**COMMENTARY**

**A BACKWARDS-STEP FOR *GILLICK*: TRANS CHILDREN’S INABILITY TO CONSENT TO TREATMENT FOR GENDER DYSPHORIA *– Quincy Bell & Mrs A* v *The Tavistock and Portman NHS Foundation Trust and* *Ors* [2020] EWHC 3274 (Admin)**

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**ABSTRACT**

The case of *Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors* is a Judicial Review into the treatment practices of the Gender Identity Development Service (GIDS) run by Tavistock NHS Trust. The Divisional Court considered whether children and young people with Gender Dysphoria can ever be *Gillick* competent to consent to treatment with Puberty Blockers, and if so whether GIDS provided sufficient information to support an informed consent. This commentary examines the six key areas of the judgment: the nature of Gender Dysphoria and its treatment with Puberty Blockers; the categorisation of Puberty Blockers as experimental treatment; the high bar set to achieve *Gillick* competence; the convergence of information provision and competence; the role of parental consent; and finally the protective jurisdiction of the court. The conclusion of the court that transgender children aged under 16 will find ‘enormous difficulties’ in reaching the *Gillick* threshold to be able to consent to Puberty Blockers, and that even 16-17 year olds would benefit from a ‘best interests determination’ from the court, signals judicial thinking which is markedly protectionist. Considering the broad contemporary stance in healthcare of facilitating competence, valuing patient participation and respecting rights, I argue that this judgment is out of step. It has implications not only for transgender children, but it may be a worrying signal of a greater general retreat from *Gillick* and a corresponding advance in emphasis on judicially determined best interests.

**KEYWORDS:** Children, Decision-Making, Experimental Treatment, Gender Dysphoria, Gillick Competence, Transgender.

I.**INTRODUCTION**

It is tempting to view the Judicial Review into the treatment practices of the Gender Identity Development Service (GIDS) in *Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors[[1]](#footnote-1)* as acase about transgender children and the courts’ declaration on their likely inability to consent to treatment with Puberty Blockers (PBs) for Gender Dysphoria (GD). Doubtless, context is important. Sitting within the wider discussion about trans rights,[[2]](#footnote-2) the case illustrates the ‘societal polarisations and tensions’[[3]](#footnote-3) between concerns over the nature and purpose of treatment for GD, and the ever increasing demand for children’s gender identity services.[[4]](#footnote-4) Nor, should the impact of the judgment in *Bell* on the lives of some individual trans children be underestimated.[[5]](#footnote-5) Nonetheless, the significance of *Bell* is wider reaching than all of this. Whilst most of the case-law over the 35 years since the House of Lords created the test for child competence [[6]](#footnote-6) has focused on judicial reluctance to permit child treatment refusal, the High Court in this case squarely confronts the ability of children to positively *consent* to treatment – and in my view, comes to an untenable conclusion.

The judgment contains six key features that I will discuss in this commentary. First, the court’s uneasiness around the concept of GD and its diagnosis. Second, the novel labelling of PB’s as “experimental” treatment. Third, the court’s very narrow interpretation of *Gillick* competence to consent. Fourth, the problematic convergence of information provision and competence. Fifth, the surprising absence of consideration of parental consent. Sixth, the protectionist role of the court, and the determination of best interests in trans treatment cases.

Overall, the result is a judgment which is markedly protectionist. Considering the broad contemporary stance in healthcare of facilitating competence, valuing patient participation and respecting rights,[[7]](#footnote-7) I argue that this judgment is out of step. Even in the more welfare focused arena of child decision-making, it seems contrary to the intention of both the statutory provisions[[8]](#footnote-8) and common law tests[[9]](#footnote-9) aimed at permitting children to exercise autonomy in consenting to treatments that affect their own bodies and well-being. Whether, this stance of the court is specific to its context or is a worrying signal of a greater general retreat from *Gillick* and a corresponding advance in emphasis on judicially determined best interests, remains to be seen.

**II.BACKGROUND**

The starting point in relation to children’s healthcare decision-making is the presumption that under 18s lack decisional competence and those with parental responsibility will act as proxy decision-makers in accordance with the Children Act 1989.[[10]](#footnote-10) Before the courts, decisions are made in accordance with the child’s welfare,[[11]](#footnote-11) - a principle also enshrined in Article 3 of the United Nations Convention on the Rights of the Child (UNCRC). However, the law recognises that some children are capable of making their own decisions about their health. Under the Family Law Reform Act 1969 (FLRA), the consent of young people aged 16-17 to medical treatment is acknowledged to be as effective as if they were adults.[[12]](#footnote-12) For under 16s, *Gillick v West Norfolk and Wisbech* *AHA, [[13]](#footnote-13)* sets a threshold test of child competence, reached when a child demonstrates ‘sufficient understanding and intelligence to enable him or her to understand fully what is proposed’.[[14]](#footnote-14)

This seemingly strong position regarding children’s participatory rights is affirmed under Article 12 of the UNCRC. Yet, the *Gillick* and FLRA provisions have come under increasing strain;[[15]](#footnote-15) particularly when applied to treatment refusal.[[16]](#footnote-16) However, it is vital not to lose sight of the fact that *Bell* is a case about treatment *consent*. Consent cases are few and far between; a notable recent example being *An NHS Trust* v *ABC,[[17]](#footnote-17)* where, as I have written elsewhere,[[18]](#footnote-18) the court encouragingly took an unambiguous stance to a finding of *Gillick* competence as ‘the end of the matter’, permitting the child to make a determinative choice.[[19]](#footnote-19) Taken with the strong statement issued by the Academy of Medical Royal Colleges in June 2020 affirming the importance of *Gillick*,[[20]](#footnote-20) suggests a clear position regarding consent. However, a month after *Bell,* a judgment was handed down in *Re X (A Child),[[21]](#footnote-21)* where Sir James Munby rejected the claimant’s argument that traditional approaches had not kept up with changes in children’s rights, the Mental Capacity Act 2005 (MCA), or ideas around patient autonomy. He upheld the court’s right of veto over not only child refusal, but also consent. I agree with Cave’s assessment that *Re X* ‘is a blow to children’s rights to be heard’,[[22]](#footnote-22) as is the judgment in *Bell.*

