

IN THE SUPREME COURT OF VICTORIA
AT MELBOURNE
COMMON LAW DIVISION
GENERAL LIST

Not Restricted

S ECI 2024 03560

IN THE MATTER of an application by the ROYAL CHILDREN'S HOSPITAL; Re CD

JUDGE: Richards J
WHERE HELD: Melbourne
DATE OF HEARING: 31 July 2024
DATE OF JUDGMENT: 31 July 2024 *ex tempore*
Written reasons published 2 August 2024
CASE MAY BE CITED AS: Re CD
MEDIUM NEUTRAL CITATION: [2024] VSC 456

FAMILY LAW AND CHILD WELFARE – CHILD WELFARE OTHER THAN UNDER FAMILY LAW ACT 1975 AND RELATED ACTS – Other matters – *Parens patriae* jurisdiction – Child aged 12 years old diagnosed with gender dysphoria wishing to commence puberty suppression treatment – Where one parent consents to treatment but other parent not available to give consent – Whether court approval required for treatment without affirmative consent from both parents – Whether parental responsibility can be exercised independently by each parent – Consent of one parent sufficient in this case – Not necessary to exercise *parens patriae* jurisdiction – Application dismissed – *B and B: Family Law Reform Act 1995* (1997) 21 Fam LR 676 – *Re Jamie* (2013) 278 FLR 155 – *Re Kelvin* (2017) 327 FLR 15 – *Re Imogen (No 6)* (2020) 61 Fam LR 344 distinguished – *Medical Treatment Planning and Decisions Act 2016* (Vic) pt 4 div 2, ss 50, 52, 55, 58.

<u>APPEARANCES:</u>	<u>Counsel</u>	<u>Solicitors</u>
For the Applicant	Ms E Bennett SC with Mr R Marsh and Mr D Dexter	Ms AM Lofaro, Minter Ellison

HER HONOUR:

- 1 The Royal Children's **Hospital** has applied to the Supreme **Court** of Victoria for orders enabling the provision of medical treatment to a 12 year old child (**CD**), in accordance with the recommendation of her treating practitioners.¹ CD does not yet have capacity to consent to medical treatment, and so her mother (**AB**) has consented to the treatment. Both AB and CD want the Hospital to commence the treatment as soon as possible, consistent with the advice of CD's paediatrician and her psychologist.
- 2 However, the Hospital is uncertain whether AB's consent is sufficient. That uncertainty has arisen because:
 - (a) The treatment concerned is the administration of puberty suppression treatment for gender dysphoria, often referred to as 'stage 1 treatment'; and
 - (b) CD's biological **father**, who has had no involvement in her life since she was a baby, is not available to give consent to the treatment.
- 3 The proceeding initially came before me as the judge sitting in the Practice Court when the proceeding was commenced by originating motion filed on 10 July 2024. The orders sought by the Hospital have been refined over the course of the proceeding, and the Hospital now seeks declarations that either:
 - (a) AB can validly consent to stage 1 treatment on CD's behalf (and has so consented); or
 - (b) In the alternative, that the Court itself consents to stage 1 treatment on CD's behalf in its *parens patriae* jurisdiction.
- 4 The question at the heart of the Hospital's application is whether AB's consent to stage 1 treatment for her daughter is proper consent, in circumstances where CD's

¹ Consistent with CD's gender identity and longstanding preferences, I refer to her using the pronouns 'she' and 'her'.

father is absent and his views are not known. For the reasons that follow, I have concluded that it is. There is therefore no occasion for the Court to make orders in its *parens patriae* jurisdiction, and the application will be dismissed.

