FAMILY COURT OF AUSTRALIA

RE: LOGAN ***[2016] FamCA 87***

FAMILY LAW – CHILDREN – Medical Procedures – Where the applicants, who are the parents of the child, seek a declaration that the child is competent to consent to the administration of stage 2 treatment for Gender Dysphoria – Where alternative orders are sought to authorise the parents to consent to the treatment – Where orders are sought to maintain the confidentiality of the proceedings – Where an order is made dispensing with the rule requiring service upon the respondent, the relevant child welfare authority – Where a finding is made that the child is *Gillick* competent to consent to the medical treatment – Where the applications are otherwise dismissed - Where orders relating to confidentiality are made

Family Law Act 1975 (Cth)
Family Law Rules 2004

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Norton & Locke (2013) FLC 93-567
Re: Flynn [2015] FamCA 629
Re: Isaac [2014] FamCA 1134
Re: Jacinta [2015] FamCA 1196
Re: Jamie (2013) FLC 93-547
Re: Jamie [2015] FamCA 455
Re: K (1994) FLC 92-461
Re: Kate [2015] FamCA 705
Re: Martin [2015] FamCA 1189
Re: Spencer [2014] FamCA 310
Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218

APPLICANTS:	The Mother and the Father
RESPONDENT:	Relevant Child Welfare Authority
FILE NUMBER:	**By Court Order File Number is suppressed**
DATE DELIVERED:	19 February 2016
JUDGMENT OF:	Watts J
HEARING DATE:	12 February 2016

REPRESENTATION

By Court Order the names of solicitors have been suppressed

FINDING

1. The court finds that the child, Logan, born … 1998 is *Gillick* competent to consent to stage 2 medical treatment for Gender Dysphoria as classified in the *Diagnostic and Statistical Manual of Mental Disorders 2015* (DSM-5).

ORDERS

2. The requirement of Rule 4.10 Family Law Rules 2004 (Cth), that the Initiating Application filed 11 February 2016 be served on the prescribed child welfare authority, be dispensed with.

3. Orders 1 and 2 as sought in the Initiating Application filed on 11 February 2016 are dismissed.

4. The name of the child, Logan, born … 1998, the child's family members and their occupations, the child's medical practitioners, this court's file number, the State or Territory of Australia in which these proceedings were initiated and any other fact or matter that might identify the child shall not be published in any way.

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

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

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

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

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order File Number is suppressed

The Mother and the Father
Applicants

And

Relevant Child Welfare Authority
Respondent

REASONS FOR JUDGMENT

INTRODUCTION

1. Logan has been diagnosed as having Gender Dysphoria.

2. Logan's parents made a joint application for the following declaration and, in the alternative, the following order:

    1. That the Court declares that the child, [Logan], born … 1998 is competent to consent to the administration of Stage 2 treatment for the condition of transsexualism called Gender Dysphoria in adolescence and adults in the Diagnostic and Statistic Manual of Mental Disorders 2015 (DSM-5).

    2. By way of an alternative Order, the child's parents, the Mother and the Father, are authorised to consent to the Stage 2 treatment of the child under the guidance of the child's treating medical practitioners including but not limited to the child's endocrinologist, Dr [L] and Psychiatrist, Dr [A].

3. In addition, Logan's parents seek a short listing of the matter and orders seeking confidentiality and restrictions on persons who shall be permitted to search the court file.

THE LAW

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

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

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

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

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

6. Varying approaches have been taken in similar Gender Dysphoria cases by judges at first instance in the 24 published cases decided since *Re: Jamie*. In 19 of those cases, there has been a finding of *Gillick* competence.

