# Case note: Re Kelvin [2017] FamCAFC 258 (30 November 2017)

The full court of the Family Court has held that in non-controversial cases, transgender children and their families are no longer required to seek authorisation from the court to undertake stage two hormone treatment. The decision also clarifies that a determination of whether a child has competence to consent to stage two hormone treatment (ie whether they have *Gillick* competence) can be made by the treating medical practitioners, and a declaration from the court is not required.

The landmark decision of [Re: Kelvin](http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FamCAFC/2017/258.html) brings the law into closer alignment with medical science and the treatment of young people with gender dysphoria and will remove one of the many barriers faced by young transgender people in Australia seeking to transition to their innate gender.

However, for children whose decision to access treatment is not supported by one or both of their parents, as was the case for the applicant in [Re: Isaac [2014] FamCA 1134 (17 December 2014)](http://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-case-note-re-isaac-2014.docx), and for children in state care, a court order is still required.

## Useful definitions

**Gender Dysphoria:** A medical term that describes the distress experienced by a person due to incongruence between their gender identity and their sex assigned at birth. Being transgender is now largely viewed as part of the natural spectrum of human gender diversity, but gender dysphoria is associated with severe psychiatric co-morbidity and social, educational, vocational and economic disadvantage.

**Gender identity**: A person’s internal sense of being male, female, or, for some people, a blend of both or neither.

***Gillick* competence:** The principle established in *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7, that a child can consent to medical treatment if they have sufficient understanding and intelligence to understand fully what the proposed treatment involves.

**Stage one treatment:** Puberty blocking hormone treatment which stalls the irreversible effects of puberty. Treatment affords the child time to mature emotionally and cognitively so that they can provide informed consent to subsequent treatment. The effects of stage one treatment are reversible when used for a limited time (three to four years).

**Stage two treatment:** Gender affirming hormone treatment, involving the use of either oestrogen to feminise the body or testosterone to masculinise the body. This treatment is irreversible and may cause long-term infertility.

**Stage three treatment:** Surgical interventions to assign gender, which may include chest reconstructive surgery, phalloplasty, or vaginoplasty.

## Facts

Seventeen-year-old Kelvin was assigned female gender at birth. He began displaying symptoms meeting the criteria of gender dysphoria from the age of nine, and at the age of 13, Kelvin disclosed to his father that he was transgender. He has had significant issues with anxiety, depression and self-harming, problems that were not helped when his first high-school indicated they could not accommodate a transgender student. Kelvin did not undergo stage one treatment and his distress was heightened when he began experiencing female puberty. After several school changes, Kelvin transitioned socially as a transgender person in grade eight and the following year began seeing medical specialists in relation to his gender identity.

When Kelvin was 16, his father made an application to the Family Court on his behalf, seeking a declaration that Kelvin was competent to consent to stage two treatment, or, in the alternative, an order authorising stage two treatment.

Justice Watts at first instance (*Re Kelvin* [2017] FamCA 78), found Kelvin to be have *Gillick* competence to consent to stage two treatment, but the application for authority to commence treatment was referred to the full court pending determination of questions of law, primarily:

* whether the court confirmed the decision in *Re Jamie:* [[2013] FamCAFC 110](http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FamCAFC/2013/110.html) (also of the full court), that stage two treatment requires court authorisation, unless the child is *Gillick* competent to consent to the treatment, and
* where the child consents to stage two treatment, the parents do not object to the treatment, and the medical practitioners agree that the child is *Gillick* competent to give that consent, whether is it mandatory to apply to the court for a determination as to whether the child is *Gillick* competent.

In *Re: Jamie*, the question for the court on appeal was whether a court order was required for both stage one and stage two treatment. The court held that even though stage two treatment was therapeutic in nature, unlike stage one treatment its effects were irreversible (except with surgery) and as such, the procedural safeguard of court involvement was required.

## The decision

The court in *Re: Kelvin* held in the negative in relation to both questions.

In relation to the first question, the majority saw fit to depart[[1]](#footnote-1) from the previous authority of *Re Jamie* citing developments in science since that case was decided, and the subsequent evolution of the understanding of the court. The cited developments included:

* changes in the diagnostic definition of gender dysphoria
* the development of [standards for the care of children experiencing gender dysphoria](https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/Australian%20Standards%20of%20Care%20and%20Treatment%20Guidelines%20for%20Trans%20and%20Gender%20Diverse%20Children%20and%20Adolescents.pdf)
* new data on the persistence of gender dysphoria in young people (ie it is not ‘just a stage’), and
* increased knowledge of the risks associated with not treating a young person experiencing gender dysphoria.

In relation to the second question, the court held that where the child consents, the treating professionals agree that the child is *Gillick* competent, and the parents do not object to the treatment, court authorisation is not required for stage two treatment.

The court recognised that where the diagnosis results from a proper assessment, the proposed treatment aligns with best practice guidelines, and parents and doctors are in agreement, this is an issue more appropriately determined in the medical realm. The impact of the considerable cost and delay associated with court processes on young transgender people and their families was of itself, ‘*a significant pointer to this court holding that there is no role for courts in the process, absent a dispute between parents or between parents and doctors’.*

The court stressed the importance of differentiating between therapeutic and non-therapeutic treatment, and acknowledged that this characterisation of treatment depends on the state of the science, stating [at 47]:

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

## Commentary

The outcome of *Re: Kelvin* is that Family Court authorisation is no longer required for a young person where:

1. stage two treatment is proposed
2. the young person consents to treatment
3. the treating medical practitioners agree that the young person is *Gillick* competent to consent, and
4. the young person’s parents to do not object to the treatment.

However, Family Court authorisation would still be required in the following situations:

1. the young person is **not** considered *Gillick* competent by their treating medical practitioners, and/or
2. the young person’s medical practitioners do not propose treatment, and/or
3. one or both of a young person’s parents object to the treatment.

It is worth noting that, as the Family Court states, stage two treatment is ideally commenced at an age where the young person is sufficiently mature to provide informed consent. Young people receiving stage two treatment are generally post-pubescent. Therefore, it is less likely that a situation would arise where a young person’s treating medical practitioners did not consider the young person to be *Gillick* competent.

It is also worth noting that the case does not address the need for court authorisation where the child is under child protection care.

1. While the majority did not see the court’s previous decision as being ‘plainly wrong’, as was submitted, and therefore saw no need to overrule it, two judges stated that they considered the statement of principle in *Re Jamie* as erroneous. [↑](#footnote-ref-1)