CD's circumstances

5 CD's family circumstances were described in two affidavits made by AB. AB became pregnant with CD in 2011, during a brief relationship with CD's father. The relationship ended when CD was only a few months old, and she has had no contact with her father since then. In 2012, AB applied to the Magistrates' Court of Victoria for a family violence intervention order against the father. The reasons for the application included threatening and abusive behaviour toward AB, alcohol and drug abuse, and unsafe care of CD. In late 2012, the Magistrates' Court made a final family violence intervention order against the father, for a period of 12 months. In circumstances where there had been no breaches of the order and only very limited further contact from the father, the order was not renewed beyond that period.

6 When CD was about one year old, the father commenced legal action to enable him to have contact with her. He did not pursue this to a conclusion, and AB has had no contact with him since then. A couple of years later, she heard that he had moved interstate. He has not sought contact with AB or CD in all that time. AB does not know his whereabouts or have any means of contacting him. She is extremely hesitant to seek him out now, and remains concerned for her and CD's physical and psychological safety were contact to be made.

7 AB has been able to raise and parent CD without any direct involvement from CD's biological father for almost all of CD's life. AB has made all of the decisions about where and how CD lives, her education, and all of her health care needs. Until now, AB has not had to consider the father's views or involve him in any of those decisions.

8 Although AB has exercised sole parental responsibility for CD since she was a baby,

she has not sought to formalise this by obtaining a parenting order under the *Family Law Act 1975* (Cth).

- 9 CD's gender assigned at birth was male, but she has identified as female for many years. When she was seven years old, CD told AB that she was no longer her son, she was her daughter. She chose a feminine name, which she has used at home, at school, and in the wider community since that time. She lives and presents as a girl, with a preference for stereotypically female colours and clothing.
- 10 In 2020, when she was eight years old, CD began attending the Royal Children's Hospital Gender Service, which is a multidisciplinary service for transgender children and adolescents. I was provided with reports from a paediatrician and a clinical psychologist who work at the Gender Service, who have seen CD regularly over the last three and four years respectively. They both diagnose CD with gender incongruence of adolescence, and gender dysphoria in adolescents. These diagnoses were confirmed by a second paediatrician who has seen CD on two occasions when her primary paediatrician was on leave.
- 11 CD's treating practitioners explained in their reports that the marked incongruence between her experienced gender and her assigned gender is associated with clinically significant distress. The commencement of puberty has increased CD's anxiety in relation to the impending and unwanted irreversible changes in her body. She is distressed at the prospect of her voice breaking, of her Adam's apple developing, and of facial and increased body hair. Recently, her level of distress has been so high that it has affected her functioning at home and at school, and last year she began to report suicidal thoughts.
- 12 CD's treating clinicians strongly recommend that she commence stage 1 puberty blocking treatment using gonadotrophin releasing hormone analogues (GnRHa). This treatment halts the progression of the physical changes that come with puberty, but is reversible and may be stopped at any time. The clinicians say that

undertaking stage 1 treatment will provide CD with both immediate psychological relief, and additional time to explore her gender identity before making decisions about the use of other 'stage 2' hormonal treatments, such as oestrogen. Her paediatrician's opinion is that CD is likely to remain stable in her female gender identity, in which case she will also derive long term benefit from having had GnRHa treatment to prevent unwanted and irreversible masculinisation during puberty. If she later becomes unsure about her gender identity, she can stop the treatment.

- 13 As mentioned, AB consents to the treatment and CD is very keen to start it. There is an element of urgency, because CD is in the early stages of puberty.
- 14 However, the Hospital is unsure whether it can provide CD with the treatment recommended by the clinicians in its Gender Service. Its hesitation is due to ongoing uncertainty about the appropriate approval or authorisation for treatment for gender dysphoria. This treatment has been the subject of a series of decisions of the Family Court of Australia over the last 20 years, in its welfare jurisdiction under s 67ZC of the Family Law Act. The Family Court has since become part of the Federal Circuit and Family Court of Australia, but for brevity I will refer to both courts as the 'Family Court'.