7. The outcomes in those 19 cases have been one of the following:

   7.1. Making a declaration that the child is *Gillick* competent to consent to stage 2 treatment for Gender Dysphoria (see for example Johns J in *Re: Spencer* [2014] FamCA 310; Bennett J in *Re: Martin* [2015] FamCA 1189; Austin J in *Re: Jacinta* [2015] FamCA 1196);

   7.2. Making an order authorising the child to consent to the treatment (see for example Johns J in *Re: Kate* [2015] FamCA 705; Thornton J in *Re: Jamie* [2015] FamCA 455);

   7.3. Making an order that the court was satisfied that the child is competent to consent to therapy and able to make his/her own decision in relation to therapy (see for example Berman J in *Re: Flynn* [2015] FamCA 629); or

   7.4. Making an order allocating parental responsibility for making decisions about treatment to the *Gillick* competent child pursuant to s 64B of the Act (see for example Cronin J in *Re: Isaac* [2014] FamCA 1134).

8. The question arises as to whether any of these approaches is what was envisaged by the Full Court in *Re: Jamie*.

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

10. In *Re: Jacinta*, Austin J took the view that the Full Court could not have literally meant that the court had no further role once the finding of *Gillick* competence is made. Austin J said:

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

11. I am unable however to agree that a finding of *Gillick* competence, which is prominently set out, would be difficult for doctors to find and understand or that the child would be left without a clear answer. I am of the view that it is not unpalatable, wrong or absurd to make a finding of *Gillick* competence and make no other order or declaration.

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

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

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

13. The Full Court in *Re: Jamie* did not identify the jurisdiction and power being exercised when the court establishes whether or not a child is *Gillick* competent to give informed consent to stage 2 treatment for Gender Dysphoria.

14. The threshold issue identified by the Full Court is akin to the establishment of a relevant jurisdictional fact. In a different context, the Full Court in *Norton &*

Locke (2013) FLC 93-567 said at [43], "This court, does, however, plainly have jurisdiction to determine if it has jurisdiction – in this case the jurisdiction to embark upon proceedings which seek to establish or deny the relevant jurisdictional facts".

15. The power to conduct the threshold inquiry in respect of *Gillick* competence is inherent or implied. When conducting this inquiry, given the provisions of s 67ZC(1) of the Act are not yet enlivened, the court is neither required to have regard to the best interests of the child as the paramount consideration (s 67ZC(2)) nor consider all the matters in s 60CB – s 60CG of the Act, although there may be an overlap between the facts relevant to making a finding about *Gillick* competence and some of the s 60CC(2) and (3) considerations, particularly s 60CC(3)(a) of the Act.

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

PROCEDURAL ASPECTS

17. The applicants named the Director-General of the relevant child welfare authority as a respondent to this application for authorisation but the matter came on before me prior to the Director-General being served. Given the evidence before me, I dispense with the requirement of Rule 4.10 Family Law Rules which normally requires that applications for medical procedures in relation to a child must be served on a prescribed child welfare authority.

18. When assessing the *Gillick* competence of a child, it is a basic right of the child to be provided with the opportunity to be heard. In this case, the court can hear the child's voice by having regard to anything contained in a report given to the court under s 62G(2) of the Act and by making an order under s 68L of the Act for the child's interests in the proceedings to be independently represented by a lawyer.

19. The Full Court in *Re: K* (1994) FLC 92-461 discussed the categories of cases in which the appointment of an Independent Children's Lawyer should normally be made and included:

> (xiii) Applications in the Court's welfare jurisdiction relating in particular to the medical treatment of children where the child's interests are not adequately represented by one of the parties.

20. When discussing this category, the Full Court in *Re: K* considered when the appointment of an Independent Children's Lawyer may not be necessary and went on to say:

> However, in any case [involving the application of the court's welfare jurisdiction] where the child is capable of expressing a view....we think it desirable that a separate representative be appointed.

21. In this case, my inquiries indicated that if the court made an order pursuant to s 68L of the Act, a lawyer was available who could expeditiously interview the child. My inquiries also indicated that a Family Consultant could also make time to see the child expeditiously and provide a report in relation to the child's maturity and views. Accordingly, in this case I made an order for the appointment of an Independent Children's Lawyer and for a family report. The order for the family report was in the following terms:

> 1. Pursuant to section 62G, I direct a Family Consultant give the Court a report about:
>
> a. Whether or not [Logan] has a sufficient understanding and intelligence to enable her to understand fully what is the medical procedure and related ongoing treatment for gender identity dysphoria.
>
> b. Whether or not [Logan] is competent to make her own decision in respect of the proposed gender identify treatment.