**III. FACTS AND REASONING**

This case was a judicial review of the practices of The Tavistock and Portman NHS Foundation Trust. Although the judgment did not reveal the precise grounds founding the application for judicial review, it related to the legal requirements of the process of obtaining consent for treatment provided through GIDS for children (aged 10-15) and young people (aged 16-17) experiencing GD. In particular, the court was asked to review the use of gonadotropin-releasing hormone agonists (GnRHa); a type of puberty blocker (PB) used to supress the progress of puberty.[[23]](#footnote-23) Upon referral by GIDS, PBs were administered by clinicians at either University College London Hospital or Leeds NHS Trusts.[[24]](#footnote-24) GIDS’ treatment protocol has three possible stages of intervention, with stage 1 being the administration of PB’s, possibly followed by stage 2 cross-sex hormones (CSH), and stage 3 surgery.[[25]](#footnote-25) The practice of GIDS and the Trusts was to administer these treatments on the basis of the valid consent of the competent child patient, rather than seeking consent from those with parental responsibility.[[26]](#footnote-26) The claim for judicial review was bought by Keira Bell, a former patient of GIDS, who had chosen to de-transition,[[27]](#footnote-27) and Mrs A, the mother of a 15-year old daughter with Autistic Spectrum Disorder who objected to a potential referral to GIDS.[[28]](#footnote-28) Their case contained two claims: First, that the information given by GIDS to under 18s is ‘misleading, and insufficient’[[29]](#footnote-29) to ensure they can give informed consent. Second, that no child under 18 is *Gillick* competent to consent to the administration of PBs.[[30]](#footnote-30) GIDs and both Trusts denied these claims, contending that their practices were compliant with NHS Service Specifications and International Frameworks.[[31]](#footnote-31)

The court declared that the question of *Gillick* competence must come before that of information sufficiency, and tackled the claims in that order.[[32]](#footnote-32) They held that the administration of PBs for GD is rightly categorised as an ‘experimental treatment’, due to the lack of evidence of the short and long-term consequences, its efficacy, or its purpose.[[33]](#footnote-33) They produced six key principles; first, whilst *Gillick* competence was decision and person-specific, the more significant and life-changing a decision the greater the onus on understanding, and second, that lines could be drawn below which no child could be deemed competent.[[34]](#footnote-34) Third, that clinicians should work with children to help them achieve *Gillick* competence, but that, fourth, not every child under 16 will achieve this. Fifth, that the bar should not be set too high; in particular that the level of information provision set out in *Montgomery v Lancashire Health Board*,[[35]](#footnote-35) is not necessary for achieving *Gillick* competence.[[36]](#footnote-36) Sixth, that in deciding salient facts and sufficient understanding ‘it is necessary to have regard to matters which are those which objectively ought to be given weight in the future’ – including impact on fertility and future sexual functioning.’[[37]](#footnote-37)

In conclusion, the categorisation of PBs as “experimental treatment” plus the assertion that their commencement inevitably leads to CSH,[[38]](#footnote-38) required the child to understand the nature and consequences of *both* treatments to attain competence to consent to PBs [[39]](#footnote-39) – a high bar indeed.[[40]](#footnote-40) Stressing for *this* particular context and for *this* cohort of patients, the court deemed specific guidance to be necessary. Declaring that there would be ‘enormous difficulties’ in under 16s understanding and weighing the necessary information, they added that it would be ‘highly unlikely’ that under 13s would be *Gillick* competent and ‘doubtful’ for 14-15-year olds. [[41]](#footnote-41) A ‘best interests determination’ would be necessary,[[42]](#footnote-42) and despite the legal presumption of competence, [[43]](#footnote-43) doctors may seek prior authorisation even for 16 and 17-year olds.[[44]](#footnote-44)

By way of post-script, *AB v CD & Ors,[[45]](#footnote-45)* came before the High Court in March 2021. AB, sought a declaration that she had the legal ability to consent to the administration of PBs on behalf of her 15-year old trans daughter who was currently receiving PBs under the care of GIDS, and was therefore directly affected by the judgment in *Bell.* The court considered whether parents retain ‘a concurrent right’ to consent with a *Gillick* competent child, and whether PBs fall into a “special category” of medical treatment requiring an application to the Court.[[46]](#footnote-46) Relevant parts of this judgment are referred to in the analysis below.

**IV. CRITICAL ANALYSIS**

1. *Gender Dysphoria*

It is pertinent to begin where the court began – with an examination of the context of decision-making. This is important because, as per Lord Scarman in *Gillick*, ‘the courts should establish a principle flexible enough to enable justice to be achieved by its application to the particular circumstances (…)’[[47]](#footnote-47) - in other words competence is determined on a person-specific and decision-specific basis. The court rightly noted that it was not its role to assess the merits or efficacy of the treatment in question; that is a job for the clinicians, but that ‘[t]he sole legal issue’ is the circumstances in which the child may be competent and the process of obtaining consent.[[48]](#footnote-48) Yet, with 17 pages given over to an examination of GD and its treatment demonstrated the difficulty in disentangling these two tasks. Whilst it is not my purpose to comment on the appropriateness of PBs, I agree with Duffy’s assessment that the court in *Bell* took a ‘particularly pathologised’ approach to trans identity.[[49]](#footnote-49) Judicial reticence is perhaps understandable given the poor evidence base presented to the court.[[50]](#footnote-50) Nonetheless they drew some questionable conclusions from the data that *was* available. Adopting the psychological diagnosis of GD as found in the DSM-5,[[51]](#footnote-51) the court expressed concern about statistics given on age distribution, gender split and co-morbidities. Patients were labelled as ‘vulnerable young people’,[[52]](#footnote-52) and treating GD with PBs painted as different to other interventions, given it was a condition with ‘no direct physical manifestation’ but a treatment with ‘direct physical consequences’.[[53]](#footnote-53) First, this stress on a mind/body split is questionable, with the implication that mental conditions are taken less seriously than physical ones. Second, stating that PBs are a different intervention is inaccurate when lots of treatments for mental disorders have physical implications, such as antidepressants increasing the level of serotonin in the brain, or Electro-Convulsive Therapy triggering seizures.