Family Court authority

- 15 Initially, the Family Court took the view that both stage 1 and stage 2 medical treatment for gender dysphoria were 'special medical procedures', which required court approval.² This approach was followed for many years.
- 16 The approach changed in 2013, when the Full Court of the Family Court determined in *Re Jamie*³ that stage 1 treatment was not a special medical procedure, and absent any controversy, fell 'within the wide ambit of parental responsibility reposing in

² *Re Alex* (2004) 180 FLR 89.

³ (2013) 278 FLR 155 (*Re Jamie*).

parents when a child is not yet able to make his or her own decisions about treatment'.⁴ Where there was no dispute between the child, their parents, and their doctors that stage 1 treatment should be undertaken, the treatment did not require court authorisation.⁵

17 A further development took place in 2017, with the decision of the Full Court of the Family Court in *Re Kelvin*,⁶ that parents could consent to stage 2 treatment without court authorisation. In light of developments in both legal principle and medical science, the Full Court held that consent to stage 2 treatment did not lie outside the bounds of parental authority and did not require the imprimatur of the Court.⁷ Following *Re Kelvin*, court approval has generally not been required where the child, their parents, and their treating practitioners all agree that stage 2 treatment is appropriate. For some time, the Family Court's jurisdiction was invoked only to resolve a dispute, for example if the child's parents were unable to agree.⁸

18 One such case was *Re Imogen*,⁹ which concerned a child aged 16 years and 8 months who had been undertaking stage 1 puberty suppression treatment for gender dysphoria, and who wished to proceed to stage 2 gender affirming hormone treatment. Imogen's father supported her decision to undertake this treatment, but her mother did not consent to the treatment and did not accept that Imogen was competent to consent to the treatment on her own behalf. Justice Watts of the Family Court found that Imogen was 'Gillick competent'¹⁰ – that is, sufficiently mature to

⁴ *Re Jamie*, [108] (Bryant CJ).

⁵ *Re Jamie*, [179] (Finn J), [194] (Strickland J).

⁶ (2017) 327 FLR 15 (*Re Kelvin*).

⁷ *Re Kelvin*, [164]–[165] (Thackray, Strickland, and Murphy JJ).

⁸ *Re Kelvin*, [167] (Thackray, Strickland, and Murphy JJ).

⁹ *Re Imogen (No 6)* (2020) 61 Fam LR 344 (*Re Imogen*).

¹⁰ The term 'Gillick competent' derives from the House of Lords' decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (*Gillick*). Their Lordships decided 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. *Gillick* was approved by the High Court as reflecting the common law position in Australia: *Secretary, Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 237–39 (Mason CJ, Dawson, Toohey, and Gaudron JJ) (*Marion's*

be able to give informed consent to medical treatment — and that stage 2 treatment would be in her best interests.¹¹ His Honour made orders authorising the administration of stage 2 treatment to Imogen.

19 In the course of reaching this decision, Watts J summarised the development of the law regarding consent to treatment for gender dysphoria, and gave the following answers to ‘outstanding questions’ raised in the case:¹²

- a) If a parent or a medical practitioner of an adolescent disputes:
 - i) The *Gillick* competence of an adolescent; or
 - ii) A diagnosis of gender dysphoria; or
 - iii) Proposed treatment for gender dysphoria,
 an application to this Court is mandatory;
- b) 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;
- c) Notwithstanding a finding of *Gillick* competence, if there is a dispute about diagnosis or treatment, the court should:
 - i) Determine the diagnosis;
 - ii) Determine whether treatment is appropriate, having regard to the adolescent’s best interests as the paramount consideration; and
 - iii) Make an order authorising or not authorising treatment pursuant to s 67ZC of the Act on best interest considerations;
- d) 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

Case).

¹¹ *Re Imogen*, [199], [231].

¹² *Re Imogen*, [35].

it, without court authorisation.