22. I have been greatly assisted by an insightful family report and the submissions made by the Independent Children's Lawyer.

23. Having since reviewed the authorities, I am mindful that it might be that the additional assistance that I have gratefully received in this case may not have been necessary to achieve the outcome. Bryant CJ in *Re: Jamie* said:

> 139. .... The material in support of such an application [for determination of *Gillick* competence], whilst needing to address the proposed treatment and its effects, and the child's capacity to make an informed decision, would not need to be as extensive as an application for the court to authorise treatment and I can see no reason why any other party need be involved, absent some controversy. It would be an issue of fact to be determined by the court on the material presented.

24. In hindsight, it may have been sufficient to hear Logan's voice through the evidence of her two parents and her two doctors which was undisputed on the papers.

25. This hearing was conducted without any of the witnesses giving oral evidence.

BACKGROUND

26. Logan is the second child of the mother and the father. She was born in 1998. She has an older brother and two younger brothers.

27. Logan was born male and identifies as transgender. She has commenced stage 1 treatment for Gender Dysphoria.

28. Logan's parents commenced a de facto relationship in 1988. They separated in in 2007. Since January 2008, the parents have had equal shared parental responsibility for their four children.

29. For a period in 2012, Logan remained in the father's full time care as she did not want to spend any time with the mother. Since this time, Logan and the mother have reconciled. After their reconciliation, Logan returned to living with both parents on a shared care basis. From early 2014, Logan has been in the mother's full time care after her relationship with the father became strained and she chose not to spend time with him. Logan's relationship with the father is now much improved.

30. As a child, the mother observed Logan to be "sweet, sensitive, compassionate, nurturing, empathetic, kind, caring and affectionate". The mother says that Logan indicated no interest to pursue sport or ride a bike but was observed to play with dolls.

31. Logan's closest friends have mostly been and are still female. When Logan was approximately 10 years of age she was furious after having a haircut.

32. The Family Consultant noted that Logan "experienced bullying and violent physical (including beatings) and emotional treatment" by boys in late primary school and early high school. Logan told the Family Consultant that she believed that the perpetrators were threatened by her "trans gender and gayness."

33. The Family Consultant records that during puberty, Logan felt uncomfortable with the physical changes that occurred to her body and felt "gross" and "hatred for gender like aspects" of her body. The mother also says that Logan "strongly dislikes the male parts of her body and is very self-conscious of them being obvious. She dislikes being flat chested." Logan has told her mother that she would like breasts. Logan started identifying as transgender from approximately Year 8 and Year 9 at school. It was from this time that she changed her name to Logan.

34. As a child and a teenager, Logan disliked the clothing the mother bought for her including items with images of skulls and male underwear. Logan was adamant that she would not wear this clothing and refused to have the clothing in her drawers, either hiding them or throwing them away. When Logan was 15 years of age, she asked her mother to assist her with the purchasing of clothes online. After Logan informed the mother of her Gender Dysphoria, she showed the mother the items of clothing she had previously purchased being "from a … female fashion line and included a dress, … skirt and top, tights and a garter belt."

35. In 2012, during a meal with her brothers, Logan said words to the effect of, "I am bisexual."

36. In August 2012, the father discovered that Logan had been self-harming. During this period, Logan "became very unhappy and distressed" and began "drinking

alcohol and smoking cigarettes and marijuana." Logan subsequently attended upon a psychiatrist who prescribed her with anti-depressant medication after being diagnosed with anxiety and depression. Logan continues to be prescribed Lovan, an anti-depressant.

37. For much of 2012 and 2013, Logan saw a psychologist for cognitive behaviour therapy to address her self-harming issues and depression.

38. Towards the end of 2013 during an interstate holiday, Logan told her older brother, his girlfriend and her paternal aunt that she was female.