Additionally, the multiplicity of reasons for administering PBs, such as buying “time to think”, reducing suicidal ideation, or facilitating easier transition to CSH or surgery, was portrayed as giving rise to ‘dispute’.[[54]](#footnote-54) I question the need for a sole purpose – multiplicity of reasons does not undermine authenticity of action. There was particular scepticism of the “time to think” justification, contending that ‘the treatment might be supporting persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself’.[[55]](#footnote-55) This reveals an attitude to persistence as a negative outcome, evidenced by the claim that ‘[t]he use of puberty blockers is not itself a neutral process by which time stands still for the child on PBs’.’[[56]](#footnote-56) But neither is non-intervention a neutral process.[[57]](#footnote-57) Very little consideration was given to the ‘the physical and psychological consequences of requiring a child to go through the “wrong” puberty’.[[58]](#footnote-58) Children on PBs will not skip puberty completely, it will just be delayed until they cease PBs, or take CSH. There is little purpose in preventing children from accessing PBs until an age when natal pubertal changes are largely complete, especially when administrating PBs early can be ‘life savers’.[[59]](#footnote-59) Much was made of treatment regret, with Bell’s story serving as an example, however she did not commence treatment until she was 16, so the relevance of her story to the issues before the court was questionable. Additionally, Giordano identifies a conceptual confusion between de-transition, regret and unfavourable outcomes - de-transition does not necessarily indicate regret of PBs.[[60]](#footnote-60)

Whilst acknowledging that GIDS see PBs and CSH as two separate treatments,[[61]](#footnote-61) the court relied on testimony of Dr de Vries that only 1.9% of patients did not progress to CSH.[[62]](#footnote-62) This resulted in a problematic conflation of the two stages, with the judges agreeing that ‘commencing PBs in practice puts a young person on a virtually inexorable path to taking CSH’.[[63]](#footnote-63) This cannot be correct. First, as Duffy contends ‘correlation is not destiny’.[[64]](#footnote-64) Indeed, it maybe that GIDS processes are so thorough that only the most persistent and severe cases of GD are prescribed PBs, and therefore evidence of large percentages continuing to CSH is validation that GIDS “got it right”. Second, the court declined to appreciate that only 16% of patients utilise the endocrine services, with only 8.7% approved for CSH.[[65]](#footnote-65) GIDS stress that they are ‘primarily a psycho-social service’.[[66]](#footnote-66) This conflation aided categorisation of treatment as ‘lifelong and lifechanging in the most fundamental way imaginable’ (…) which ‘goes to the heart of the individual’s identity’.[[67]](#footnote-67)

1. *Experimental Treatment*

The factor that had the most impact on the final outcome of the case was the court agreeing with the claimants’ argument that the administration of PBs is a treatment which is experimental, with a very limited evidence-base, and highly controversial.[[68]](#footnote-68) Lieven J in *AB* also noted *Bell’s* analysis on this was ‘highly relevant’.[[69]](#footnote-69) Yet, it is difficult to see how PBs are rightly categorised as “experimental”. As Duffy explains ‘the international evidence base for their use shows them to be both safe and reversible’.[[70]](#footnote-70) Giordano and Holm’s persuasive rebuttal demonstrates PB’s long history of use in children with endometriosis and precocious puberty, and that professional guidance for GD has existed for over 20 years.[[71]](#footnote-71) They explore, and dismiss, objections raised in the case including PBs being “off label” and unknown long-term effects.[[72]](#footnote-72) In *Bell*, Professor Butler for UCLH contended that use of “off-label” paediatric treatments was common,[[73]](#footnote-73) and Giordano and Holm confirm that unlicenced does not mean unevidenced. Instead, doctors employ “ethical prescribing” to determine patient benefit. [[74]](#footnote-74) They also reject the label of “experimental” merely because of unknown long-term effects, for example on bone-density or reproductive capability, as most drugs have unknown long-term effects when initially marketed. Nor can individual responses be predicted, or effects of PBs be disentangled from those of other life-style or health factors.[[75]](#footnote-75)

There is a precedent for a different approach to experimental treatment. In *Simms v Simms,* the administration of truly experimental treatment to two incapacitous teenagers suffering from vCJD, was justified by contending that ‘a patient who is not able to consent to pioneering treatment ought not to be deprived of the chance (…)’.[[76]](#footnote-76) In the adult context, *UCLH & Ors v KG* authorised the use of novel treatment PRN100 for a middle-aged man with CJD.[[77]](#footnote-77) However, Lieven J in *AB* rejected these cases as being unhelpful, as they involved fatal conditions with no alternative treatment. She claimed that PBs raised different issues, ‘[i]n particular, the child is not facing a terminal illness, and the treatment has life-changing and life-long consequences, the implications of which are not fully understood’.[[78]](#footnote-78) This assessment shows the same conflation with CSH as seen in *Bell.* Whilst true that GD is not fatal in the sense that CJD is, nor are PBs “experimental” in the sense that PRN-100 is. Lieven J’s appraisal reveals a lack of insight into both the nature of GD and the purpose of PBs. Aside from psychological therapy, there is no alternative treatment. The level of suicidal ideation means that untreated severe GD can be fatal.[[79]](#footnote-79) I agree with Fletcher, even if PBs *are* rightly categorised as experimental, why is a negative view, effectively denying children access to them, inevitable?[[80]](#footnote-80)

The implications of categorising PBs as experimental treatment are two-fold. First, it meant a significant raising of the bar of *Gillick* competence, with the court claiming it ‘does go to the critical issue of whether a young person can have sufficient understanding of the risks and benefits to be able lawfully to consent to that treatment’.[[81]](#footnote-81) Second, it raised questions around parental rights to consent on behalf of their child, or whether PBs would require court authorisation because they constitute a “special category”. Parental consent was quickly dismissed in *Bell*, but was the focal question in *AB.*