- 20 It appears that the answer in paragraph (d) has been interpreted by some to require the positive express consent of both parents, rather than the absence of any objection or dispute.¹³ In several cases since, applications have been made under the Family Law Act for a court to provide consent for treatment for gender dysphoria in the absence of one of the child's parents.¹⁴
- 21 The Hospital's reasons for making this application were outlined in an affidavit of Associate Professor Thomas Connell, the Executive Director of Medical Services and Chief Medical Officer of the Hospital. Associate Professor Connell said that, for most illnesses or injuries, the Hospital either obtains the consent of the present parent or parents, or treats on the basis of a practitioner's assessment that the child is *Gillick* competent. He also said that the Hospital understands that the provision of stage 1 treatment is not medically distinct from many of the other treatments provided to young people with the consent of only the present parent or of a *Gillick* competent child.
- 22 Associate Professor Connell has sought legal advice about the issue of consent to stage 1 treatment, and whether Hospital practitioners could administer that treatment without risk of being criminally or civilly liable in the event that valid consent has not been given if one parent is not available to consent. The advice from external lawyers, which had been settled by senior counsel, was to the effect that:
- (a) if a child is not *Gillick* competent, there is uncertainty as to the state of the law, but there is a risk that the consent of a non-present parent is required and that a failure to obtain consent may amount to a 'dispute'; and

¹³ This view was reinforced by a further statement that a medical practitioner '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': *Re Imogen*, [63].

¹⁴ *Re G4* [2021] FCWA 102 (*Re G4*); *Re Kelly* [2022] FedCFamC1F 380 (*Re Kelly*); *Re G9* [2022] FCWA 65 (*Re G9*).

(b) if a child is not *Gillick* competent and the non-present parent cannot be contacted or does not consent to the proposed treatment, there is a risk that valid consent has not been given and that the Hospital or its medical practitioners could be civilly or criminally liable.

23 Associate Professor Connell added that his understanding is that, if treatment is provided without valid consent, there may be a risk of professional conduct proceedings for individual practitioners involved in the provision of that treatment.

Parens patriae jurisdiction

24 It is because of the uncertain state of the law regarding consent to treatment for gender dysphoria that the Hospital has made this application, in the *parens patriae* jurisdiction of the Supreme Court.

25 The Court's *parens patriae* jurisdiction derives from the responsibility of the Crown to care for those who cannot look after themselves, in particular children.¹⁵ It is 'essentially protective in nature', and may be exercised either through the machinery of wardship or by *ad hoc* orders.¹⁶ The jurisdiction may be exercised to make a decision that a child's parents may make. It extends to making decisions beyond parental responsibility, such as consenting to a special medical procedure. In all cases, the jurisdiction is to be exercised in the best interests of the child.¹⁷ The welfare jurisdiction of the Family Court is a statutory equivalent of the *parens patriae* jurisdiction of the State Supreme Courts.

26 While the *parens patriae* jurisdiction is broad, it must be exercised with restraint and with proper respect for the views of anyone else who is exercising parental responsibility for the child. In *Director-General, Department of Community Services*;

¹⁵ *Marion's Case*, 259 (Mason CJ, Dawson, Toohey, and Gaudron JJ).

¹⁶ *Marion's Case*, 279–80 (Brennan J).

¹⁷ *Marion's Case*, 259 (Mason CJ, Dawson, Toohey, and Gaudron JJ); *Re Beth* [2013] VSC 189, [118]–[119], [127](c).

Re Jules,¹⁸ Brereton J of the New South Wales Supreme Court said:¹⁹

The *parens patriae* jurisdiction is, of its nature, one that involves the court assuming parental responsibility in part or in whole in respect of a child, where those otherwise entrusted with that responsibility are found by the court not to be exercising it — or not to be able to exercise it — in the best interests of the child. The court respects the autonomy of the parents and will interfere only to the minimum extent necessary, respecting the wishes of the child and the wishes of the parents.