39. In approximately January 2014, prior to the commencement of her Year 10 studies, Logan informed her mother of her gender dysphoria and stated that her name was Logan. Logan told her mother that she had told her closest friend at school, that she was a girl and to call her Logan. Logan said to the mother words to the effect of, "Since about the end of last year, I have been introducing myself to people outside of school as [Logan]." She said, "Please do not tell anyone else. Just use the name 'Scott' in front of people I know." After Logan's disclosure, the mother took her to attend upon their then general practitioner, Dr P. Dr P provided Logan and the mother with some preliminary information about Gender Dysphoria.

40. During her Year 10 studies, the mother observed Logan to become distressed if called by her birth name or if a male pronoun was used in reference to her. Further, Logan became disengaged from school. She often truanted from school and failed to complete homework and assignments.

41. In the fourth term of Year 10, Logan attended her school Year 10 formal wearing a dress and one of her close friends helped with her hair and make-up. The mother says that Logan enjoyed the event.

42. Prior to Logan's commencement at Z School, the mother arranged for her name to be recorded on the school role as Logan. The mother observed Logan to be relieved when she was referred to by her preferred name and with female pronouns. She has observed Logan to become "emotional and hurt when others misname her and use it instead of her preferred name."

43. In the second half of 2014, Logan contacted a support organisation called 'GA Group.'

44. From early 2014, Logan has used public female toilets as "she feels too uncomfortable to use the male toilets." At school in 2014, Logan avoided using the male toilets unless necessary. Since 2015, Logan has used the female toilets at school.

45. In September 2014, Logan told her younger brothers about her Gender Dysphoria. Since this time, both younger brothers have called her Logan. In approximately November 2014, the father indirectly ascertained that Logan had

decided to transition from male to female after hearing her younger brothers refer to her as Logan.

46. In December 2014, Logan told her cousin of her Gender Dysphoria.

47. In January 2015, Logan told her father of her Gender Dysphoria.

48. In January 2015, Logan attended upon Dr S, psychiatrist, after being referred to him by 'GA Group'. Dr S referred Logan to a psychiatrist experienced in providing treatment for transgender people and to a paediatric endocrinologist to provide Logan with hormone and puberty blockers following a psychiatric assessment.

49. In about March 2015, Logan wanted to tell the mother's parents of her Gender Dysphoria. The mother says that Logan's father told his parents about Logan's Gender Dysphoria in early 2015.

50. Since approximately March 2015, Logan has attended upon Dr A, psychiatrist, for ongoing care and support for her anxiety and depression.

51. On 25 May 2015, the mother and Logan attended upon Dr L, paediatric endocrinologist, at the X Hospital. Dr L provided advice in relation to commencing hormone/puberty blockers (stage 1 treatment for Gender Dysphoria). The Family Consultant explains that the stage 1 treatment that Logan is currently receiving "blocks all testosterone production" causing a decline in the growth of facial hair, softer skin, a reduced sex drive and prevents the voice from continuing to deepen. The Family Consultant states that prior to commencing stage 1 treatment, Logan was "terrified about growing facial hair and having a deep voice".

52. On 1 June 2015, the mother and Logan attended upon Dr D at the X Fertility Centre. Logan had previously said that she would adopt children rather than have her own biological children but the mother wanted to obtain advice on fertility. On 4 June 2015 and 11 June 2015, Logan attended upon the X Fertility Centre to provide a sample. On both occasions, she was advised that her sample was not suitable for cryostorage. The mother observed Logan to be very reluctant to provide a sample as "she was not comfortable having an erection or masturbating." After providing a sample on both occasions, Logan was too distressed to attend school for the remainder of the day. Upon Logan's request, no further appointments were made for sperm cyrostorage.

53. On 15 June 2015, Logan received her first injection of Lucrin. On 10 August 2015, 19 October 2015 and 11 January 2016, Logan received her second, third and fourth injections respectively. Since starting the stage 1 treatment, the mother has observed Logan to be less distressed.

54. In approximately mid-August 2015, the mother and father applied to the Registry of Births, Deaths and Marriages for Logan to have her name changed on her birth certificate from her male birth name to the name by which she now

is known. Logan has also expressed her intention to change her gender on her birth certificate.

