MERIDIAN
LAWYERS

June 2021

Health Insights

UK: Winding back *Bell v Tavistock*[1]; High Court affirms that parents can consent to puberty blockers on behalf of their children, which are not (of themselves) part of any "special category" of treatment requiring Court approval

Key takeaways

In *AB v CD* & *Ors*[2], the UK High Court effectively reversed the practical effects of *Bell* (which is under Appeal)[3] by confirming that parental responsibility extends to the ability to consent to treatment on behalf of a child.[4] The parent's right to consent to treatment continues even when the child is *Gillick*[5] competent to make the decision,[6] save where the parents are seeking to override the decision of the child.[7]

Further, the Court found that despite the complex issues raised by *Bell*, puberty suppressants do not justify a "special category"[8] by which parents are unable to consent in law,[9] nor do they give rise to the need for Court authorisation either as a legal requirement[10] or as a matter of best practice. Given the "*central, fundamental*

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[1] *Bell v Tavistock and Portman NHS Trust*[2020] EWHC 3274) ("Bell").

[2] *AB v CD* [2021] EWHC 741 ("AB v CD").

[3] The Bell Appeal is listed for hearing in June 2021. The Service was granted a stay in respect of paragraph 138 of the judgment alone, and foreshadowed a further application in respect of the cohort of patients identified in *AB v CD*.

[4] Reference to Child or Children refers to those under the age of 16, which is consistent with the interpretation in Bell at Above n 1, at [11]. It is of passing interest to note that Article 1 of the United Nations Convention of the Rights of the Child (1989) defines 'child' as any human under the age of 18, unless under the law applicable to the child, majority is attained earlier.

[5] *Gillick* competency refers to the precedential common law test elucidated by the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112 for assessing whether a child under 16 can legally consent to medical treatment, as accepted by the High Court of Australia in Re Marion, *Secretary of the Department of Health and Community Services v JWB and SMB*, (1992) 175 CLR 218. Parental responsibility terminates when the child "*achieves sufficient understanding and intelligence to understand fully what is proposed",* citing Lord Scarman.

[6] *AB v CD* at [67]: Lieven J sets out her view as to the "very essence" of Gillick which is that the parental right to consent or determine treatment of a child is limited by an inability to trump or overbear the decision of the child. In Gillick, the parent did not have a right to know about the treatment sought by the child and hence the parent was in no position to stop or withhold consent to that treatment.

[7] Above n 2, at [114].

[8] Above n 2, at [71]: the basis for proposing PB's may fall into a "special category" of treatment is said to be referrable to the matters considered in Bell at [134] – [137].

[9] Above n 2, at [128].

[10] By operation of some common law rule.

and critical role of parents in their children's lives and decision making about their lives",[11] a "*best interests*"[12] application should only be made to the Court in circumstances where there is a clinical disagreement; possible alternative treatment of the medical condition in issue; or the decision is, in the opinion of clinicians, finely balanced.[13]

Background

In Bell, the Court found that the complex nature of Gender Dysphoria,[14] paired with the experimental yet life changing nature of the treatment, rendered it "*highly unlikely*"[15] that a child would be deemed to have the requisite capacity to consent to treatment themselves.[16] This was fatal to the factual matrix of the case as it was the practice of the Service[17] to obtain consent from the child alone (and not the parents).[18] *Bell* expressly did not deal with the issue of parental consent for treatment, be it applied to *Gillick* or *non-Gillick* competent children or young persons.[19]

Following *Bell*, NHS England (which administers the Gender Identity Development Service, **GIDS**) amended its Service Specification[20] and instructed the treatment Trusts to seek Court approval in relation to continuing

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[11] Above n 2, at [39].

[12] Founded in International law (Article 3 of the *Convention on the Rights of the Child*, adopted by the United Nations General Assembly in November 1989 and effective from September 1990) and applicable in both the UK and AU context, the 'Best Interests' principle is directed to the protection of children by imposing an obligation on all players (public, private and parental) that all decisions made and actions taken should be in the child's 'best interests', which is the primary consideration. The principle, which is sometimes referred to as the 'Welfare principle' is codified in the *Children Act 1989* (UK) and the *Family Law Act 1975* (AU).

[13] Above n 2, at [116].

[14] Gender Dysphoria is recognised in the Diagnostic and Statistical Manual of Mental Disorder (DSM-5), published by The American Psychiatric Association (APA) in 2013 and updated in 2020, as a psychological condition where the person experiences significant distress and problems functioning because of a mismatch between their perceived identity and their natal (naturally assigned) sex. GD is an overarching diagnosis with specific criteria for children and for adolescents and adults, of which at least two must persist, for at least 6 months.