27 In considering whether the orders sought by the Hospital should be made in the Court's *parens patriae* jurisdiction, three matters may be accepted:

- (a) The Hospital and the health practitioners who are treating CD must obtain proper consent for any kind of medical treatment, including stage 1 treatment for gender dysphoria.
- (b) CD is not yet able to consent to medical treatment on her own behalf — to use the medico-legal parlance, she is not yet *Gillick* competent.
- (c) Consent to stage 1 treatment is within the scope of parental responsibility where a child is not yet able to make their own decision.

28 This brings me to the question at the heart of this case: whether AB's consent to stage 1 treatment for her daughter is proper consent, in circumstances where CD's father is absent and his views are not known.

Parental responsibility and consent to medical treatment

29 In Victoria, consent to medical treatment is governed by the *Medical Treatment Planning and Decisions Act 2016* (Vic). In brief summary:

- (a) Section 50 provides that, before a health practitioner administers medical treatment to a person who does not have decision-making capacity to make the medical treatment decision, the health practitioner must make reasonable

¹⁸ (2008) 40 Fam LR 122 (*Re Jules*).

¹⁹ *Re Jules*, [15].

efforts to ascertain if the person has (relevantly) a medical treatment decision maker. The definition of 'decision-making capacity' in s 4 is similar to the common law test of *Gillick* competence,²⁰ and it is uncontroversial that a child who is not *Gillick* competent does not have capacity to make medical treatment decisions.

(b) Section 55(4) provides that the medical treatment decision maker of a child is the child's parent or guardian or other person with parental responsibility who is reasonably available and willing and able to make the medical treatment decision. It is notable that this section uses the singular, although it is implicit that more than one person may have parental responsibility for a child.

(c) Division 2 of Pt 4 of the Act applies to medical treatment other than palliative care and special medical procedures.²¹ Under s 58(1), a health practitioner who proposes to administer medical treatment to which Div 2 applies to a person who does not have capacity for that medical treatment, must obtain or ascertain a medical treatment decision in accordance with Div 2. Relevantly here, that involves a decision by the person's medical treatment decision maker in accordance with s 61.

(d) Section 52(1) provides that a health practitioner who administers medical treatment to a person under Pt 4, who believes on reasonable grounds that the requirements of Pt 4 have been complied with, is not because of the administration of that medical treatment:

- (i) guilty of an offence;
- (ii) liable for unprofessional conduct or professional misconduct;

²⁰ See [18] above.

²¹ *Medical Treatment Planning and Decisions Act 2016* (Vic), s 57.

- (iii) liable in any civil proceeding; or
- (iv) liable for contravention of any code of conduct.

30 It is clear enough that a decision about medical treatment of a child may be made by a parent of the child who is reasonably available and willing and able to make the decision. Nothing in the Medical Treatment Planning and Decisions Act suggests that the consent of all persons with parental responsibility must be obtained. While s 61(4) obliges a medical decision maker to consult with others, a failure to consult does not of itself give rise to any liability for the medical decision maker.²²

31 This reflects the default position under the Family Law Act that each parent of a child has parental responsibility for the child, and may exercise this responsibility independently of each other. Section 61B of the Family Law Act defines 'parental responsibility' to mean, in relation to a child, 'all the duties, powers, responsibilities and authority which, by law, parents have in relation to children'. Parental responsibility includes the power to consent to medical treatment for a child who cannot yet do so – or, in the terms of the Medical Treatment Planning and Decisions Act, to be a medical decision maker for the child. Section 61C(1) of the Family Law Act provides that each of the parents of a child who is not 18 has parental responsibility for the child. The subsection has effect despite any changes in the nature of the relationships of the child's parents,²³ but subject to any order of a court.²⁴

32 In *B and B: Family Law Reform Act 1995*,²⁵ the Full Court of the Family Court considered the effect of the recently enacted *Family Law Reform Act 1995* (Cth), which had inserted Part VII—Children into the Family Law Act. The Full Court said the

²² Medical Treatment Planning and Decisions Act, s 61(5).