PROPOSED TREATMENT AND ITS EFFECTS

55. Dr A' report dated 31 August 2015 notes that stage 2 treatment will result in Logan developing "breast growth, a more feminine fat distribution and skin changes. She will appear more feminine".

56. Dr L's report, dated 12 January 2016, explains that remaining on stage 1 treatment in the long term is "not a viable option given that this will result in a number of risks including osteoporosis and heart disease".

57. Dr L's report notes that stage 2 treatment for Gender Dysphoria involves prescribing Logan "oestrogen, the female sex hormone, to feminise her body. This will be accompanied by concurrent use of Lucrin to stop her testicular hormone output and if required Spironolactone 100mg twice daily to block the effects of testosterone from other sources on her body until she reaches full oestrogen replacement which will be approximately 18-24 months from starting". Dr L proposes to commence Logan on either an oral form (Progynova) or an oestrogen patch at the recommended dosage. This dose will initially be low and increase gradually. This will be used concurrently with Spironolactone 100mg twice daily and ongoing use of puberty blockers until she reaches full replacement doses. The treatment will result in the body depositing fat and mood changes.

58. Dr L's report states that the specific risks of Oestrogen include:

    58.1. Chronic problems with veins in the legs

    58.2. Heart disease

    58.3. Risk of blood clots

    58.4. Type 2 diabetes

    58.5. Liver disease

    58.6. High cholesterol and high blood pressure

    58.7. Gallstones

    58.8. Headaches or migraines

    58.9. Prolactinoma

59. Dr L's report states that the specific risks of Lucrin are reduction in bone mass if continued for an extended period without sex steroid (oestrogen or testosterone) replacement.

60. Dr L's report states that the specific risks of Spironolactone if needed are:

60.1. Gastrointestinal symptoms

60.2. Drowsiness

60.3. Lethargy

60.4. Headache

60.5. Skin reactions

THE CHILD'S CAPACITY TO MAKE AN INFORMED DECISION

61. As indicated in May 2015, Dr L provided advice in relation to commencing hormone/puberty blockers (stage 1 treatment for Gender Dysphoria). The mother observed Logan to understand the risks and side effects of the treatment as explained by Dr L. Logan subsequently indicated to both the mother and Dr L that she wanted to proceed with the first stage of treatment. Following the consultation, the mother discussed the proposed treatment with the father. Both the mother and father provided consent for Logan to commence the treatment.

62. Both parents are supportive of Logan proceeding with stage 2 treatment and believe that it is in her best interests. They believe that she understands what is involved in the treatment and that it is of an irreversible nature.

63. Both parents depose that Logan is capable of providing consent to undergoing the treatment. Logan has expressed the desire to undertake sex reassignment surgery upon attainment of 18 years of age.

64. Dr L's report concludes that "[Logan] is Gillick competent to make the decisions regarding continuation of stage 2 (oestrogen) treatments." He bases this opinion on the fact that Logan "engaged in sophisticated discussion around the issues of her gender identity, fertility preservation and the long term consequences of treatment both in terms of physical and psychological health and wellbeing." "[Logan] was aware of having female gender feelings since early in childhood although was unable to recognise these feelings as gender dysphoria since early in high school after reading more about this on the internet. [Logan] came to me with a detailed understanding of how the medications worked and the expected effects they would have on her body. We have discussed the consequences of stage 2 treatment including the likelihood that long term oestrogen use may affect her fertility." Dr L states that he spoke to Logan about "the risk of smoking and how this further increases the risk of blood clots (deep vein thrombosis, pulmonary embolism and stroke), and so she understands that my recommendation is that she should stop smoking prior to starting oestrogen".

65. Dr A's report, dated 31 August 2015, confirms that Logan has had "a clear history of gender dysphoria from a young age". She concludes that "[Logan] is an intelligent and well-informed girl. She has been pro-active in seeking this treatment and has done a lot of research on her own. She is able of making an informed decision on this treatment."