[15] Above n 1, at [145].

[16] See earlier article for full discussion: L Biviano & A Saxton, "R v Tavistock, Gender Dysphoria and Children: puberty blockers "interlinked" with cross-sex hormones such that informed consent extends to understanding future physical consequences of treatment; under 16s "highly unlikely" to be Gillick competent." 2021 29(2) Australian Health Law Bulletin, 22.

[17] The author's use of 'The Service' collectively refers to the chain of entities that provide care and treatment to children and young persons with Gender Dysphoria in the UK. NHS England commissioned the Gender Identity Development Service ("GIDS"), which is operated by the Tavistock and Portman NHS Trust ("Tavistock"). GIDS do not themselves provide treatment but rather have a preparatory and counselling role. If treatment is appropriate, GIDS on-refers patients to one of two separate endocrine services for treatment, both being NHS Trusts ("treatment Trusts"). The third respondent is one of those treatment Trusts.

[18] Above n 1, at [36] – [47]. Refer also to Above n 15.

[19] Above n 2, at [6], referring to Above n 1, at [47].

[20] The Service Specification is essentially a contract between GIDS, Tavistock and the treatment Trusts.

treatment to existing patients on puberty blockers, (**PBs**), and to not commence any transgender children on PBs,[21] effectively halting treatment to this vulnerable cohort.

Rather than seeking parental consent to validate the legal basis for continued (or commencing) treatment with PBs, the Service envisaged a two stage process to be applied individually to each patient currently receiving treatment: firstly, an internal reassessment[22] of *Gillick* competency based on the *Bell* factors,[23] and secondly, a 'best interests' application to the Court for those cases in which it was found that PBs should be continued.[24] Such a course would result in treatment delays,[25] further burden an overloaded judicial system, and cause extreme distress[26] to young trans patients who would be at a real risk of developing unwanted and irreversible secondary sexual characteristics should treatment be withheld for a period of time.

The Service and associated treatment Trusts rely on general practitioners (**GPs**) to prescribe PBs as part of a multi-disciplinary approach to treatment. Before *Bell*, the treatment Trusts would prescribe PBs only when a GP refused to do so. After *Bell*, the appetite for GPs to continue to prescribe PBs pending the outcome of the appeal is vexed, with some refusing to do so.[27]

AB v CD

AB v CD makes clear that it endorses Bell and is not a critical review of the reasoning or conclusions in that decision as to the appropriate test for *Gillick* competency,[28] but rather an attempt to clarify a practical grey area created by swift service reforms affecting a specific cohort of patients, namely those young trans patients who have had their treatment halted, with uncertain future treatment prospects and timeframes.

One of those patients is XY, a 15 year old trans child who had been receiving treatment through the Service for 5 years, having commenced PBs in July 2019. XY's next round of treatment fell due in April, roughly four

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[21] Above n 2, at [24]; [26].

[22] Framed by the Service as a 'Clinical Review'.

[23] The '*Bell* competency factors' are set out in paragraph [138] of that judgment and set out the information that must be understood, retained and weighed by a young trans patient to be deemed *Gillick* competent. Those factors are: "*(i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.*"

[24] Above n 2, at [24].

[25] Above n 2, at [25]. The Service informed the court that XY's clinical review would take at least three months to complete.

[26] Above n 2, at [7]. XY herself identified the prospect of such progression as "deeply distressing" at [31].

[27] Above n 2, at [26] – [28].

[28] Above n 2, at [9]: due to those matters likely being the subject of the Appeal in any event, the Judge was a member of the Divisional Court who determined Bell.

months after the Application was made by her mother (AB) seeking a proactive declaration from the Court that she (together with XY's father, CD, whom she had separated from) have the ability to consent in law to the continuation of treatment on behalf of XY.[29] AB argued that as parents, they ought to be able to exercise parental responsibility prior to the Court intervening in decisions about the child's healthcare. The Service agreed that clarification was needed post Bell as to the basis (if any) on which medical practitioners could continue to prescribe.[30] XY's GP had continued to prescribe PBs post *Bell* but there was no certainty that course would continue uninterrupted.

