CHILDHOOD IN TRANSITION: CAN TRANSGENDER AND NON-BINARY MINORS PROVIDE LAWFUL CONSENT TO PUBERTY BLOCKERS?

THE year 2020 was particularly significant for transgender (trans) children and parents in England and Wales. In *R. (McConnell) v Registrar General* ([2020] EWCA Civ 559), the Court of Appeal confirmed that a legal male who gives birth must be registered as the "mother" of his child. In *In re W, F, C and D (minors)(Name changes disclosing gender reassignment and other)* ([2020] EWHC 279 (Q.B.)), Master McCloud sought to enhance the privacy protection of young people who amend their name by enrolling a public Deed Poll. Finally, in September, the Government announced that it would continue to exclude minors from the Gender Recognition Act 2004.

On 1 December 2020, the High Court (sitting as a Divisional Court with Dame Victoria Sharp P., Lewis L.J. and Lieven J.) issued judgment in *R. (Bell and A) v Tavistock and Portman NHS Trust* ([2020] EWHC 3274 (Admin)). The case involved a judicial review of NHS protocols for prescribing puberty blockers (PBs) to trans minors. PBs are the first stage in a potentially three-step medical transition pathway. They are usually administered at the onset of puberty (Tanner Stage 2), although the evidence in *Bell* suggests that older children may also be prescribed PBs. Subsequently, in adolescence and adulthood, individuals may access cross-sex hormones (CSH, Stage 2) and gender-affirming surgery (Stage 3). Although the High Court expressed uncertainty about the purpose of PBs, especially their ability to create a neutral space for children to explore their gender identity (at [137]), these medications are typically understood as avoiding puberty-related distress and facilitating future transitions.

The first defendant was an NHS Trust, whose Gender Identity and Development Service (GIDS) provides gender-affirming healthcare for young people. Although GIDS determines the suitability of children for PBs, it is the second and third interveners – two NHS Trusts in London and Leeds – who provide hormone treatments. The first claimant was an individual who had accessed PBs and subsequent gender-related treatments. She later de-transitioned, deciding to live in her birth-assigned female gender. The second claimant was a mother who was concerned that her child might be referred to GIDS – although it was clear that her child would not satisfy the requirements for PBs (at [89]). The claimants argued that "children or young persons under the age of 18 are not capable of giving consent to the administration of PBs" (at [90]).

Reviewing the available evidence, the High Court made a series of notable findings. Citing an apparent lack of evidence around the purpose, efficacy and long-term consequences of PBs, the judges concluded that

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these treatments are "properly described as experimental" (at [134]). In addition, observing the high number of young people who progress to CSH, the High Court suggested that PBs were a "stepping-stone" to those more invasive treatments (at [136]–[137]). To give valid consent to PBs, therefore, a child must also understand the consequences of CSH.

Drawing upon these and other conclusions, the High Court identified eight factors which young people must "understand, retain and weigh" in order to be *Gillick* competent for PBs (at [138]): (1) the "immediate consequences" of PBs in "physical and psychological terms"; (2) that the "vast majority" of young people proceed to CSH and are "on a pathway to much greater medical interventions"; (3) the relationship between CSH and gender-affirming surgery as well as the "implications of such surgery"; (4) that CSH "may well lead to a loss of fertility"; (5) the impact of CSH on sexual functioning; (6) the impact of PBs and gender-affirming treatment pathways, as understood by the High Court, on "future and life-long relationships"; (7) "the unknown physical consequences of taking PBs"; and (8) that there remains a "highly uncertain" evidence base for PBs.

To satisfy these eight factors, a child must be able to "demonstrate sufficient understanding of the salient facts" (at [131]). In the context of PBs, this will, according to the High Court, be "highly unlikely" for those under 14 years and "very doubtful" for those aged between 14 and 15 years (at [145]). With regards to minors aged 16–17 years, there is a statutory presumption of capacity (at [146]). Save where a dispute arises with parents, there is generally no role for the courts to intervene. However, even for this older group, the High Court observed that clinicians should seek a best interests determination "where there may 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 [147]).

The judgment in *Bell* is a landmark statement on the rights of trans children in England and Wales – an area of law which, despite growing social and political debate, has received comparatively little judicial consideration.

The decision of the High Court will undoubtedly impact the provision of gender-affirming medical care. Following the ruling, despite a stay, NHS England immediately revised its service specification for GIDS so that no young person under 16 years will be referred for PBs "unless a 'best interests' order has been made by the Court" (NHS England, *Amendments to Service Specification for Gender Identity Development Service for Children and Adolescents*, E13/S(HSS)/e, 1 December 2020, at [1a]). For those aged under 16 years who are already accessing PBs, clinicians must now apply for a best interests determination if they believe that PBs should continue or that the young person should proceed to CSH (at [1b]). Where a clinician decides not to apply for such an order, they must make "arrangements for puberty blockers to be withdrawn within a clinically appropriate timeframe and within safe clinical arrangements"

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(at [1b]). Post *Bell*, there are reports of planned treatment being suspended as GIDS and other NHS clinicians consider their position. This is likely to exacerbate already lengthy waiting times at GIDS – a problem condemned by the Care Quality Commission in January 2021.

