Neutral Citation No: [2021] NIFam 17 *Judgment: approved by the Court for handing down (subject to editorial corrections)**	*Ref:* KEE11527 *ICOS No:* 2021/24 *Delivered:* 26/05/2021

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

OFFICE OF CARE AND PROTECTION

Between:

A HEALTH AND SOCIAL CARE TRUST

Plaintiff

and

B

First Defendant

and

THE OFFICIAL SOLICITOR TO THE COURT OF JUDICATURE IN NORTHERN IRELAND

Amicus to the Court

Ms Laura McMahon (instructed by DLS Solicitors) for the Plaintiff
Mr Steven McQuitty (instructed by Phoenix Law Solicitors) for B
Ms Louise Murphy instructed by the Official Solicitor

KEEGAN J

Nothing must be published which would identify the person at the heart of this case. The case has been anonymised as this involves a young person and matters of sensitive medical treatment.

Introduction

[1] This case comes before the court by way of an application for declaratory relief brought by the Health and Social Care Trust in relation to a young person who is now aged 16½. The court is being asked to make a declaration that the young person may be treated with hormone blocking treatment (GnRH analogues). This application is brought with the consent of the young person and her mother and step-father. The young person is estranged from her father. He has parental

responsibility as he is named on the birth certificate. He separated from the young person's mother shortly after birth. He has had contact with B throughout her life however this is described as inconsistent. The last interaction appears to have been in April 2019 when he sent a birthday card using the young person's previous name. B does not want him involved in these proceedings.

[2] In Northern Ireland these treatments are provided by the Gender Identity Development Service known as Knowing Our Identity ("KOI").

[3] The relevant reports set out the history. This young person has a diagnosis of gender dysphoria. The clinicians are unanimous in recommending the provision of hormone blocking treatment in this context. This was to have begun in February 2021 however it has been paused due to the decisions that I refer to in England and Wales.

[4] The case raises some legal issues which have been highlighted by two decisions in England and Wales, namely *Bell and another v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 Admin and *AB v CD and Tavistock and Portman NHS Foundation Trust and University College London NHS Foundation Trust and XY* [2021] EWHC 741 Fam. This is the first case of its kind in Northern Ireland as far as I am aware.

[5] I have heard submissions from all parties and considered the skeleton arguments in this case which set out the law. I have also heard evidence from some of the treating doctors in this case, namely Dr Abid who is the treating endocrinologist and who is ready to prescribe the medication and Dr Kierans, the specialist clinical psychologist, who told me that she considers the young person is competent to make this decision. I received a report from Dr Fulton, consultant psychiatrist, without the need for formal proof. I have also read the Trust care plan which recommends provisions of hormone blocking treatment.

[6] I summarise further background and evidence as follows. B is a young person who was born male but now lives as her preferred (female) gender. She is now 16 and will be 17 in October. B is in full time education. She changed her name by deed poll in August 2019. B is described as a complex young person who was experiencing significant levels of distress in her life namely mood disturbance, anxiety, identity issues, relationship difficulties, self-harm and suicidality. She displayed anger control issues and was referred to Child and Adolescent Mental Health Services ("CAMHS") in 2014. Her behaviour also caused professionals to query a neuro-development disorder namely autistic spectrum disorder although this was never diagnosed.

[7] Clearly B has had intensive professional input and at times she was seen very regularly due to crisis (relating to suicidality). It is reported that B first told her mother that she was transgender and wanted to be female in June 2018 and a referral was made to the KOI clinic in November 2018. At that time B began to socially

transition and this has continued in that she continues to live as her preferred female gender. It is reported that this improved B's mood although she still experienced high anxiety and required medication. B has been attending the KOI clinic since December 2019 and is reported as stable. She has a diagnosis of gender dysphoria. B lives with her mother and stepfather who are her sole carers. They are supportive of her transition and proposed treatment and B's mother has signed a written consent in respect of this. B's father has not been part of the process.

[8] I allowed B to instruct her own lawyers, however, by agreement the Official Solicitor has remained in the case to assist the court. The Official Solicitor is in support of the application.

[9] I have also received a statement of evidence from the young person herself in which the distress caused by delay in treatment is clearly explained. This statement also asks the court to provide help for all of young people living with gender dysphoria.

[10] In a report dated 31 March 2020 Dr Fulton states that B's mental health has been stable for more than one year, with continued positive engagement with CAMHS. B's mood is also described by Dr Kierans as "very stable" and that she is "functioning very well at present." On 12 March 2021 Dr Fulton also noted that B showed "no evidence of significant psychopathology in terms of disturbance of thoughts or perception."

