogen's marked incongruence between her experienced/expressed gender and assigned gender is associated with her clinically significant distress and impairment in social and other important areas of functioning. Accordingly, I find that Imogen has Gender Dysphoria as described at paragraph 302.85 in the DSM-5.

IS IMOGEN GILLICK COMPETENT?

1. It is Dr C's (Imogen's treating psychiatrist's) opinion that she is Gillick competent. It is Dr D'Angelo's opinion that she is not. By the end of the hearing the mother still asserted Imogen was not Gillick competent.
2. In Dr C's report of 16 December 2019, he assesses Imogen's Gillick competence under the following eight headings:
    1. Able to comprehend and retain both existing and new information regarding the proposed treatment;
    2. Able to provide a full explanation, in terms appropriate to her level of maturity and education, of the nature of phase 2 treatment;
    3. Able to describe the advantages of phase 2 treatment;
    4. Able to describe the disadvantages of phase 2 treatment;
    5. Able to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when she should proceed with phase 2 treatment;
    6. Able to understand that the decision to proceed with phase 2 treatment could have consequences that cannot be entirely foreseen at the time of the decision;
    7. Able to understand that phase 2 treatment will not necessarily address all or any of the psychological and social difficulties that she had before the commencement of treatment;
    8. Being free to the greatest extent possible from temporary factors that could impair judgment in providing consent to the procedure.

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3. I note that this list of considerations is for practical purposes the same list as that considered by Johnston J in Re Lincoln (No. 2) [2016] FamCA 1071 and Tree J in Re Elliott [2017] FamCA 1008 at [22], save that those lists did not explicitly include item 6.
4. Dr C believes that Imogen has demonstrated a knowledge of the nature, duration, affects and the likely medical and mental health risks of feminising hormone therapy and that she is able to understand and integrate any new information that is presented to her. He is of the view that Imogen is able to weigh the risks and benefits in the balance and to state her intention as to whether or not she will proceed with the treatment and if so, when she would like to proceed. In relation to Imogen's ability to understand that there could be consequences that cannot be entirely foreseen, Dr C opines that Imogen understands that she may feel differently about her gender identity at some time in the future and desire to fully or partially detransition. Dr C maintains that Imogen's responses to his questions were at least as knowledgeable and mature as other adolescents of the same age who were accepted as Gillick competent in order to proceed with this same treatment.
5. The ICL points out that in relation to Gillick competence, Dr C's assessment is buttressed by a separate assessment by Associate Professor J, although it is to be acknowledged that Associate Professor J did not specifically address the range of factors set out in a way that Dr C had.
6. Dr D'Angelo opines that Imogen is not Gillick competent.
7. Prior to his interviews with Imogen, Dr D'Angelo had already generally formulated reservations about an adolescent's ability to understand all the ramifications of gender affirming hormone treatment. Dr D'Angelo opines:

There is an ongoing controversy about whether young people are able to fully understand the implications of the choices they are making, when they have not yet experienced adult relationships, sexuality and have been sheltered in the relatively protected world of home and school. Can a young person who has not had any sexual experiences consent to a procedure that will likely impair his capacity to experience sexual pleasure? Can a young person who has had no experiences of dating, intimacy or sexuality consent to a treatment that will forever alter the way he/she forms intimate relationships? Can young people, often in a state of distress, really understand what it will mean to be a trans person in our current community, with ongoing discrimination and negative public reaction? And can a young teen really know that having a child will always be of no importance to them even if it seems that way at the age of 14? Many young people present with a sense of urgency to undergo gender-affirming treatments because they are in such distress that they desperately want the treatment they believe will bring relief. Is this the appropriate state of mind for someone to calmly weigh all of the evidence and make a decision about what is best for them?

1. Dr D'Angelo relies heavily upon Imogen's presentation to him during their two interviews by electronic means. At paragraphs 14.128 and 14.129 of his report, he relied upon Imogen's apparent defensiveness to conclude that Imogen was not Gillick competent. The ICL submits that Imogen's presentation needs to be

considered in its context. Imogen is estranged from her mother. In August 2019 the father shared with Imogen the text messages he received from the mother saying that she was going to cut off Imogen's inheritance and get the maternal grandparents to do the same. The father did not see any reason not to show Imogen these text messages, notwithstanding he knew Imogen would be very hurt by them. Imogen knew that her mother wanted Dr D'Angelo to prepare the report. Dr D'Angelo conceded in the circumstances that Imogen's obvious defensiveness with him was understandable.