1. *Gillick Competence*

The key questions for the court were whether under 18s could ever be *Gillick* competent to consent to PBs, and if so, whether information provision was sufficient.[[82]](#footnote-82) They began with a rather puzzling examination of case-law, focusing on two treatment refusal cases, and a third consent case, but in the context of adoption.[[83]](#footnote-83) Relying on the precedent in *Re W,[[84]](#footnote-84)* the court affirmed its ability under the inherent jurisdiction to override treatment decisions of even 16-17 year olds and tied the FLRA provision to a presumption of *Gillick* competence.[[85]](#footnote-85) This is problematic given that the FLRA states a 16-17 year old can give consent as if they were an adult. Therefore, this should be akin to capacity under the MCA, which applies to over 16s[[86]](#footnote-86) and recognises the right to consent to and refuse treatment that can only be overridden in cases of incapacity - [[87]](#footnote-87) which is apparently not so under *Gillick*. *Re L[[88]](#footnote-88)* and *Re S,[[89]](#footnote-89)* deemed to involve ‘difficult medical and ethical situations’,[[90]](#footnote-90) were found to be instructive. From *Re L* the court focused on the impact of limited life experience,[[91]](#footnote-91) presumably to suggest that children with GD do not have sufficient experience to make the decisions they are tasked with. This is disputable, as these children may have many years of lived experience of GD, thus gaining insights which no amount of adult experience will be able to provide. From *Re S* they drew attention to Cobb J’s use of MCA concepts and language in determining *Gillick* competence[[92]](#footnote-92) - an idea that has appeared in several recent child cases, perhaps suggesting that the *Gillick* test needs further clarification and that capacity under the MCA is analogous. Munby J’s judgment in *Re X* may cast doubt on this, as he disagreed with *Bell’s* assessment of the relationship of *Gillick* to MCA capacity. Proclaiming that MCA capacity and *Gillick* competence ‘are…both historically and conceptually quite distinct’ due to their origins in different areas of scientific knowledge, the former being in the realm of psychiatry whilst the latter in child developmental psychology, he concluded that the MCA has ‘nothing to say’ about children of any age who are *Gillick* competent.[[93]](#footnote-93) Whilst, there may be a valid point here for under 16s this reasoning is less convincing for 16-17 year olds. Additionally, on information provision the court in *Bell* approved of Cobb J’s finding that *Gillick* competence required a demonstration of ‘sufficient understanding of the salient facts’ and not those which were ‘peripheral’.[[94]](#footnote-94)

Contrary to the protectionist reasoning gleaned from *Re L* and *Re S,* had the court considered consent cases they would have seen strong statements about children’s rights. In *NHS Trust v ABC & a Local Authority,* Mostyn J holds that it is implicit that if the *Gillick* threshold is reached, then a child is free to choose a treatment ‘even if the result of that would lead her to take steps which are wholly contrary to her best interests’. [[95]](#footnote-95) *PD v SD*, a case involving a16 year-old trans boy’s desire to keep his GIDS treatment confidential from his adoptive parents, saw Keehan J proclaim that consent to medical treatment (by implication this involves PBs or CSH) is valid by virtue of the FLRA[[96]](#footnote-96)

Feeding in their assessments on the nature of GD and the categorisation of PBs as experimental, the court produced six key principles, as outlined in section III above. The determination that PBs are ‘significant and life changing’ seems to stem from the problematic conclusion that the consequences which ‘flow from’ taking PBs necessarily include those that come from taking CSH and to undertake separate *Gillick* assessments for each ‘does not reflect the reality’.[[97]](#footnote-97) The requirement that the child should show sufficient understanding of the salient facts,[[98]](#footnote-98) indicates that information provision *is* used as an aspect of achieving *Gillick* competence, despite the claims of the court to keep the two issues separate. Additionally, there is a disconnect between the requirement for an explanation ‘in broad terms’, yet the need to understand ‘salient facts’; the nature of which maybe such that ‘*Gillick* competence cannot be achieved, however much information and supportive discussion is undertaken’.[[99]](#footnote-99) Eight factors were listed that a child has to understand, retain and weigh,[[100]](#footnote-100) (again, referring to MCA principles), [[101]](#footnote-101) most of which conflated PBS and CSH. First, the immediate physical and psychological consequences of treatment. Second, that they are on a pathway where the majority go on to take CSH. Third, the relationship between CSH and surgery (and its implications). Fourth, that CSH may lead to loss of fertility. Fifth, the impact of CSH on sexual function. Sixth, the impact on future and life-long relationships. Seventh, the unknown physical consequences of taking PBs. Eighth, that the evidence base is highly uncertain. [[102]](#footnote-102) These eight factors can be summed up as all of the (real and perceived) risks and none of the benefits!

The implications of this finding are hugely concerning. Requiring children to understand factors which relate not only to PBs but also to CSH,[[103]](#footnote-103) undermines the decision-specific principle set out in *Gillick*. The court contends that the child’s understanding of how loss of fertility will affect their adult life, or their attitude to having biological children or experiencing sexual fulfilment, is ‘likely to change between childhood and adulthood’.[[104]](#footnote-104) This goes far beyond Lord Fraser’s requirement of understanding ‘moral and family’ questions in *Gillick*,[[105]](#footnote-105) and is unfair to expect 13-year olds to understand factors that relate only to CSH, which they are ineligible to receive until at least 16. As Duffy posits, the courts have chosen to ‘use a reasonable-person standard that it is holding high above the heads of children’.[[106]](#footnote-106) It is questionable whether these issues are much easier to understand even at 18, yet adult decision-making is unfettered despite the marked difference in outlook and experience between young adults and the middle-aged. Relying on evidence of neuroscientist Professor Scott, the court was persuaded that under 18s making “emotional” decisions are more likely to make different, more risky decisions than adults.[[107]](#footnote-107) But Giordano, Garland and Holm question the invalidation of decision-making due to emotional investment.[[108]](#footnote-108) Many healthcare decisions, such as abortion or organ transplantation, would equally involve strong feelings. Indeed, ‘there is nothing emotionally special about the treatment of gender diverse minors’.[[109]](#footnote-109) The court in *Bell* went further still, by also undermining person-specificity. It set out broad age-based categories and concluded that within them *Gillick* competence of trans children of under 13 was ‘highly unlikely’ and for 14 and 15-year olds ‘very doubtful’.[[110]](#footnote-110) This could be a reaction to the court’s apparent worry that the assessment process was not robust enough because ‘it was extremely unusual for either GIDS or the Trusts to refuse to give PBs on the ground that the young person was not competent to give consent’.[[111]](#footnote-111) Fletcher rightly observes that this blanket approach is contrary to the trend towards facilitating capacity in a person-specific way, and directly pits issues of functionality against those of status.[[112]](#footnote-112) It is also in opposition to the paramountcy of the welfare of the individual child as per the Children Act 1989.[[113]](#footnote-113)Categories undermine the spirit of *Gillick* where Lord Scarman observed that ‘[i]f the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change’.[[114]](#footnote-114) Not only this, as Mermaids notes, the judgment treats ‘trans young people and their rights differently from their peers, simply because they are trans’,[[115]](#footnote-115) potentially in contravention of the Equality Act 2010 where gender reassignment is a protected characteristic.