[11] In relation to B's capacity to consent to this type of treatment Dr Fulton said that B was "able to engage in conversation about the process of medical transition. She understands what this might mean for her in terms of taking hormone blockers and also that not everyone who takes hormone blockers decides to proceed to taking cross sex hormones. She understand that some people who begin the process of medical transition change their minds and although she is able to acknowledge this could be the case for her, she believes the chance of this occurring is extremely small."

[12] Dr Kierans confirmed that B "has made the informed decision to commence hormone blocking medication to pause pubertal development, reduce gender dysphoria and give her the opportunity of living without male hormones to allow her time and psychological space to make decisions about future physical interventions." I was told that this first phase would be for 1 year before the second phase of cross sex hormones would be prescribed. Dr Kierans also specifically stated that she felt that the criteria in *Bell* were all met by the KOI process of obtaining consent and that B is "assessed at this time as able to understand, retain, use and weigh the information we have provided and to communicate their current treatment decision to others and thus as having capacity."

[13] On 5 March 2021 B's mother reported to Dr Fulton that B was "very upset, frustrated and distressed upon hearing that she would not be able to proceed with

hormone blocking treatment." B herself told Dr Fulton on 12 March 2021 that she had been "upset and frustrated that she has now to go through a legal process to be able to receive hormone blockers." In her statement B explains how the delay has exacerbated her dysphoria.

[14] During the evidence I was told that B has been attending the KOI clinic for over a year and that with the support of her mother and step father she fully understands the process and wants to proceed. Dr Abid also explained that she had two appointments with B in November 2020 and February 2021 before recommending that the medication commence. Dr Abid explained that the only reason for delay is a hesitation following the *Bell* judgement.

[15] It will be apparent from the above that there is consensus in this case. All of the witnesses were clear that B understands what is happening and that this course is best for her. I have heard no contrary evidence about this. I have also heard no expert evidence about the use of this treatment in general although I understand that there may be different views and this is a controversial subject.

[16] I was concerned about the actual position in Northern Ireland and so I asked for further evidence from the Trust. This is instructive and is contained in an affidavit of 16 April 2021. First there is a document setting out the background to KOI filed by Billie Hughes, Service Manager, and Dr Kierans. This tells me that the in 2014 the Health & Social Care Board commissioned a Regional Gender Identity Service from Belfast Trust. Referrals to KOI originated in the community via CAMHS. The care pathway was designed to include an endocrine pathway which could be assessed when appropriate following a careful psychological assessment. The documents states that services are delivered in line with the World Professional Association for Transgender Health Guide (WPATH) Standards of Care document (7th version 2012), the Endocrine Society (US) Clinical Practice Guidelines (updated 2017) and with reference to NHS England Service Specification 2016-2020 for the Tavistock Identity Development service.

[17] This paper states that "due to the lack of adult gender service provision, changes were made to the service specification for KOI in March 2020. Following the High Court ruling in the case of *Bell*, further consideration was given to the service on the implications for clinical care and legal advice was sought." It also states that KOI has offered access to gender affirming endocrine interventions for young people following careful psychological assessment and consideration since 2014. However, due to the pressures on the Adult Gender Identity Clinic, known as "Brackenburn", over recent years creating lengthy waiting list and more recently no available service, this led to the position that there was no available transition pathway for young people at age 18 for safe continuation of endocrine treatment and a lack of psychological support alongside medical changes.

[18] In this documentation I am also informed that the Public Health Agency and the Health and Social Care Board are leading a commissioning process to address future life span of gender provision in Northern Ireland.

[19] The current guidance following the *Bell* ruling is set out as follows:

1. There is limited access to the endocrine pathway to continue as stated in March 2020.

2. For those patients under 18 years who have been referred to endocrinology who wish to be considered for provision of hormone blockers, legal advice must be obtained in light of the *Bell* ruling, to consider best interests and legal implications.

3. For patients under 18 not previously referred to endocrinology who wish to be considered for provision of hormone blockers, legal advice must be obtained in light of the *Bell* judgement with particular consideration of age, capacity individual circumstances and the availability of parental consent.

4. For patients under 18 who are already prescribed and are receiving puberty blockers or cross sex hormones it is not clinically indicated and potentially harmful to interrupt treatment. These young people will have continuing clinical review with ongoing consideration of their best interests and taking into account current legal guidance.