2. That defensiveness was increased by the fact that Dr D'Angelo asked Imogen questions about surgery in circumstances where she is not contemplating surgery at this stage. He asked questions about particular studies that he asserted had a 30 per cent loss to follow up rate and sought that Imogen speculate about what that might mean. As already indicated, in oral evidence, Dr D'Angelo was more measured. He said because of that follow up rate it was not possible to rely on those studies. The ICL submitted that that was not the way that he had put the issue to Imogen. To Imogen he said:

What if many of these people are lost to follow up because they are unhappy or dissatisfied?

1. Imogen's measured response was entirely accurate, "We just don't know".
2. Dr D'Angelo opines that Imogen has demonstrated only a superficial knowledge and understanding of the likely medical and mental health risks of cross-sex hormones. Dr D'Angelo opines that during her assessment with him, Imogen read the risks of the proposed stage 2 treatment from a list in a cursory and disinterested fashion. In his opinion, Imogen showed no awareness of the potential seriousness of the risks. Dr D'Angelo also found that Imogen refused to discuss more serious risks and acknowledged that she prefers not to think about them. In Dr D'Angelo's view, Imogen displayed an immaturity not consistent with someone 16 years of age when discussing the likely risks of her sexual functioning. Dr D'Angelo concluded that Imogen does not have the cognitive and/or emotional maturity to fully understand whether gender-affirming treatment is best for her in the long run or what the adult consequences of early transition may be.
3. Counsel for the mother submits that neither Dr C nor Associate Professor J specifically asked Imogen any questions in relation to the issue of relationships and sexuality and it was only Dr D'Angelo that tested Imogen about the impact of stage 2 on those issues. In that discussion, Imogen essentially shut down, telling Dr D'Angelo that she did not think that those topics were relevant. Counsel for the mother submits that in relation to the Gillick competent checklist, in respect of Imogen's ability to weigh advantages and disadvantages in the balance and arrive at an informed decision, is compromised because she failed to turn her mind to future intimate relationships and sexuality (terms counsel for the mother used interchangeably) and had not properly thought through the effect of stage 2 treatment on her future ability to have intimate sexual relationships with a person.

4. A letter from Dr H at the Children's Hospital sets out her discussion with Imogen around fertility in the course of treatment at that hospital. I am satisfied that Imogen has considered issues in relation to her future fertility. As already noted, Imogen attended the K Fertility Clinic and undertook sperm cryopreservation.
5. Counsel for the mother submitted that Imogen's failure to disclose to the mother's expert during her two interviews with him that she was sourcing drugs from overseas is indicative of Imogen's immaturity. I find however that it is clearly related to the dysfunctional relationship that Imogen currently has with her mother. In the letter from Dr Y, there is an explicit statement that Imogen did not want any medical information shared with her mother and she knew if she told Dr D'Angelo about the overseas drug, that information would be shared with her mother.
6. Apart from speculation by the mother's expert (which is based on Imogen's intelligence, access to the internet and ability to speak about gender dysphoria), there is no actual evidence that Imogen has been infected by contagion as a result of involvement with the internet or social media. I accept that given the timing of Imogen's weekend away with Ms R and the timing of Imogen coming out to her mother, the mother is suspicious that Ms R influenced Imogen. There is, however, no evidence that Ms R said anything to Imogen that would have unduly influenced Imogen to express the views that she has about transitioning to be female.

Conclusion

1. Imogen is an adolescent of intelligence and maturity and has demonstrated a sophisticated ability to recognise that gender issues impact on all of the areas in which she is feeling distress, whilst recognising there are other issues also impacting upon her. She has demonstrated an ability to understand the information that she has been given in relation to proposed stage 2 treatment and to provide a full explanation of that understanding to her level of maturity and education. She has been able to describe the advantages and disadvantages of the treatment and I am satisfied has been able to weigh those in the balance. The decision that she herself has reached is an informed one. I am also satisfied that she understands that there are possible consequences that cannot be entirely foreseen. Further, Imogen understands that the proposed treatment is not a magic bullet for all her psychological and social difficulties. Her hope is that treatment will reduce her Gender Dysphoria to manageable levels. Finally I am satisfied that Imogen is fully alert and orientated and not in physical pain or severe anxiety when expressing her opinions. She was not suffering from any hallucinations or delusional thoughts. There is no evidence she was using intoxicants.
2. I conclude that Imogen was free to the greatest extent possible from any temporary factors that could impair her judgment when she provided her consent to stage 2 treatment. I find that she was Gillick competent to provide that consent.