66. The Family Consultant states that:

> 8. [Logan] presents as an articulate, highly intelligent and engaging young person. She was candid, self-possessed and comfortable to discuss her views and feelings and understanding of gender identity dysphoria and the treatment. She is adamant that she has manifested a clear gender dysphoria for as long as she can remember. She appeared highly knowledgeable about the treatment that was entailed in achieving a transgender change. She was also highly informed and erudite about different sexual orientations and identities. She said that her understanding had come from speaking to professionals, association with other people who were transgender and her involvement with the Lesbian, Gay, Bisexual and Trans Youth Group.
>
> ....
>
> 16. [Logan] presents as mature, intelligent and very well informed of her condition and the treatment options open to her. Her reasoning for wanting to commence Stage 2 of her treatment prior to gaining 18 years of age and becoming a legal adult is clear and appears to be well considered and based on her emotional, psychological and social experiences of her gender incongruence.

67. On 12 February 2015, the Independent Children's Lawyer, made submissions in court that "[Logan] is well above average intelligence, incredibly well informed, way beyond any knowledge that [the Family Consultant] or I have about medical issues to do with the gender issue. She is a font of information. She is a delightful young woman with very solid plans".

THE CHILD'S WELFARE

68. The parents have observed Logan to experience "much distress and emotion in her current state" and believe that the transition will "help alleviate her gender dysphoria and provide her with an opportunity to live a fulfilling life".

69. Dr L's report explains that "[Logan] has already physically transitioned to being female although has not yet had female hormones. From reports in other young transgender women, there would be an expectation of further improvement in [Logan's] mood and behaviour with commencement of oestrogen treatment. Denying her ongoing treatment would compromise her health and wellbeing and I do not believe that this is appropriate or acceptable."

70. Dr A's report notes that by undergoing stage 2 treatment, Logan will "feel less anxious, agitated and upset." Dr A further explains that "having a smooth transition (change from one gender to another) leads to improvement of depressive and self-harm symptoms which are commonly co-morbid with gender identity issues. It can allow her more time in the feminine gender and adjusting to this before having to make any further decisions regarding gender reassignment such as surgery. In my clinical experience, this is a psychologically

and socially safer route than a rushed transition later in adulthood". She states that "If the procedure is not carried out, [Logan] will likely have continuing distress, increasing depression and hopelessness and as her body becomes more masculine, will be more at risk from the community at large. Therefore, I believe that this procedure is necessary for [Logan's] welfare".

71. The Family Consultant notes that Logan has wanted to commence stage 2 treatment "for a long time" and is adamant that "she will not be able to lead a happy and healthy life without taking oestrogen". The Family Consultant states that Logan has citizenship in the United Kingdom and plans to relocate to Europe once she has completed school in Australia. Logan has expressed that she wants to commence stage 2 treatment "while she has familiar medical infrastructure in place".

72. The family report states that "[Logan] is at an important stage at school and in her development to adulthood. At her developmental age being with peers, socialising and being accepted in society is important to developing a secure self-identity and becoming a confident and optimally functioning adult. This last year of school is also a challenging and potentially stressful time academically and it appears from [Logan's] statements that her gender dysphoria is an ongoing stress for her." The report notes that Logan stated that without the treatment she "will be at risk of prejudice and violence". The report therefore explains that "if [Logan] does not commence the next stage of her treatment she is likely to feel highly frustrated and distressed. These feelings may lead to significant risks to her ongoing development, such as heightened depression, anxiety and low self-esteem; greater risk of using drugs and other risk taking behaviours." Without commencing stage 2 treatment, the Family Consultant stated that Logan would be at "psychological and social risk of being visually gender non-conforming, which places her at considerable risk." Consequently, the Family Consultant recommends that the necessary orders should be made "so that [Logan] can commence stage 2 treatment for gender dysphoria."

CONFIDENTIALITY

73. It is appropriate to make orders for confidentiality and restrictions on persons who shall be permitted to search the court file, as sought.

CONCLUSION

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

I certify that the preceding seventy-four (74) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Watts delivered on 19 February 2016

Associate:

Date: 19.2.2016