5. For patients who are over 16 who have completed 1 year of treatment with hormone blockers and are assessed a suitable for transition from hormone blockers to cross sex hormones they will have continuing clinical review with consideration of their best interests and current legal guidance however these transition can proceed if all necessary criteria are satisfied.

[20] Some statistics are also provided in the papers as follows: 407 patients have been referred to KOI since 2014. 72 out of 407 were referred to endocrinology for consideration of physical intervention. 64 are currently open to the KOI service. 24 out of 64 were referred to endocrinology. The remaining 40 of 64 patients are at different levels of a readiness and some may not be referred to endocrinology for a variety of reasons.

[21] Of the 72 patients referred to endocrinology, 54 commenced hormone blockers, 36 progressed to cross sex hormones and 18 had to no treatment at all. The average number of referrals a year is 9. The current number of patients being treated is 24, 7 on hormone blockers only, 15 on second phase cross sex hormones and 2 out of 24 have not yet received treatment.

[22] I was not provided with the age make up of patients. The papers also state that treatment is ongoing on the endocrine pathway and that cases are now considered on a case by case basis.

Legal Background

[23] I start with the *Bell* decision as it obviously frames this case. The *Bell* case was a judicial review brought by two applicants in relation to this type of treatment. It is a substantial judgment which deals with the law and ethics in relation to current treatments for gender dysphoria. In that case the claimants challenged the hospital's practice of prescribing puberty blocking drugs to children under 18 and claimed that it was unlawful on the ground, *inter alia,* that persons below that age lacked competence to give valid informed consent to the treatment and that the cases of children under 18 ought to be referred to the Court of Protection.

[24] The Divisional Court ("the court") which decided the case set out various principles for different categories of children. In particular, it held that whether a person under the age of 16 was legally competent to make the relevant decision depended on the nature of the proposed treatment as well as that person's individual characteristics; that where the decision was significant and life changing there was a greater onus to ensure that the child understood and was able to weigh the information and that the child or young person needed to be able to demonstrate sufficient understanding of the salient facts both present and future. The court decided that not every individual under 16 might be able to achieve competence in relation to the treatment proposed and, where the consequences of the treatment were profound, the benefits unclear and the long term consequences to a material degree unknown, it might be that competence could not be achieved however much information was provided and supported discussion undertaken.

[25] In the course of the judgment the court described puberty blocker treatment as unusual and said that there was real uncertainty over of the short and long term consequences of the treatment with very limited evidence as to its efficacy, or quite what it was seeking to achieve, and it was thus properly described as "experimental treatment". The court said that there was a lack of clarity over the purpose of the treatment. The court also referred to the consequences of treatment as potentially life long and fundamentally life changing. The court referred to the pathway from puberty blocking hormones to cross sex hormones which are irreversible and then surgery. The court considered that this pathway went to the critical issue of whether a young person could have sufficient understanding of the risks and benefits to be able lawfully to consent to that treatment.

[26] In relation to under 16s the court decided that there had to be a particularly careful consideration of competence. It decided that it was highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers and it was also doubtful that a child aged 14 or 15 could

understand and weigh the long term risks and consequences of the administration of puberty blocking drugs.

[27] The court said the legal position was different in respect of young persons aged 16 and over, in that there was a presumption of capacity under section 8 of the Family Law Reform Act 1969 (which is the provision in England and Wales equivalent to the Age of Majority (Northern Ireland) Act 1969), that while that did not mean that a court could not protect the child under its inherent jurisdiction if it considered the treatment not to be in the child's best interests, so long as the young person had mental capacity and the clinicians considered the treatment to be in the child's best interests, then, absent a possible dispute with the parents, the court generally had no role. However, the court also said that given the long term consequences of the clinical interventions at issue, and given that the treatment was as yet innovative and experimental, clinicians might well regard such cases as those where the authorisation of the court ought to be sought before starting treatment with puberty blocking drugs and that it would be appropriate for clinicians to involve the court in any case where there might be any doubt as to whether the long term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in the present case. This is expressed in paragraph 146 of the judgment applying a case of *Re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1992] Fam 64.

[28] The second case which followed *Bell* is the *AB* case. This involved a situation where the parents of a young person who had been prescribed puberty blockers but who was affected by a pause in treatment due to *Bell* wanted to consent on behalf of the young person to allow the treatment to continue. This case involved a boy aged 15. The court decided that the parents' right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child. In other words, the court considered that the parents could "step into the breach." The court also thought that court intervention may not be required.