WHAT TREATMENT IS IN IMOGEN'S BEST INTERESTS?

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1. Notwithstanding whether an order is made authorising treatment (pursuant to s 67ZC of the Act) or an order is made for parental responsibility (pursuant to s 65D(1) of the Act), the question as to what treatment Imogen has is to be determined having regard for Imogen's best interests as the paramount consideration (s 67ZC(2) and s 60CA of the Act). In doing so, I must consider relevant matters set out in s 60CC(2) and (3) of the Act (see s 60CB(1) and s 60CC(1) of the Act).
2. Imogen has a robust relationship with her father in whom she has a great deal of trust and will continue to have a meaningful relationship with him.
3. Imogen's parents are in warring camps. Imogen has been exposed to a history of family violence and dysfunction. The difficulties in the relationship between the parents has become more entrenched across time. Currently only Olivia is able to move between the two households. There is little hope that Imogen will have the benefit of a meaningful relationship with her mother in the short term. There may be hope that, with treatment, there will be some level of resolution of her distress but whether or not that will ever lead to a stable platform that allows Imogen to repair and redevelop a relationship with her mother is unknown.
4. The father has been involved in Imogen's therapy and the mother has been excluded from it.
5. Imogen has been exposed to family violence involving herself and members of her family. Dr D'Angelo opines that there is a need for her to have psychotherapy to assist what he has diagnosed as post-traumatic stress disorder arising from, amongst other things, exposure to family violence.
6. The most significant factor is the views expressed by Imogen who is Gillick competent (see s 60CC(3)(a) of the Act). As already comprehensively discussed, Imogen has now been consistently, persistently and insistently expressing the view by words and actions that she wishes to be on a path to transition for nearly two years.
7. Imogen has had a long term relationship with her therapist, Ms T, whom she has been seeing since October 2018 (see Exhibit 10). In the event that Imogen commences at the Back to school program, she would be involved with a multi-disciplined team of educators and mental health professionals. It is primarily for that reason that the ICL does not support Imogen receiving psychotherapy.
8. Imogen has a long-standing therapeutic relationship with Dr C. Clearly Imogen's mother has no confidence in Dr C whatsoever. The important thing however is that Imogen does.
9. The evidence that emerged about Imogen sourcing medication from overseas was troubling but spoke eloquently of the dangers that have been created by the dispute in this case.
10. Counsel for the mother submitted that the father took a risk allowing Imogen to access medication from overseas because there is no quality control over it and that there was no evidence that he had any testing done in respect of that medication. I accept the father took some level of comfort in the fact that the packaging of the drug including the asserted manufacturer was identical to that

prescribed by Associate Professor J. I am reassured that Imogen's father has had the sense to take responsibility for administering Imogen's medication and limiting her to 2mg a day. I am also reassured that the A Hospital have not raised any red flag arising from Imogen's blood tests, in relation to the level of oestrogen that Imogen is currently taking.

11. Counsel for the mother submitted that the mother's demeanour on the last day of the hearing was angry, hurt and upset, because of the information she had been given sourcing oestrogen from overseas. There is always the chance the mother might change her mind and again oppose treatment. It might be a brave practitioner who is prepared to take on the management of Imogen's case in those circumstances. The ICL submits that, if an order for authorisation for treatment is made, it is less likely that Imogen's treating practitioners will be reticent to provide her with treatment and that consequently, further litigation will be less likely. I accept the force in that argument.
12. Finally, under the catchall consideration of any other fact or circumstance that the Court thinks is relevant, I am left to consider the competing recommendations for Imogen's treatment.