1. *Information Provision*

The second question the court tackled was that of informed consent. This separation from competence was promising, suggesting a pattern more often seen in adult cases. Whereas the presumption of incompetence for children had lead to information insufficiency being used to deny competence, when the child otherwise reached the *Gillick* threshold.[[116]](#footnote-116) GIDS stated that it was their practice to require ‘informed consent’ from the child,[[117]](#footnote-117) but the claimants argued that advice given to children about PBs was misleading on reversibility, purpose and benefits.[[118]](#footnote-118) The court considered arguments from counsel on the appropriate level of information provision and understanding,[[119]](#footnote-119) including a submission that the patient-centred approach in *Montgomery* was of limited relevance given it involved adult decision-making and founded on the presumption of capacity found in the MCA.[[120]](#footnote-120) Whilst GIDS and the Trusts said their processes were ‘deeply Montgomery compliant’,[[121]](#footnote-121) it *is* questionable that *Montgomery* applies to children at all. Cave and Purshouse characterise this doubt as arising from the double obstacles of best interests decision-making, combined with the provision of proxy consent.[[122]](#footnote-122)

The courts rightly rejected a *Montgomery* level of understanding for competence,[[123]](#footnote-123) and held that the correct approach was that ‘the child must have sufficient understanding of the salient factors’.[[124]](#footnote-124) However statements such as ‘[t]here is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years’,[[125]](#footnote-125) suggests a requirement for a detailed level of knowledge beyond that necessary to found a finding of competence. As Fletcher notes, [[126]](#footnote-126) this basic standard necessary to determine competence and avoid battery, has been conflated with the *Montgomery* standard, which concerns actions in negligence and requiring a higher level of information provision.[[127]](#footnote-127) Sufficient information is one of the three legs of a valid consent, but the lack of it is NOT something that should automatically undermine *Gillick* competence.

*E .Parental Responsibility*

Suprisingly, the court declined to consider whether parents had the right to consent in the child’s best interests, stating that ‘[i]t follows that is not necessary for us to consider whether parents could consent to the treatment if the child cannot lawfully do so because this is not the policy or practice of the defendant and such a case could not currently arise on the facts’.[[128]](#footnote-128) This is strange, as a finding of incompetence normally drives the court towards best interests decision-making. As White and Newbegin observe, if GIDS policy is not to treat without parents being on board, then they are already obtaining parental consent, or at least approval.[[129]](#footnote-129) This judicial reluctance is incongruous when the court was willing to undermine GIDS consent processes with blanket categories and requiring court authorisation, despite all parties being in agreement as to best interests - a situation the Good Law Project’s lawyers were ‘unable to identify any precedent in English Law for’.[[130]](#footnote-130)

*AB* did tackle the issue, considering whether parents retained a concurrent right of consent with a *Gillick* competent child. Lieven J adopted the analysis from *Bell* on the nature of PBs, experimental treatment, reversibility and treatment-pathway.[[131]](#footnote-131) What was less clear was whether a finding of competence and a child wishing to consent, terminated the parental right to consent*. Re X* was reviewed, and whilst Munby J upheld *Re W* and *Re R*,[[132]](#footnote-132) Lieven J concluded that as the case did not concern concurrent consent, it took her no further forward. [[133]](#footnote-133) Encouragingly, she distinguished her reasoning from the stark protectionism seen in *Re X*, declaring that ‘[t]he very essence of *Gillick* is, in my view, that a parent’s right to consent or “determine’ treatment cannot trump or overbear the decision of the child. (…) I cannot accept that Lord Scarman was drawing the distinction between the child making the decision and the parent being able to give legally operative consent that Lord Donaldson seems to have drawn in *Re R’*. [[134]](#footnote-134) Her conclusion was that parents do retain a concurrent right to consent to PBs, only to be utilised where a competent child does not object, or where she is incompetent.[[135]](#footnote-135) On the second issue, as Jackson observed, the only scenario where case law has restricted parental responsibility and required authorisation of the court is sterilisation/ hysterectomy.[[136]](#footnote-136) I would question whether the administration of PBs are in any way analogous to sterilisation. After considering the reasoning in the child sterilisation cases, *[[137]](#footnote-137)* and similar cases involving incapacitated adults,[[138]](#footnote-138) Lieven J observed a move away from court authorised special categories, in favour of parental consent if Drs were satisfied that the procedure was for therapeutic purposes.[[139]](#footnote-139) Acknowledging no special restriction ‘[i]n all other contexts, including whether a parental decision will lead to a child’s life ending,[[140]](#footnote-140) the court held parents will be in the same position to exercise their right to consent as for any other medical treatment.

Whilst hailed as a hugely significant decision, [[141]](#footnote-141)*AB* is not without its problems. As a pragmatic solution it will only be helpful to children with supportive parents.[[142]](#footnote-142) However, it does nothing to address the fundamental curtailing of the scope of *Gillick* and undermining of competent children’s rights to consent to legitimate medical treatment. The perceived distinction between parents, as adults with full-capacity, and children, led the court to claim that the factors in *Bell* did not justify removing parental rights to consent as although‘[t]he experimental nature of the PBs should give any parent pause for thought, (…) parents can and do routinely consent on their child’s behalf to experimental treatment, sometimes with considerable, including life-changing, potential side-effects’.[[143]](#footnote-143) I contest the strength of this distinction. Whilst parents may have certain insights, they lack the thing that trans children have first-hand experience of - the embodied reality of living with GD.