[29] I was informed that the *Bell* decision has been appealed by the respondents and I am told that an appeal is to be heard in June 2021. Pending the decision I have been informed that NHS England has paused new referrals and that there is a general review of cases at the Tavistock clinic. Also I am aware that an expert report is awaited from Dr Hilary Cass who is reviewing the entire system.

The Issues

[30] A preliminary issue that has been raised is whether the court should grant leave to the Trust to bring the application pursuant to Article 173(2) of the Children (Northern Ireland) Order 1995. This requires a Trust to seek leave of the High Court if seeking the court to exercise its inherent jurisdiction with a child. Under Article 173(3) the court may only grant leave if it is satisfied that the result the Trust wishes to achieve in the application could not be achieved through the making of any other

order which the Trust is entitled to apply for and that there is reasonable cause to believe that if the court's inherent jurisdiction is not exercised, the child is likely to suffer significant harm. Having considered this it seems to me that whilst there is a potential route under the Children Order by way of Specific Issue Order this is not well suited for this type of case. Therefore, I am satisfied that the Trust should have leave.

[31] So having granted leave to proceed, a number of core questions arise which I have had to consider in reaching my conclusions:

(i) Does the court need to intervene in the particular circumstances of this case involving a child over 16, deemed competent by professionals where there is clinical consensus?

(ii) Does the court need to take any steps regarding the natural father?

(iii) What is the impact of *Bell* on practice in Northern Ireland?

Conclusions

[32] The context of this case is important. First, it involves children and families dealing with complex gender issues. The court appreciates that this is a massive life event the effects of which are only truly understood by those affected. Second, following *Bell* everyone should be aware that decisions about treatment in this area must be closely examined and properly made given the lifelong consequences. Third, the court strives to recognise the autonomy of competent children while maintaining a protective role. Fourth, there is a wider picture given the fact that this is an area involving medical practice which has provoked different opinions. Fifth, there is an ongoing review of good practice.

[33] Given the above it is clear that these cases have to be handled with great care. *Bell* highlights the fact that the wrong choice can be made and so understandably the court was at pains to make sure that any consent for such life changing treatment should be fully informed. There cannot be much argument about that. Also *Bell* highlights the fact that this area is under review. Again, that should be a positive in that practice can be improved. *Bell* did not prohibit this type of treatment altogether and so it continues on a case by case basis under strict control. In that regard I understand why practitioners have sought the assistance of the court particularly in this interim phase.

[34] The review of service provision in England & Wales appears to be replicated in Northern Ireland and will presumably involve RQIA and a consideration of enhanced clinical safeguards. In my view it is also crucial that service provision for those over 18 is addressed otherwise young people will be faced with further delays when on a pathway which cannot be good practice.

[35] From the above it is clear as I have said that we are in an interim phase and it remains to be seen how practice will develop. What is clear is that treatment for transgender children will have to be provided in some form. Also many young people are already in the system like B and are distressed having been taken through the process to find there is a problem. This raises ethical issues which the court has had to consider. In *AB* the court allowed for parents to consent to treatment going forward. In this case B is over 16 and consents and has support from her primary carers. She asks for the first stage of treatment to proceed having attended KOI since December 2019 and having been approved. I bear in mind that B is deeply distressed and says that her dysphoria has been exacerbated by the delay.

[36] I stress that I am dealing with a particular factual circumstance. This case is about medical treatment for a young person over 16. The relevant legislative provision is section 4 of The Age of Majority Act (Northern Ireland) 1969 which provides as follows:

> **"4. Consent by persons over 16 to surgical, medical and dental treatment**
>
> (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.
>
> (2) In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.
>
> (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted."

[37] It is clear from this legal provision that a child who has attained the age of 16 years is capable of giving effective consent to his or her own treatment. Since the House of Lords decision in *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC112 it is law that a child under 16 was capable of giving consent to medical treatment if he was capable of understanding what was proposed and of expressing his own wishes. I do not understand *Bell* to change the law however it reaffirms the need to ensure *Gillick* competence taking into account the particular context. The

decision also points to the fact that for children over 16 the court's role is limited but not extinct.