Recommendations for treatment

Imogen's treating psychiatrist

1. It is Dr C's recommendation that Imogen commences feminising gender affirming hormone therapy, to be continued for as long as Imogen and her treating health professionals determine it to be desirable and necessary for her mental health and wellbeing. That therapy would be undertaken under the direction, supervision and regular monitoring of a qualified and experienced endocrinologist in collaboration with Imogen's general practitioner until Imogen attains legal majority, when medical care may be transferred to a sexual health physician or an appropriately experienced general practitioner if Imogen so chooses. Dr C also recommends that Imogen continues to attend regular ongoing individual outpatient gender affirming psychological therapy. He also recommends that she attend outpatient reviews and/or therapeutic sessions with himself, maintains adherence to any necessary and beneficial prescribed psychotropic medications as recommended by a treating psychiatrist (currently she prescribed a low dose of Prozac).
2. Although currently closed as a result of the COVID-19 pandemic, when they are up and running again, Dr C recommends that Imogen reinvolve herself with recognised and reputable peer support groups such as the Transphobia Group at the Gender Centre for as long as she finds that attendance to be useful and beneficial.
3. Dr C is of the opinion that Imogen's experienced gender identity is stably established as female and that this should be accepted and affirmed. Dr C says that Imogen's self-identification as female should be supported and take place at a pace which Imogen herself controls. It is his opinion that not to do so places Imogen's ongoing mental health at significant risk. Given Dr C's assessment of Imogen's mental capability, he holds the view that she is deserving of autonomy

in her health care decisions and is entitled to the benefits of safe evidence-informed medical and mental health care. Dr C's view is that the suffering that Imogen will very likely experience through being deprived gender affirming treatment at this stage in her life carries far more risk of harm (including but not limited to deliberate self-harm) than the potential risks of harm from later regret.

4. Dr C is of the view that Imogen is of much higher medical and psychiatric risk if she access feminising hormones independently, without qualified medical supervision and monitoring. I accept that risk is increased given that Imogen has already sourced gender affirming hormones from overseas.
5. Dr C says that if Imogen were to receive neither stage 1 or stage 2 hormone treatment her body will resume masculinising. A transition to female in adulthood would be, in Dr C's view, more financially and psychologically costly as well as a poorer result as she will be taller, have broader shoulders, larger hands and feet, a deeper and more resonant voice, a masculinised bone structure of her face and may require painful electrolysis for permanent removal of unwanted hair.
6. Dr C says that any physical changes induced by a standard protocol of feminising hormone therapy that will occur between now and Imogen's 18th birthday are likely to be at most moderate in degree and reversible with time (eg restoration of fertility, body fat distribution) or with surgery (removal of breast tissue) while there are long term risks of bone health in continuing stage 1 therapy alone. Overall, Dr C is of the view that Imogen's mental health and social re-engagement that will be facilitated by the reduction of Imogen's gender dysphoria achieved through hormonal therapy is very likely to significantly outweigh any current or future risks to her health and wellbeing.

Dr D'Angelo

1. It is Dr D'Angelo's recommendation that Imogen should have at least 12 months of intensive psychotherapy addressing issues other than, and including, her gender identity as a pre-requisite. He recommends that there be no administration of cross sex hormones in that 12 month period with that position to be reviewed at the end of that time.
2. Weekly psychotherapy should focus upon past trauma and should also address Imogen's withdrawal, anxiety, school refusal and social difficulties. Treatment should be undertaken by a therapist who is capable of "agenda free" psychological exploration, as opposed to gender-affirming therapy.
3. Dr D'Angelo's position is that it would be preferable for Imogen to gain greater insight into her distress and a deeper understanding of who she is as a person before she commenced potentially irreversible treatments.
4. Dr D'Angelo relies upon his clinical experience, saying that he has or is successfully treating about 35 adolescents who have presented with marked gender incongruence without prescribing them gender affirming hormones. Dr D'Angelo says gender dysphoria sometimes remits when an adolescent is helped to know themselves more deeply. He is careful to point out that the aim of psychotherapy is not to get an adolescent to identify with their natal gender but rather to achieve a remission of gender and body dysphoria. He opines that one

outcome might be that Imogen still identifies as female, non-binary or one of the many other genders currently being expressed but may decide she does not need to have medical or surgical intervention.

5. Dr D'Angelo's view is that treating gender dysphoria as a stand-alone diagnosis effectively takes it out of the context in which it has been developed and is an inappropriate methodological approach.
6. In Dr D'Angelo's opinion there has been an absence of appropriate psychological intervention by Imogen's treating practitioners aimed at exploring relevant contextual factors and how they may have related to Imogen's feelings about her body and her gender.