*F. Best Interests and the Protective Role of the Court*

The outcome of *Bell* was a declaration that any decision for under 16s on the administration of PBs would need a best interests determination by the court, [[144]](#footnote-144) and that this might be appropriate for 16-17 year olds, if there is any doubt about long-term best interests.[[145]](#footnote-145) For older adolescents this contradicts both the FLRA and MCA presumptions of capacity, and undermines the court’s own statement that they cannot ‘adopt an intrusive jurisdiction in relation to one form of clinical intervention’.[[146]](#footnote-146) The court’s claim of real benefit in judicial oversight[[147]](#footnote-147) is questionable, given Jackson’s observation that the added stress and potential months long time-delay, would leave the child in limbo.[[148]](#footnote-148) This approach is also out of step with international norms, as seen in a series of Australian cases beginning where *Bell* finishes, with *Re Alex* in 2004 declaring that PBs were ‘special medical treatment’ requiring the authorisation of the court. [[149]](#footnote-149) Yet by 2017, Australian jurisprudence both removed this label and deemed both PBs and CSH to be separate stages,[[150]](#footnote-150) to which either competent supported children or parents could consent, without court approval.[[151]](#footnote-151) In *AB*, Lieven J said the court in *Bell* saw the position with GD and PBs differently than the Australian courts. [[152]](#footnote-152) Indeed, the truth of this is illustrated in the difference in language, as exemplified in *Re Jamie* where the court held that it would be contrary to the UNCRC and *Gillick* ‘to hold that there is a particular class of treatment (…) that disentitles autonomous decision-making by the child’.[[153]](#footnote-153) They went on to say that ‘treatment for something as personal and essential as the perception of one’s gender and sexuality would be the very exemplar of when the rights of the Gillick-competent child should be given full effect’.[[154]](#footnote-154) I suggest that the Australian approach is the correct one. The resource implications of holding best interests hearings were quickly dismissed as ‘not the correct approach’ because the court’s role is to protect children.[[155]](#footnote-155) Yet, as Lock explained, family division judges would have to find space for up to 500 additional cases a year, the challenges of which are ‘not insignificant’.[[156]](#footnote-156) Given that all parties are in agreement about the treatment, the precise role of the court in the best interests assessment is also questionable.[[157]](#footnote-157) It could become a pointless check-box exercise, or if the reticence around PBs was adopted by later courts, it is unlikely that the treatment would ever be in the child’s best interests.

The overall flavour of the of the judgment in *Bell* was a protectionist one, creating a particular view of trans children as an anomalous group, fuelled by a view that PBs would undermine valuable “normal” social experience, noting that ‘the child or young person will have missed a period, (…) of normal biological, psychological and social experience through adolescence’ something that ‘can never be truly recovered or “reversed”.’[[158]](#footnote-158) Recognising the clash between autonomy and welfare flagged up by GIDS, [[159]](#footnote-159)the court nonetheless concluded ‘this treatment to be one where the protective role of the court is appropriate’.[[160]](#footnote-160) Drawing on psychological distress not as a symptom that needed alleviating through treatment, but as a character facet which makes trans children ‘highly vulnerable’. Yet, at the same time down-playing the weight of distress, with the court contending that trans children see the trade-off in fertility or sexual function as a result of endocrine treatments as a ‘small price to pay’ and that they do not always consider the longer-term consequences as ‘perhaps a statement of the obvious’.[[161]](#footnote-161) However, lauding adult experience over that of the child, reveals something more fundamental about how we view children, something captured in Crompton’s injunction that ‘we need to consider children as complete entities rather than simply immature adults’.[[162]](#footnote-162) Protectionist reasoning acts to obscure this. Zimmermann frames the question we really need to ask as ‘not so much a question as to whether a child should be recognized as having a capacity to give informed consent, but whether a person, who happens to be a child, bears such a capacity’.[[163]](#footnote-163)

**V. CONCLUDING THOUGHTS**

Criticised as being ‘introduced with ugly and undue haste’,[[164]](#footnote-164) the first consequence of the judgement was immediate amendments made by the NHS to GIDS Service Specification,[[165]](#footnote-165) barring GIDS from making new referrals for PBs without court authorisation, and requiring a full clinical review of each existing case to ascertain the necessity of a best interests hearing if prescription of PBs or CSH were to continue. For capacitous 16-17-year olds, treatment could continue on condition of the unanimous agreement of the parties. GIDS response was one of disappointment,[[166]](#footnote-166) whilst Mermaids questioned the blanket response of the NHS to treatment for all under 16s, given that the judgment itself was more subtle in its categories, and lamented the change ‘has resulted in many young people and family members terrified for their future’.[[167]](#footnote-167)Leave to appeal the judgment was granted by the Court of Appeal with the hearing listed for 23 June 2021. Meanwhile, as a result of the judgment in *AB*, the service specification was updated in April 2021, to indicate that parental consent could be relied upon for under 18s already being prescribed PBs, *if* there is full alignment between child, parents and GIDS that it is in the child’s best interests and supported by the new independent multi-professional review group that has been set up as an additional safeguard in response to the courts suggestions in *AB*.[[168]](#footnote-168)

 *AB* has addressed some of the issues arising from *Bell,* butI agree with Lock that whilst ‘*AB* could be seen as being “round 2” of *Bell v Tavistock*…that would not be wholly accurate’.[[169]](#footnote-169) Indeed, there is still plenty left for the appeal. Questions remain around the perception of GD and the role of PBs, and why the court chose not to follow the Australian jurisprudence. The categorisation of PBs as “experimental”, left unquestioned in *AB*, treatment is open to challenge. Although any success will largely depend on whether GIDS can present a stronger evidence base. Most fundamentally, the step-back from *Gillick* and the undermining of the decision and person-specific principles by the provision of blanket categories, is ripe for further examination. There will certainly be challenges based on the protected characteristic of gender reassignment under the Equality Act 2010, plus potential discrimination claims under Article 14 ECHR. Indeed, as Budhi contends, ‘Gillick Competence recognises “the evolving maturity and individuality of children”. All children. Not certain children with certain needs’.[[170]](#footnote-170) Problematic as it is, whether the notion of the ‘difference’ of PBs is enough to keep the reasoning of *Bell* contained, or if it marks a shift in judicial thinking towards greater protectionism remains to be seen. The latter could essentially roll back *Gillick* and *Axon,* and more broadly restrict the ability of children to consent in other areas such as abortion and contraception. Worryingly, the judgment in *Re X* indicates that a return to welfarism is a judicial trend with application outside of the trans context. However, Lieven J’s strong desire to protect the integrity of the purpose of *Gillick* when it comes to consent as seen in *AB,* offers a glimmer of hope.