The matter was subject to an interlocutory judgment identifying the following critical questions,[31] which were then determined by Justice Lieven[32] (who was also a member of the Divisional Court who decided *Bell*):

1. Do parents retain the legal ability to consent to the treatment?
2. Does the administration of PBs fall into a "special category" by which either (i) an application must be made to the Court before they can be prescribed; or (ii) as a matter of good practice an application should be made.

It is relevant and material that there was unanimity between the clinicians, the parents and XY that she should continue to be prescribed PBs pending the completion of her clinical review, which was expected to take at least three months.[33] It is also relevant that XY and her parents appear to have engaged in a comprehensive and sustained discourse with the Service, including focused consideration of fertility preservation treatment, which was ultimately not pursued.[34]

XY provided written evidence as to the deeply distressing prospect of developing irreversible male sexual characteristics should treatment cease for a period of time, which was accepted by her treating clinicians as being against her interests.[35]

1. Do parents have the legal right to consent to treatment – Yes

In considering whether parents retained the legal right to consent to treatment, the Court reviewed voluminous authorities and found them "*replete with judicial statements about not merely the centrality of parents in decisions about their children, but also as to why the Courts should in the vast majority of situations respect and uphold the parents' views and decision making about their children*."[36] A parent's right to consent

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[29] The factual circumstances concerning XY and her treatment journey are set out at Above n 2, at [11] – [31].

[30] Above n 2, at [29].

[31] Above n 2, at [32], which was heard by Sir James Munby who called on.

[32] Above n 2, at [32]; [34].

[33] Above n 2, at [25].

[34] Above n 2, at [20] – [21]. The matters contemplated by XY and her parents do address some of the Bell competency factors, which were said to represent a high Gillick threshold on the basis that those matters are generally beyond age-appropriate explanation and understanding; Above n 1, at [143] – [144]. See also Above n 15.

[35] Above n 2, at [31].

[36] Above n 2, at [44].

to medical treatment is a clear incident of the duty to protect the child[37] and applies even in the most serious of cases,[38] absent some significant harm arising from unreasonable parental care.[39] These are aspects of the parental rights and duties set out in Article 5 of the UNCRC and Article 8 of the ECHR.[40]

There was debate before the Court as to when parental consent rights terminated in *Gillick* competent children.[41] However, having considered the relevant authorities, her Honour concluded that parents retain parental responsibility in law and the rights and duties that go with that, even once Gillick competency is reached.[42] Parental consent rights exist concurrently with those of the child but cannot be used to "trump" the child's decision.[43] If a child is unable to make a decision by virtue of competency (lack of), consciousness or deference , parents can make those decisions on their behalf.[44]

In the case of XY, her post *Bell Gillick* competency could not be confirmed (because her clinical review had not been completed, and separately, it was not a question to which the Court was directed), but Lieven J noted that she did not object to her parents exercising their concurrent consent rights.[45] In this way, the Court reasoned that whether parental consent is given because XY is or is not *Gillick* competent need not concern the treating clinicians on the basis that legally operative consent for treatment has been given.[46]

2. Do PBs fall under a "special category" of treatment requiring court authorisation – No.

The parties were united in submitting that, if the law did in fact recognise any "special category" of treatment requiring court approval prior to treatment, it is very limited and PBs do not fall within it.[47] The treatment Trust went further to submit that any such classification would amount to 'discrimination' and render such a classification as unlawful.[48]

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[37] Above n 2, at [42], citing Ward LJ in In *Re Z (A Minor) (Freedom of Publication)* [1997] Fam 1.

[38] Above n 2, at [43].

[39] Above n 2, at [45], referring to commentary made by Baker J in *Re Ashya King* [2014] EWHC 2964 (Fam).

[40] Above n 2, at [47] – [48], referring to United Nations Convention on the Rights of the Child and the European Convention on Human Rights under the *Human Rights Act* 1998.

[41] Above n 2, at [52] – [60]. The debate was focused on judicial commentary of Lord Donaldson in *Re R (A Minor) (Wardship Consent to Treatment)* [1992] Fam 11 and *Re W* (*A Minor) Medical Treatment Courts Jurisdiction)* [1993] Fam 64 in which it appears he was seeking to find that parents retain the right to consent to treatment which a Gillick competent child has refused by using the analogy of a '(master) keyholder', which was subsequently replaced by the 'legal flak jacket'.

[42] Above n 2, at [68]

[43] Ibid.

[44] Above n 2, at [69]. Deference in this instance refers to a child who is simply silence as at a decision, perhaps due to the overwhelming nature of the decision or predicament.

[45] Above n 2, at [69].