Conclusions in relation to recommendations

1. Dr C's views are consistent with the current approach to treatment for Gender Dysphoria, currently accepted by the majority of the medical profession.
2. Dr C disagrees with Dr D'Angelo's approach that primarily addressing recollections and effects of past trauma or other conditions will resolve any or all of Imogen's conditions and problems, including Gender Dysphoria.
3. Associate Professor Winter opined, and I accept, that it is a risky and unproven strategy to opt for an approach of exclusively using psychotherapy to treat a patient for Gender Dysphoria (for say up to 12 months as proposed in this case by Dr D'Angelo) whilst suspending the administration of any gender affirming hormonal treatment.
4. I have some reservations about the basis and practicality of Dr D'Angelo's recommendations.
5. Firstly they are based upon a diagnosis that Imogen does not have Gender Dysphoria which I have not accepted.
6. Secondly, it is based upon his opinion about the superficiality of Imogen's responses during interviews with him which in his view, indicated an absence of self-reflection. I do not accept all of Dr D'Angelo's conclusions about how Imogen presented to him.
7. Thirdly, Dr D'Angelo presents as an advocate for an alternative approach to the treatment of adolescents presenting with Gender Dysphoria. Consistently with that advocacy, Dr D'Angelo believes Imogen's lack of self-reflection is likely to be due to the fact that she has been treated within a gender-affirming paradigm, which has an explicit agenda to affirm the person's experienced gender identity. His general opinion is that deeper psychological exploration is not part of this paradigm.

Conclusions in relation to best interests

1. Taking into account all of relevant s 60CC(2) and (3) considerations, I find that it is in Imogen's best interests to accept the recommendations made by Dr C and Associate Professor Winter and to make an order which would allow Imogen to have the proposed stage 2 treatment.

SHOULD AN ORDER BE MADE GRANTING PARENTAL RESPONSIBILITY TO IMOGEN OR SHOULD THE COURT MAKE AN ORDER AUTHORISING TREATMENT?

1. The father seeks that I make an order granting "parental responsibility" to Imogen herself so that she is able to make her own decisions about major long-term issues regarding her health.
2. The AHRC did not support the notion that a parental responsibility order be made which gave Imogen the ability to make her own decisions about her medical treatment. The AHRC submitted that if Imogen was found not to be Gillick competent, the Court would need to make an assessment about whether to authorise the treatment, having regard to Imogen's best interests as the primary consideration.
3. The ICL (consistently with the approach advocated by the Attorney-General), seeks the court make an order authorising treatment.
4. Section 61C(1) of the Act provides that "each of the parents of a child who is not 18 has parental responsibility for the child" but that is "subject to any order of a court for the time being in force" (s 61C(3) of the Act).
5. What the father seeks is a parenting order (s 64B(2)(c) of the Act). A court can make a parenting order it thinks proper (s 65D(1) of the Act) and allocate parental responsibility for a child in favour of a person (pursuant to s 64B(5)(d) of the Act) "a person must include "a child". In Re Isaac [2014] FamCA 1134, Cronin J concluded at [39], "That in respect of certain issues, the court has the power to give parental responsibility to the child himself or herself".
6. In Re Shay [2016] FamCA 998, Cronin J noted at [24], the comments in Gillick that "...parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child". His Honour concluded that in this case, where the parents were prepared to devolve their parental responsibility to the child, it was proper and consistent with the reasoning given in Gillick and Marion's Case for an order to be made allocating parental responsibility to the child (at [23]).
7. Notwithstanding the father's position, I am attracted to the argument by the ICL that making an order authorising treatment is in Imogen's best interests because it is consistent with the view that disputes in respect of treatment for Gender Dysphoria are best dealt with under s 67ZC of the Act (see Bryant CJ [140](b) in Re Jamie) and more effectively eliminates any uncertainty that Imogen's medical practitioners may have when providing treatment to her in the future.

OTHER ORDERS SOUGHT

Should an order be made that Imogen have psychotherapy?