1. [2020] EWHC 3274 (Admin) [↑](#footnote-ref-1)
2. Heather Brunskell-Evans, ‘The Medico-Legal “Making” of “The Transgender Child” (2019) 27(4) Med LR 640. [↑](#footnote-ref-2)
3. Hilary Cass, ‘Letter to NHS England and NHS Improvement’ (10 May 2021) <https://cass.independent-review.uk/letter-to-nhs-england-may-2021> [↑](#footnote-ref-3)
4. Subject of the Independent Cass Review. Interim report expected Summer 2021. [↑](#footnote-ref-4)
5. *AB & CD v Tavistock & Portman NHS Foundation Trust & Ors* [2021] EWHC 741 (Fam). [↑](#footnote-ref-5)
6. *Gillick v West Norfolk and Wisbech* *AHA* [1986] AC 112 [↑](#footnote-ref-6)
7. See for example; Rob Heywood and Jose Miola, ‘The Changing Face of Pre-Operative Medical Disclosure: Placing the Patient at the Heart of the Matter’ (2017) 133(Apr) Law Quarterly Review 296. [↑](#footnote-ref-7)
8. Family Law Reform Act 1968 s8 [↑](#footnote-ref-8)
9. *Gillick* (n6). [↑](#footnote-ref-9)
10. s3 [↑](#footnote-ref-10)
11. ibid s1. [↑](#footnote-ref-11)
12. s8(1). [↑](#footnote-ref-12)
13. *Gillick* (n6) [↑](#footnote-ref-13)
14. ibid189. [↑](#footnote-ref-14)
15. Emma Cave, ‘Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence’ (2014) 34(1) Legal Studies 103,105. [↑](#footnote-ref-15)
16. *Re R (A Minor)(Wardship: Consent to Treatment)* [1992] Fam 11; *Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627. [↑](#footnote-ref-16)
17. *An NHS Trust* v *ABC and a Local Authority* [2014] EWHC 1445 (fam). [↑](#footnote-ref-17)
18. Kirsty Moreton,‘*Gillick* reinstated: Judging Mid-childhood Competence in Healthcare Law:*An NHS Trust v ABC & a Local Authority* [2014] EWHC 1445 (Fam)’ [2015] 23(2) Med LR 303,307. [↑](#footnote-ref-18)
19. *ABC* (n17)[9] [↑](#footnote-ref-19)
20. *Academy of Medical Royal Colleges Statement on Gillick Competency* (25 June 2020). [↑](#footnote-ref-20)
21. (No 2)[2021] EWHC 65(Fam). [↑](#footnote-ref-21)
22. Emma Cave, ‘Confirmation of the High Court’s Power to Override a Child’s Treatment Decision: *An NHS Trust v X (In the Matter of X (A Child) (No 2)*[2021] EWHC 65 (Fam)’ [2021] Med LR doi:10.1093/medlaw/fwab007, 10. [↑](#footnote-ref-22)
23. *Bell* (n1)[4]. [↑](#footnote-ref-23)
24. *ibid* [4]. [↑](#footnote-ref-24)
25. *ibid* [15]. [↑](#footnote-ref-25)
26. *ibid* [5],[36]. [↑](#footnote-ref-26)
27. *ibid* [78]-[83]. [↑](#footnote-ref-27)
28. *ibid* [89]. [↑](#footnote-ref-28)
29. *ibid* [7] [↑](#footnote-ref-29)
30. *ibid* [7],[90]. [↑](#footnote-ref-30)
31. *ibid* [97]-[98]. [↑](#footnote-ref-31)
32. *ibid* [90]. [↑](#footnote-ref-32)
33. *ibid* [74],[134]. [↑](#footnote-ref-33)
34. *ibid*[126]-[127]. [↑](#footnote-ref-34)
35. [2015] UKSC 11. [↑](#footnote-ref-35)
36. *ibid* [128],[130]. [↑](#footnote-ref-36)
37. *ibid* [132]. [↑](#footnote-ref-37)
38. *ibid* [136]-[137]. [↑](#footnote-ref-38)
39. *ibid* [138] [↑](#footnote-ref-39)
40. *ibid* [132]. [↑](#footnote-ref-40)
41. *ibid* [151]. [↑](#footnote-ref-41)
42. *ibid* [151]. [↑](#footnote-ref-42)
43. (n8) s8(1). [↑](#footnote-ref-43)
44. *Bell* (n1)[152]. [↑](#footnote-ref-44)
45. *AB* (n5). [↑](#footnote-ref-45)
46. *ibid* [34],[49]. [↑](#footnote-ref-46)
47. *Gillick* 186 [↑](#footnote-ref-47)
48. *Bell* (n1)[9] [↑](#footnote-ref-48)
49. Sandra Duffy. ‘Puberty Blockers Ruling will have a Chilling Effect’ (3 Dec 2020) Scottish Legal News. [↑](#footnote-ref-49)
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51. *Bell* (n1)[12]. [↑](#footnote-ref-51)
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53. *ibid* [135]. [↑](#footnote-ref-53)
54. *ibid* [52]. [↑](#footnote-ref-54)
55. *ibid* [77]. [↑](#footnote-ref-55)
56. *ibid*[137]. [↑](#footnote-ref-56)
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58. White (n50). [↑](#footnote-ref-58)
59. Jack L Turban et al, ‘Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation’ (2020) 145(2) Pediatrics e20191725. [↑](#footnote-ref-59)
60. *Bell v Tavistock – The Medico-Legal Consequences* (University of Bristol, 3 March 2021). [↑](#footnote-ref-60)
61. *Bell* (n1)[56]. [↑](#footnote-ref-61)
62. *ibid* [57]. [↑](#footnote-ref-62)
63. *ibid* [68]. [↑](#footnote-ref-63)
64. Duffy (n49) [↑](#footnote-ref-64)
65. *Bell* (n1)[58]. [↑](#footnote-ref-65)
66. GIDS <GIDS.nhs.uk/about-us> [↑](#footnote-ref-66)
67. *ibid* [134]. [↑](#footnote-ref-67)