²³ *Family Law Act* 1975 (Cth), s 61C(2).

²⁴ Family Law Act, s 61C(3).

²⁵ (1997) 21 Fam LR 676 (*B and B*).

following about parental responsibility:²⁶

9.27 An important issue is whether parents may exercise this responsibility independently or whether they must do so jointly.

9.28 The UK Law Commission's report on family law, *Review of Child Law and Guardianship and Custody* (1988), suggested a need for joint but independent parenting, the consequence of which is that under the UK Act each parent may act independently of the other. As the Commission expressed it, "whether or not the parties are living together, a legal duty of consultation seems both unworkable and undesirable". It recommended that the equal and independent status of parents be preserved (absent actions such as adoption to which there is a statutory requirement of mutual consent). Although this provision has attracted some criticism in the United Kingdom, no such discussion appears to have preceded the introduction of the Reform Act in Australia. Section 60B(2)(c) and (d) respectively refer to parents sharing duties and responsibilities and agreeing about the future parenting of their children. Section 61C bestows parental responsibility on each parent, in the absence of a court order to the contrary. Section 64B(6) enables the court to make a joint specific issues order.

9.29 In the absence of a specific issues order, we think it unlikely that the parliament intended that separated parents could only exercise all or any of their powers or discharge all or any of their parenting responsibilities jointly in relation to all matters. This is never the case when parents are living together in relation to day-to-day matters, and the impracticability of such a requirement when they are living separately only has to be stated to be appreciated.

9.30 As a matter of practical necessity either the resident parent or the contact parent will have to make individual decisions about such matters when they have the sole physical care of the children. On the other hand, consultation should obviously occur between the parents in relation to major issues affecting the children such as major surgery, place of education, religion and the like. We believe that this accords with the intention of the legislation.

33 This approach to parental responsibility has been applied by the New South Wales Supreme Court in matters involving its *parens patriae* jurisdiction. In *Re Elm*,²⁷ Brereton J held:

Where (as is normal) two parents each have parental responsibility, either can exercise the duties, powers and rights of a parent separately (*In Marriage of Talbot* (1993) 113 FLR 273 at 275; 16 Fam LR 910 at 912, *In Marriage of Harrison and Woollard* (1995) 126 FLR 159 at 178; 18 Fam LR 788 at 805 (Fogarty J, Baker J and Kay J) and *In Marriage of B* (1997) 140 FLR 11 at 67-68; 21 Fam LR 676 at

²⁶ *B and B*, 730.

²⁷ (2006) 69 NSWLR 145, [19].

729-730.) Accordingly, a doctor who treated a child with the consent of one parent having parental responsibility would do so with consent, notwithstanding that the other refused consent.

- 34 His Honour held to similar effect in *Re Jules*, in which the Court consented to a baby being vaccinated against hepatitis B, where both parents had refused consent.²⁸ *Re Elm* and *Re Jules* were recently followed by Meek J in *Re Rosie (No 3)*.²⁹
- 35 The default position – that parental responsibility may be exercised independently by each parent – may be altered by a parenting order under the Family Law Act, for example an order requiring certain decisions to be made jointly,³⁰ or an order in relation to a specific issue.

Analysis

- 36 My analysis in this case turns on two matters.
- 37 First, there is no parenting order in relation to CD that might alter the default position that each person with parental responsibility for a child can, independently, make a medical treatment decision for the child. No one has invoked the jurisdiction of the Family Court to alter the usual distribution of parental responsibility, and the evidence indicates there is little likelihood of that occurring.
- 38 Second, the law is clear that stage 1 treatment is not a ‘special medical procedure’ requiring court approval. This was decided by the Full Court of the Family Court in *Re Jamie*, and was affirmed in *Re Kelvin*.³¹ As a result, the legal requirements for consent to stage 1 treatment for gender dysphoria are no different from those that apply to any other medical treatment to which a parent may consent – such as childhood vaccinations, surgery to mend a broken bone, or chemotherapy to treat cancer.