1. As indicated the parents agreed that an order should be made that the father do all things necessary to facilitate Imogen attending appointments with a psychologist/ psychiatrist with a specialisation in adolescent mental health for the purpose of psychotherapy, with such regularity as recommended by the therapist. As indicated the ICL opposes that Order being made. The expert upon which the mother relied, Dr D'Angelo, proposed a course of weekly psychotherapy for 12 months as an alternative to stage 2 treatment. Whilst Dr C indicated that there might be some value in concurrent psychotherapy this evidence was given in the most general of terms. Neither the mother or the father provided any evidence as

to who this therapist might be, what the purpose of the therapy would be and the likely frequency of the therapy. The ICL opposes this order in circumstances where Imogen has had a large number of therapists and currently has a therapeutic relationship with a psychologist. In circumstances where these matters were not explored in evidence, I am unable to conclude that it is in Imogen's best interests to make any order requiring Imogen to attend psychotherapy, including psychotherapy for post-traumatic stress disorder as sought by the mother.

Provision of information to the mother

1. The parents and the ICL agree the father is to provide the mother updates in writing with respect to Imogen on a monthly basis, including but not limited to matters concerning her health and education.

L Centre Back to school program

1. Dr C and Dr D'Angelo agree that Imogen should attend the L Centre Program for the help with school refusal, anxiety and emotional disorders. As indicated, the parties agreed that an order be made that the father do all things necessary to facilitate Imogen attending the L Centre back to school program.
2. Imogen has successfully completed the four day program at L Centre and was anticipating a letter offering her a placement. L Centre adopts a multidisciplinary approach to learning planning and has a high success rate in getting adolescents back to school.
3. In relation to the provision of material to L Centre and Imogen's mental health professionals. Imogen has consistently expressed distress including to Ms T, about not being in control of what people know about her and other practitioners discussing her without her consent or knowledge. I accept the submission by the ICL that they need not be burdened by the large volume of expert evidence in this case and that these reasons, which they can be provided, are an adequate description of that expert evidence.

The mother's application pursuant to s.121 of the Act

1. The mother sought to make an application pursuant to s 121(9) of the Act that approval be granted or a direction be made to allow her to provide a copy of Dr C's Affidavits filed in these proceedings, the Joint report prepared by Dr C and Dr D'Angelo, the transcript of cross examination of Dr C by the Respondent, to the medical complaints body. The mother has previously, unsuccessfully, complained about Dr C to the medical complaints body. Whilst the mother had sought a similar order on an interim basis in her response filed 25 March 2020 it was not an application that she had pursued on a final basis at the hearing. The mother's motivation was said to be the disclosure by Dr C that he had become aware that Imogen had accessed progynova from overseas and had not informed the mother or prior to giving oral evidence, the Court of that knowledge. The letter provided to the Court by Dr C from Dr Y dated 22 April 2020 (exhibit 13) demonstrates from at least shortly after that date Dr C was aware of what Imogen and her father were doing. When asked when he was first aware of Imogen sourcing unprescribed progynova Dr C was unable to be specific. Counsel for the

mother had an opportunity to press Dr C in relation to that issue but did not do so. The father gave evidence that Imogen and he told Dr C about the overseas acquisitions after the brought the first packet but the timing of the provision of that information was also not specific. In the circumstances I did not grant the mother leave to make the application pursuant to s 121 of the Act after the evidence in the final hearing has concluded. Any such application would need to be made in proper form supported by evidence.

I certify that the preceding two hundred and forty-four (244) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Watts delivered on 10 September 2020

Associate:

Date: 10 September 2020

SCHEDULE 1 – the history of the mother's applications

In the mother's initial application contained in her response filed 24 March 2020, she sought orders in the following terms:

1. That the parties do all things necessary to instruct Dr C and Professor J to cease providing hormone treatment (stage one or stage two treatment) to the child Imogen born ... 2004. [The evidence did not establish that stage two treatment had commenced].
2. That the parties have equal shared parental responsibility for the child Imogen with respect to medical treatment for the condition of Gender Dysphoria in Adolescents and Adults in [DSM-5].

There were two difficulties with the second order sought by the mother. The first was that it was predicated on a diagnosis of Gender Dysphoria which the mother disputed and secondly given the parents were opposed about whether Imogen has gender dysphoria and if she does how it should be treated, an order for equal shared parental responsibility would be of no utility given that it could have been confidentially predicted that there would be stalemate in any future decision making process between the parents.