[46] Ibid.

[47] Above n 2, at [73].

[48] Above n 2, at [111] – [113].

Tracing the relevant case law, her Honour accepted that there is an "*extremely limited*" category[49] of cases concerning sterilisation[50] of girls and women that have been treated as requiring court approval on the basis that such treatment involves the deprivation of a basic human right[51] and largely arises in circumstances where the patient suffers a severe mental incapacity.[52]

Further, those cases are less than clear as to whether court referral is a legal requirement or merely good practice, a distinction to which Lieven J notes is probably without much difference.[53] What is of "*critical difference*" to the caselaw is the distinction between children and incapacitated adults: namely that in the case of children, their parents would normally be in a position to consent to treatment on their behalf.[54]

This is not to say that all other cases do not require court authorisation. Rather, Lieven J acknowledged "*there are a range of cases where there does have to be Court approval, but this is where there is a clinical disagreement; possible alternative treatment of the medical condition in issue; or the decision is, in the opinion of clinicians, finely balanced. These are fact specific instances rather than examples of any special category of treatment where the Court's role is required simply because of the nature of the treatment*."[55]

By finding that there is no requirement or best practice obligation to seek court approval where parental consent is given for treatment with PBs, her Honour essentially sidestepped the discrimination issue.[56]

It is worth mentioning that Lieven J was directed to the Australian cases of *Re Jamie* [2013][57] and *Re Kelvin* [2017],[58] citing a passage[59] from the latter directed to the critical and legitimate role caring and committed parents play (in combination with appropriately qualified clinicians) in making difficult treatment decisions for the child and taking that decision to the courtroom would sadly replace a holistic healthcare approach.[60]

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[49] Above n 2, at [73].

[50] See Above n 2, at [73] – [96] which canvass cases concerning children, young persons and incapacitated adults the subject of sterilisation applications.

[51] Above n 2, at [75], referring to the reasoning of Heilbron J in *Re D (A Minor) (Wardship Sterilisation)* [1976] 1 All ER 326 which concerned a sterilisation application in respect of an 11yo girl for non-therapeutic purposes.

[52] Lieven J refers to the cases of *Re B (A Minor) (Wardship Sterilisation)* [1987] 2 All ER 206 ("Re B") regarding a sterilisation application in respect of a mentally handicapped girl of 17 years (with a mental age of 5/6 years) – see Above n 2, at [76] – [78]; *F v West Berkshire Health Authority* [1990] 2 AC 1 ("Re F") regarding a sterilisation application with respect to 36 year old woman with a severe mental disability – see Above n 2, at [79] – [82]; and *Re E (A Minor) (Medical Treatment)* [1991] 2 FLR 585 ("Re E") which dealt with a sterilisation application with respect to a severely mentally handicapped 17 year old girl for therapeutic purposes only.

[53] Above n 2, at [72].

[54] Above n 2, at [84]; [90]; [117].

[55] Above n 2, at [116].

[56] Above n 2, at [113].

[57] Fam CAFC 110. See Above n 2, [100].

[58] CAFC 258. See above n 2, [101]

[59] Above n 2 at [101], citing relevant passage from *Sam and Terry (Gender Dysphoria)* [2013] 49 Fam LR 417.

[60] Lieven J also noted the change in judicial appetite between those two cases for requiring approval between the different treatment stages. *Re Kelvin* negated the need for court approval for Stage 2 treatment with cross-sex hormones that has been set by *Re Jamie*. Both cases concluded that the commencement of PBs did not require court approval. See also article "From Re Jamie to re Kelvin: access to gender dysphoria treatment for transgender adolescents", Luke Mclean, 2018 HLB,31.

These sentiments are repeated by her Honour in concluding that "*courts should be slow to displace the decision making role of committed and loving parents*"[61] and there is a real risk that Courts "*become too involved in highly complex moral and ethical issues on a generalised, rather than case specific, basis*" if PBs were to be included in any 'special category'.[62] While there is an academic argument supporting the gravity of the decision to commence PBs, that decision is no more enormous than consenting to a child being allowed to die, or consenting to essentially experimental treatment like PBs.[63]

Judicial concerns arising from parental consent rights

Lieven J identified two concerns arising from her conclusion that parental rights can be exercised in respect of the use of PBs in children with gender dysphoria, recognising that the mode of treatment itself has given rise to "highly polarised" clinical and controversial ethical views.[64]

Firstly, her Honour acknowledged that the structure of the Service and treatment Trusts may mean that clinical difference and disagreement will not necessarily be fully exposed.[65] Appropriate regulatory and oversight measures may temper such a risk, to which her Honour proposed an additional requirement for an independent second opinion from a qualified clinician on the basis that the same would act as a better safeguard[66] for the child rather than removing parent consent rights.