[38] As to the latter point it has always been the case that the court exercising its inherent jurisdiction can override the wishes of a child over 16 if it is in the best interests of the child to do so. This principle is explained in *RE W (A Minor) (Medical Treatment: Courts Jurisdiction*) [1992] 3 WLR 2FCR 785 a case involving a 16 year old with anorexia who refused treatment. It is clear that someone over 16 cannot have their consent to medical treatment overridden by a parent however the court retains an inherent jurisdiction to make decisions if necessary. This is discussed in *Hershman & McFarlane* Volume 1 B 1239-1245.

[39] Having heard the evidence I am satisfied that the young person is competent to make her own decision. She is also supported by her primary carers who consent to her treatment so, even if there were a doubt, there is parental consent. The parental support in this case is a reassuring factor which I imagine is present in most if not all cases. The witnesses have told me they have applied the higher standards which flow from *Bell* in relation to this case and there is no reason for me to doubt that a rigorous examination has been conducted in line with the points raised in *Bell.* The only question is whether the court should override the consent of the young person. In the case of a young person over 16 this would be unusual and must be for good reasons. I have no evidence that would support such a course. The witnesses are all strongly of the view that this course is best for B as is the Official Solicitor.

[40] I appreciate that there are some remaining questions flowing from *Bell*. In my view the first relates to the treatment providers and the commissioning Health Board. I was told that post *Bell* some correspondence has been sent indicating that new referrals are suspended in England and Wales while a best interest review of existing cases takes place. Northern Ireland is a sister jurisdiction aligned to the Tavistock Clinic although separate. If there is a clinical concern about this treatment the issue really lies with the Commissioning Board to consider. If there is confirmation that treatment can continue (and I have not been told otherwise) I see no reason at present why it cannot be progressed for B who has already been assessed.

[41] I am not minded to issue guidance given the ongoing review, however, for my own part I do not consider that in cases of young people over 16 with consent and clinical consensus there is a particular need for court intervention. Most of these cases will involve parental support as here and that is an added safeguard. For younger children I think court intervention will be necessary following *Bell* in the absence of parental consent. Or where there is any doubt there can be recourse to court.

[42] The only other potential issue relates to the young person's father, who has parental responsibility. The position in relation to him is rather vague. It seems clear that the father knows about B's transition and so this is different to secret

adoption and the case referenced by Ms Murphy. There is some suggestion that this man may not fully support B, however, Mr McQuitty told me that this varies. It appears that the father does not currently have contact with B and the young person does not want him involved in relation to her treatment. As she is over 16 and competent, that is her right. Parental responsibility is also a dwindling right as a child gets older, however, it lasts until the child reaches age 18. The father has not been consulted as part of the KOI process as the father cannot override the child's consent. I have not heard any contrary argument about the father's right to know. Also, arguably a parent may have a right to be heard if the court's jurisdiction is invoked to make a best interests decision.

[43] At the moment there is no proper evidence of an objection or parental dispute upon which I can adjudicate. If the Trust is truly concerned about this issue it would need to take some steps before asking the court to adjudicate in the abstract or the Official Solicitor may be able to assist to make sure that this is properly dealt with, without delay, if it is a real issue. B has Article 8 rights but the father may also have rights which engage Article 6. I express no concluded view on this, however, it is something which all parties should consider not least to avoid uncertainty. I also point out that the family court retains a flexibility in terms of procedure if sensitive issues arise.

[44] So, I want the parties to reflect on this last issue as it may avoid something arising at a later stage after this judgment is published which might adversely affect B or shape family relationships in the short or longer term. This all requires some careful thought. I am open to further argument particularly on the Convention points that may or may not arise.

Disposal

[45] The ultimate question is whether the court should grant the declaratory relief sought. In a case such as this where the clinicians are all agreed, there is no doubt among them, the young person is over 16 and has consented in satisfaction of *Gillick* principles and to *Bell* standards, her primary carer has consented to this treatment and where there is no contrary argument as to her best interests I do not consider that the court really has a role. To suggest otherwise is to open up court proceedings for already vulnerable young people and to cause delay.

[46] It appears clear on the evidence I have been provided with that B is able to make her own decision having been fully informed of the issues and with the support of her mother and step-father. I can make a declaration to that effect if required. If further issues arise the court will consider any application. In the meantime I hope that decisions can be made swiftly for this young person who is clearly in need of appropriate medical care and attention. This case can be brought back to me at short notice if I am required to adjudicate on any other matter or assist any further.

[47] I encourage the parties to discuss the outworking of this judgment and it should be carefully explained to B. The parties may then draw up an order or refer any matter back to me as there is liberty to apply.