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71. Simona Giordano and Soren Holm, ‘Is Puberty Delaying Treatment “Experimental” Treatment?’ [2020] 21(2) International Journal of Transgender Health 113,114. [↑](#footnote-ref-71)
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73. *Bell* (n1)[70]. [↑](#footnote-ref-73)
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75. *ibid* 116. [↑](#footnote-ref-75)
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81. *Bell* (n1)[74]. [↑](#footnote-ref-81)
82. *Bell* (n1)[8]. [↑](#footnote-ref-82)
83. *Re W* (n16); *Re L (Medical Treatment: Gillick Competency*) [1998] 2 FLR 810; *Re S (A Child) (Child Parent: Adoption Consent)* [2019] 2 Fam 177. [↑](#footnote-ref-83)
84. *Re W* (n16) [↑](#footnote-ref-84)
85. *Bell* (n1)[110]. [↑](#footnote-ref-85)
86. S2(5) [↑](#footnote-ref-86)
87. s1(2),s1(4),S4; *Re MB (Medical Treatment)* [1997] EWCA Civ 3093. [↑](#footnote-ref-87)
88. *(Medical Treatment: Gillick Competency*) [1998] 2 FLR. 810 [↑](#footnote-ref-88)
89. *(A Child) (Child Parent: Adoption Consent*) [2019] 2 Fam 177. [↑](#footnote-ref-89)
90. *Bell* (n1)[114]. [↑](#footnote-ref-90)
91. *ibid* [114]-[115]. [↑](#footnote-ref-91)
92. *Re S* (n89)[15],[16],[34]-[37] [60]. [↑](#footnote-ref-92)
93. *Re X* (n21)[73]-[76]. [↑](#footnote-ref-93)
94. *Bell* (n1)[118]. [↑](#footnote-ref-94)
95. *ABC* (n17)[10]. [↑](#footnote-ref-95)
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97. *ibid* [136]. [↑](#footnote-ref-97)
98. *Bell* (n1)[131]. [↑](#footnote-ref-98)
99. *ibid* [129]. [↑](#footnote-ref-99)
100. S3. [↑](#footnote-ref-100)
101. S3. [↑](#footnote-ref-101)
102. *Bell* (n1)[138]. [↑](#footnote-ref-102)
103. Fletcher (n80). [↑](#footnote-ref-103)
104. *Bell* (n1)[139]. [↑](#footnote-ref-104)
105. *Gillick* (n6) 189. [↑](#footnote-ref-105)
106. Duffy (n49) [↑](#footnote-ref-106)
107. *Bell* (n1)[46] [↑](#footnote-ref-107)
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110. *Bell* (n1)[145]. [↑](#footnote-ref-110)
111. *ibid* [44] [↑](#footnote-ref-111)
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113. S1 [↑](#footnote-ref-113)
114. *Gillick* (n6) 186 [↑](#footnote-ref-114)
115. Mermaids, ‘Latest updates – Tavistock Judicial Review’ (6 Oct 2020) [↑](#footnote-ref-115)
116. See *Re E (A Minor) (Wardship: Medical Treatment)* [1991] 1 FLR 386. [↑](#footnote-ref-116)
117. *Bell* (n1)[8] [↑](#footnote-ref-117)
118. *ibid* [94]. [↑](#footnote-ref-118)
119. *ibid* [121]-[123] [↑](#footnote-ref-119)
120. *ibid* [124]. [↑](#footnote-ref-120)
121. *ibid* [98]. [↑](#footnote-ref-121)
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123. *Bell*(n1)[128],[130]. [↑](#footnote-ref-123)
124. *Bell* [124] [↑](#footnote-ref-124)
125. *Bell* [144] [↑](#footnote-ref-125)
126. Fletcher (n80). [↑](#footnote-ref-126)
127. Cave (n122) 271. [↑](#footnote-ref-127)
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133. *AB* (n5)[52],[59]. [↑](#footnote-ref-133)
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136. Bianca Jackson, ‘Best Interests Application’ *Bell v Tavistock – The Medico-Legal Consequences* (University of Bristol, 3 March 2021). [↑](#footnote-ref-136)
137. *Re D (A Minor)(Wardship:Sterilisation)* [1976] 1 All ER 326; *Re B (A Minor)(Wardship:Sterilisation*)[1987] 2 All ER 206; *Re E (A Minor) (Medical Treatment)* [1991] 2 FLR 585. [↑](#footnote-ref-137)
138. *F v West Berkshire HA* [1990] 2 AC 1; *Re GF (Medical Treatment)* [1992] 1 FLR 293; *Re S (Sterilisation Patients Best Interests)* [2000] 2 FLR 389. [↑](#footnote-ref-138)
139. *AB* (n5)[74]-[90]. [↑](#footnote-ref-139)
140. *ibid* [116]. [↑](#footnote-ref-140)
141. Good Law (n130). [↑](#footnote-ref-141)
142. Duffy (n70). [↑](#footnote-ref-142)
143. *AB* (n5)[120]-[121]. [↑](#footnote-ref-143)
144. Bell (n1)[149]. [↑](#footnote-ref-144)
145. *ibid*[147]. [↑](#footnote-ref-145)
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147. *ibid*[149]. [↑](#footnote-ref-147)
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149. [2004] FamCA 297. [↑](#footnote-ref-149)
150. *Re Jamie* [2013] Fam CAFC 110 [108] [↑](#footnote-ref-150)
151. *Re Kelvin* [2017] FamCA 78. [↑](#footnote-ref-151)
152. *AB* (n5)[102]. [↑](#footnote-ref-152)
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162. Margaret Crompton, *Children and Counselling* (Edward Arnold 1992). [↑](#footnote-ref-162)
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