²⁸ *Re Jules*, [18].

²⁹ [2023] NSWSC 37, [73]–[78].

³⁰ See, for example, *Board of Studies, Teaching and Educational Standards v Vandenbovenkamp* [2016] NSWCA 268, [76]–[85] (Ward JA, Leeming and Payne JJA agreeing).

³¹ See [16]–[17] above.

39 Neither of these matters is affected by what Watts J said at [35](d) of *Re Imogen*. That was a different case, in a different jurisdiction, about a different family, in which there was a dispute between the parents about whether Imogen should undertake stage 2 treatment for gender dysphoria, and whether she could consent to that treatment on her own behalf. The statement that is said to have given rise to the legal uncertainty that prompted this application is clearly *obiter* – that is, it was not necessary for the decision, which was that Imogen was *Gillick* competent and that stage 2 treatment was in her best interests. There was no question in *Re Imogen* about consent to stage 1 treatment, and the views of both parents were known.

40 I should add that, even if the statement formed part of the *ratio*, as a decision of a single judge of the Family Court it would not be binding authority for a judge of the Supreme Court of Victoria. It would, at most, be persuasive authority.

41 There are two decisions of the Family Court of Western Australia and one decision of the Family Court in which the *obiter* statement at [35](d) of *Re Imogen* has been applied as if it had legislative effect.³² None of those decisions is binding on a judge of the Supreme Court of Victoria. I do not consider that they correctly state the law in relation to consent to stage 1 treatment for gender dysphoria. In particular, I do not agree that it is necessary to seek court approval for that treatment only because the affirmative consent of an absent parent has not been obtained.

42 I have reached that view as a result of three decisions of the Full Court of the Family Court that do bind me: *B and B*, *Re Jamie*, and *Re Kelvin*.³³ In combination, those decisions require the conclusion that AB has power to consent to stage 1 treatment for CD, independently from CD's absent father. In other words, AB's consent is sufficient.

43 It is concerning that an *obiter* statement of a single judge of the Family Court has

³² *Re G4*, [25]–[27], [43]; *Re Kelly*, [41]; *Re G9*, [22].

³³ *Farah Constructions Pty Ltd v Say-Dee Pty Ltd* (2007) 230 CLR 89, [135].

created additional uncertainty for families like CD's where one parent has been absent from the child's life for many years, effectively abdicating their parental responsibility. It is difficult to see how it could be in a child's best interests to re-initiate contact with an absent parent for the sole purpose of ascertaining whether they consent to this particular form of medical treatment, when the absent parent has not otherwise been involved in medical decision-making for the child. Having regard to AB's evidence, in particular her second affidavit, I am well satisfied that it would not be in CD's best interests to seek out her father at this juncture.

44 It follows that AB's consent to stage 1 treatment for CD is sufficient, and is not undermined by the absence of consent from CD's father.

Disposition

45 The Hospital urged me to make a declaration that AB had validly consented to stage 1 treatment for CD. I do not consider that it would be an appropriate exercise of the Court's *parens patriae* jurisdiction to make that declaration.

46 The primary reason for that is that CD already has a parent who is exercising parental responsibility for her and who has given informed consent to stage 1 treatment. There is no need for the Court to assume parental responsibility, because AB is already exercising it with love and care, and in CD's best interests. I consider that in this case, in this family, AB's consent to stage 1 treatment for CD is enough.

47 The second reason is that a declaration of the kind sought by the Hospital would have no utility. It would determine no controversy, would bind no one but the Hospital, and would not remove any legal barrier to providing treatment. My reasons for decision should resolve the legal uncertainties that have troubled the Hospital in this case.

48 For those reasons, the Hospital's application will be dismissed. There will be no order as to costs.