The mother amended the orders she sought at the commencement of the hearing as follows:

1. That the parties do all acts and things, including signing all documents, necessary to instruct Dr C and Professor J to cease providing hormone treatment (stage one or stage two treatment) to Imogen;
2. That the Applicant father do all things necessary to facilitate Imogen attending the L Centre Back to School Program and appointments with a psychologist/ psychiatrist who specialises in treating adolescents with Complex Post-Traumatic Stress Disorder for the purpose of psychotherapy, with such regularity as recommended by the therapist;
3. That the father shall provide the mother an update in writing with respect to Imogen on a monthly basis, including but not limited to matters concerning her health and education;
4. That the parties are at liberty to provide the following documents from these proceedings to L Centre or any mental health professional Imogen consults in accordance with these orders:

(1) Judgement;
(2) Copy of the report of Dr D'Angelo dated 10 June 2020
At the commencement of final submissions the mother sought the following
(1) That the mother neither consents nor opposes the child Imogen born ... 2004 commencing stage 2 treatment for Gender Dysphoria;
(2) That the Applicant father do all things necessary to facilitate Imogen attending the L Centre Back to School Program and appointments with a psychologist/psychiatrist who specialises in treating adolescents with Complex Post-Traumatic Stress Disorder for the purpose of psychotherapy, with such regularity as recommended by the therapist;
(3) That the father shall provide the mother an update in writing with respect to Imogen on a monthly basis, including but not limited to matters concerning her health and education;
(4) That the parties are at liberty to provide the following documents from these proceedings to L Centre or any mental health professional Imogen consults in accordance with these orders:
i) The report of Dr D'Angelo dated 10 June 2020; and
ii) Judgement
(5) That pursuant to section 121 of the Family Law Act (1975) Cth the mother be granted leave to provide a copy of Dr C's Affidavits filed in these proceedings, the Joint report prepared by Dr C and Dr D'Angelo, the transcript of cross examination of Dr C by the Respondent, to the Health Care Complaints Commission.
(6) That the father pay the mother's costs on an indemnity basis.
During final submissions a minute of proposed orders sought signed by the solicitor for the mother and the solicitor for the father which were in the following terms:

1. That the Applicant father do all things necessary to facilitate Imogen attending the L Centre Back to School Program;
2. That the Applicant father do all things necessary to facilitate Imogen attending appointments with a psychologist/psychiatrist with a specialisation in adolescent mental health for the purpose of psychotherapy, with such regularity as recommended by the therapist;

3. That the father shall provide the Respondent mother an update in writing with respect to Imogen on a monthly basis, including but not limited to matters concerning her health and education;
4. That the parties are at liberty to provide the following documents from these proceedings to L Centre or any mental health professional Imogen consults in accordance with these orders:
    - Expert affidavits filed in the proceedings; and
    - Judgement.

[1] Telfer et al, Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents Version 1.2 (The Royal Children's Hospital, 2020)

[2] Hembree et al, "Endocrine Teatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society clinical practice guideline" (2017) 102(11) Journal of Clinical Endocrinology and Metabolism 3869.

[3] Littman Lisa, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of Rapid Onset Gender Dysphoria" (2018) 13 PLOS ONE 8
[4] Ibid.

[5] Arjee Javellana Restar, "Methodological Critique of Littman's (2018) Parental-Respondents accounts of 'Rapid-Onset Gender Dysphoria', (2020) 49 Archives of Sexual Behaviour 61.

[6] Coleman et al, "Standards of Care for the Health of Transsexual, transgender, and Gener-Nonconforming People, Version 7" (2011) 13 International Journal of Transgenderism 165.

[7] Ibid.

[8] de Vries et al, "Young adult psychological outcome after puberty suppression and gender reassignment" (2014) 134(4) Paediatrics 696.

[9] deVries et al, "Puberty Suppression in Adolescents with Gender Indetity Disorder: A prospective follow-up study" (2011) 8 The Journal of Sexual Medicine 2276.

[10] Nota et al, "Occurrence of acute cardiovascular events in transgender individuals receiving hormone therapy" (2019) 139(11) Circulation. 1461.

[11] Cornell University, What we know: What does the scholarly research say about the effect of gender transition on transgender well-being (2020).

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[12] Asscheman et al, “A long-term follow-up study of mortality in transsexuals receiving cross-sex hormones” (2011) 164(4) European Journal of Endocrinology 635.

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