Secondly, Lieven J proposed a situation where parents are 'reverse pressured' into consenting to treatment by the child.[67] This situation is not unique to PBs and in any case, her Honour was satisfied that the Service and treatment Trusts are alive to the issue, which is in part remedied by the extensive and prolonged family-based approach to treatment, which necessarily involves one-to-one counselling of the patient and their parents.[68] If undue pressure was suspected, court referral would be warranted. [69]

Implications of *AB v CD*

Access to treatment

Lieven J repeated the precedential notion that Courts should be wary to intrude on the decision-making power of supportive and engaged parents, who are themselves best placed to make decisions about their children.[70]

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[61] Above n 2, at [118].

[62] Above n 2, at [121].

[63] Ibid.

[64] Above n 2, at [122].

[65] Above n 2, at [123].

[66] Above n 2, at [124]. Lieven J envisages the role of the independent clinician to involve advising whether the particular case should be bought to Court.

[67] Above n 2, at [125].

[68] Above n 2, at [127].

[69] Ibid.

[70] Above n 2, at [118].

This decision likely means that children with loving and committed parents will no longer be barred from accessing treatment with PBs on account of the *Bell* competency factors (if they are in fact upheld on Appeal). It is uncontentious to assert that trans children and young persons belong to a vulnerable cohort. As with any vulnerability, having a supportive network is half of the battle. Trans children without parental support are especially vulnerable and remain disadvantaged following *AB v CD*.

Trans rights advocates are campaigning the NHS to reverse the hasty treatment ban it introduced following *Bell*.[71] It remains to be seen whether the GIDS Service Specification will be further modified post *AB v CD* to specifically permit parental consent in relation to the commencement (or recommencement) of treatment with PBs. If this were to occur, the outcome of the *Bell* Appeal is likely to have little practical effect in terms of accessing treatment.

Sterilisation

While not a focus of the judgment (and perhaps interestingly so), the only cases that came close to being recognised as a "special category" requiring court approval were those regarding sterilisation of young persons. Much of the discussion in *Bell* was directed to the indivisible cascading pathway of treatment which PBs are said to represent, including irreversible outcomes associated with progressing to cross-sex hormones such as infertility. The very basis of the *Bell* competency factors were supported by an apparent inability of children to understand fully, weigh and retain information as to future biological risks, including sterilisation and loss of sexual function. *AB v CD* does not engage in any discussion of the comparison between direct sterilisation and progressive infertility facing trans patients by virtue of the treatment.

English versus Australia position

In *AB v CD*, her Honour gave some weight to the Australian position in respect of the primacy of supportive parents in decisions as to treatment of children with PBs. While it was recognised that the two jurisdictions took a "somewhat different approach" to the nature of PBS,[72] no interrogation has been made to date as to the basis for the fundamental distinction as to treatment being non-therapeutic and therapeutic, as well as (in)divisible, respectively.[73]

Impact

Stakeholders[74] are praising *AB v CD* as balancing the savage biopolitical intrusion to trans healthcare created by *Bell.* Others are concerned that *AB & CD* represents a broad and dangerous reversion of the rights of the child and their autonomy generally such that a stay pending the *Bell* appeal is warranted.

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[71] 'Our Parental Consent Case Against the Tavistock has Succeeded', Good Law Project (website), published 26 March 2021 (https://goodlawproject.org/news/tavistock-success/). Good Law Project funded *AB v CD* via the Trans Defence Fund.

[72] Above n 2, at [100].

[73] Refer to earlier article, Above n 16.

[74] Varying positions have been published online by stakeholders including but not limited to The Good Law Project (UK), The Transparency Project (UK) and various legal minds including David Lock QC of Landmark Chambers (who appeared on behalf of AB in the proceedings).

Either position likely elevates *AB v CD* too high: the bounds of parental consent are well established and merely re-stated. Unsurprisingly, the judgment does not offer any contemporary perspective on a polarising biopolitical issue.

Further commentary is expected following the *Bell* Appeal.

This article was originally published by Australian Health Law Bulletin in June 2021. This article was written by Principal Andrew Saxton and Associate Lauren Biviano. Please contact them if you have any questions or would like more information.

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