There is, however, less reason to believe that *Bell* will alter the general *Gillick* competence rules through which clinicians lawfully provide medical treatment to children under 16 years. Following the decision, some observers have suggested that if young people are incapable of understanding the fertility-related consequences of PBs and CSH they might also lack the capacity to consent to contraception and abortion. Yet, perhaps conscious of the wider implications of their judgment, the High Court in *Bell* was careful to emphasise that "the clinical intervention [they were] concerned with … is different in kind to other treatments" (at [135]) and that PBs constitute an "entirely different territory from the type of medical treatment which is normally being considered" (at [140]). Thus, while legitimate questions remain as to whether the High Court adequately justified distinguishing children who medically transition from cisgender minors who obtain non-gender-related care, the judgment does not appear to undermine prior case law on access to reproductive health services.

As the litigation proceeds to an appeal, three aspects of the *Bell* judgment require specific comment. First, the High Court's elision of PBs and CSH contradicts both NHS (at [56]) and international standards of care (WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Version 7 (2012), pp. 18–21). Although the judges were presented with a surprisingly sparse national dataset (at [59]), their decision amounts to a judicial reformulation of clinical protocols. This is especially striking as, in consequence, young people will now be required to understand treatments, which they may have no intention to access and which their medical practitioner considers to be clinically distinct care. Furthermore, the judges appear implicitly to favour the contested argument that high progression rates to CSH are caused by PBs confirming gender identity (at [137]) rather than NHS clinicians adopting more accurate diagnostic criteria (at [76]).

Second, although the High Court disclaimed jurisdiction to decide the merits of PBs (at [9]), scepticism about the efficacy of such treatment contributed to their determination that PBs are "experimental" treatment (at [134]). In this regard, it is unfortunate that the judges were not also drawn to the growing body of international scholarship on the benefits of early medical intervention, and the problems which trans and non-binary youth experience during puberty (W.C. Hembree et al., "Endocrine Treatment of Gender-dysphoric/Gender-incongruent Persons: An Endocrine Society Clinical Practice Guideline" (2017) 102(11) J. Clin. Endocrinol. Metab. 3869). Indeed, while the judges were rightly concerned about bodily changes, which young people may later regret, they seem to

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overlook the irreversible consequences of going through a puberty which conflicts with gender identity. Greater reflection on the positive impact of PBs and the potential consequences of limiting treatment would have allowed a more balanced proportionality analysis – particularly as gender-affirming care engages the "right of transgender persons to personal development and to physical and moral security" under Article 8 E.C.H.R. (*YY v Turkey* (Application no. 14793/08), Judgment 10 March 2015, at [109]).

Finally, even if one concedes that the High Court was correct to establish the stricter, eight-factor *Gillick* competence test for PBs, it is unclear why the judges decided to issue additional, quasi-bright-line guidance on the capacity of children under 16 years to consent. To the extent that *Gillick* assessments are "treatment and person specific" (at [145]), surely expert clinicians – having an established professional relationship with a minor and free from potentially unhelpful assumptions – are best placed to determine whether specific young people satisfy the relevant factors, without recourse to a best interest order if unnecessary.

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THE RESERVATION OF POWERS BY SETTLORS: INTENTION AND ILLUSION

IN *Webb v Webb* [2020] UKPC 22, the Privy Council held inter alia that the reservation of powers by the settlor of two discretionary trusts was so extensive that the trusts were invalid. In matrimonial proceedings in the Cook Islands, Mrs. Webb had contended that the Arorangi Trust and the Webb Family Trust, both of which were effectively settled by Mr. Webb, were invalid, with the result that the trust assets were available for division as matrimonial property. Her two key arguments were that Mr. Webb had never intended to alienate the beneficial interest in the trust assets, alternatively the trusts were shams. In closing submissions at first instance these arguments were merged into one, which Potter J. treated as "essentially a sham allegation" and rejected ([2017] CKHC 31, at [51]–[52]). The Cook Islands Court of Appeal agreed that the trusts were not shams but allowed Mrs. Webb's appeal on the basis that Mr. Webb never intended to dispose of the beneficial interest and the trust instruments failed to alienate it effectively ([2017] CKCA 4, at [65]). Mr. Webb appealed to the Privy Council.

Because the trust instruments were materially identical, they stood or fell together. Lord Kitchin (giving the judgment of the Board) reviewed the terms of the Arorangi Trust and emphasised some key features (at

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