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Case No: FD23P00213

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 1 May 2024

Before :

SIR ANDREW MCFARLANE
PRESIDENT OF THE FAMILY DIVISION

- -

Re J (Transgender: Puberty Blocker and Hormone Replacement Therapy)

- -

EF	**Applicant**
-and-	
LM	**First Respondent**
-and-	
J, a child (acting through his Children's Guardian, Sarah Gwynne)	**Second Respondent**

Jeremy Hyam KC and **Emma Sutton KC** (instructed by **Sinclairs Law**) for the **Applicant**
Dorothea Gartland KC and **Andrew Powell** (instructed by **Harrison Clark Rickerbys Ltd**) for the **First Respondent**
Elizabeth Isaacs KC and **Annie Dixon (**instructed by **Creighton & Partners Solicitors)** for the **Second Respondent**

Hearing dates: 19-21st and 23rd February 2024

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Approved Judgment

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This judgment was handed down remotely at 11am on 1 May 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Sir Andrew McFarlane P:

1. This judgment is given in proceedings relating to 'J', who is now aged 16½ years. J was assigned to the female sex at birth ['natal female'] but has for some time regarded himself as male ['affirmed male']. I shall refer to J as 'he/him'. In January 2023 J commenced a course of cross-hormone treatment and thereafter he received further injections of testosterone every 3 months. The last injection was in August 2023 and the next would ordinarily have been in November 2023 but, with the agreement of the parties including J, any further injection has been deferred in the hope that issues around future treatment will be resolved at the conclusion of these proceedings.

2. The principal matters that fall for determination in the proceedings as a whole relate, firstly, to J's capacity to consent to receiving hormone treatment and, secondly, whether the court should, in any event, exercise its powers under the inherent jurisdiction and/or the Children Act 1989 ['CA 1989'] to prevent further hormone treatment. In the event, as I shall explain, there is currently a measure of agreement, or more accurately acceptance, as to the way forward for the coming few months and, as a result, it will not be necessary to determine the principal issues between the parties in this judgment.

3. The case has been complicated by the fact that the treatment regime in place at the start of the proceedings had been established by an internet provider, 'Gender GP', rather than under the NHS. Both parents, J, his guardian and the court now have significant concerns over the involvement of Gender GP to date. Despite extensive efforts to engage with the NHS or an alternative source, Gender GP has, until recently, remained the only potential prescriber of testosterone for J. There is, now, however, the prospect that a new, London based, clinic, 'Gender Plus', may be available to become involved once an assessment of J and his needs has been undertaken. J's father ['the father'],

whilst remaining firmly opposed to the idea of any young person under the age of 18 years being prescribed cross-hormone treatment, accepts that J will, with his mother's support ['the mother'], now undergo assessment by Gender Plus – a process which may take up to six months.

4. The primary purpose of this judgment is, therefore, more one of taking stock of the issues and the evidence to date, rather than making any final determination at this stage. The final report of the review by Dr Hilary Cass, Chair of the 'Independent Review of gender identity services for children and young people' was published in April 2024 when the final draft of this judgment had been largely completed. Dr Cass' final report was not available during the most recent hearing, in February 2024, but may well be referred to at subsequent hearings. I have, therefore, deliberately not consulted the report before completing this judgment, other than to note headline points from media reporting. The content of this judgment is based on the evidence and submissions that were before the court as at the conclusion of the February hearing.

The principal issues: the current position

Capacity

5. It is agreed that the issue of capacity is decision and time specific. Currently, there is no 'decision' for J to make other than to take part in an assessment process with Gender Plus, which all parties accept he has capacity to agree to. Depending on that assessment and/or if J's testosterone level drops so that a further interim dose may be needed before the assessment is complete, there remains the possibility that, if no alternative source of testosterone is then available, the option of obtaining a further, interim, prescription from Gender GP, will once again become live. In those circumstances, it is agreed that the issue with respect to capacity would be cast in precise and narrow terms:

> ‘Does J have capacity to consent to medical treatment in the form of cross-sex hormones via an interim, holding, dose prescribed by an unregulated online clinic, Gender GP’.

6. A further complicating factor is that Gender GP has played no part in these proceedings and, although the issue on capacity is drafted on the basis that that clinic would prescribe an interim, holding, dose of testosterone there is no evidence that they would do so, or, importantly, what dosage they would prescribe. Thus, if the issue of consent to further treatment by Gender GP were to become live again, there is no certainty about the details of that treatment or what particular dosage would be medically appropriate for J at that time.

Family Law Reform Act 1969, s 8

7. As J is over 16 years of age, the provisions of the Family Law Reform Act 1969, s 8 [‘FLRA 1969’] apply so that, unless he is found to lack capacity in accordance with the Mental Capacity Act 2005 [‘MCA 2005’], he is able to consent to medical treatment.

The Father’s wider legal case

8. Further to the principal issues of capacity and consent, which are to be determined in accordance with established principles, which themselves are not in any substantial dispute between counsel, the father seeks to persuade the court that, in relation to puberty suppressant and/or cross-sex hormone treatment for any person under the age of 18 years, the court’s jurisdiction is, or should be, expanded beyond its currently understood boundaries. Given the absence of dispute over the present referral to Gender Plus, it is not currently necessary to engage with the father’s wider legal case in order to determine any live issue. In the circumstances, other than summarising the father’s wider legal case for the record, it is neither necessary nor appropriate to analyse and determine the issues he raises in any detail in this judgment.

The need for guidance

9. Finally, and in the knowledge that the court's approach to the determination of issues relating to gender dysphoria in children and young people under the age of 18 years is still developing, the court has been asked to provide some guidance in the light of lessons that may have been learned during the present proceedings.

A short account of the relevant background

10. J's parents separated and divorced in 2018. He remains living with his mother but has enjoyed regular contact with his father. Both parents have parental responsibility for J.

11. Most unfortunately, J has not enjoyed good mental health in recent years. Since 2020, he has been diagnosed with anorexia and autistic spectrum disorder. There have been bouts of self-harming and, in September 2021, J was detained under the Mental Health Act 1983, for treatment pursuant to s 3 for 9 months. As a consequence of his difficulties, J did not attend mainstream schooling in 2021 and 2022 but returned to school in early 2023.

12. Gender GP is an offshore, online, healthcare resource for trans-gender patients. Its website describes Gender GP as a 'Worldwide Transgender Clinic'. In October 2022, J, supported by his mother, first engaged with Gender GP's online presence by paying an initial fee and completing a questionnaire. By the end of December 2022, Gender GP informed J and his mother that the 'appraisal pathway' for treatment had been completed and a prescription of testosterone was issued. During the two month 'appraisal pathway', J had only had direct communication with one representative of Gender GP, namely an unregistered counsellor. Although Gender GP issued a private (i.e., non-NHS) prescription for both puberty blockers and hormone treatment, J has

never taken up the administration of puberty blockers. In mid-January 2023, J's local NHS GP administered the first injection of testosterone to J, further to the prescription issued by Gender GP.

13. In April 2023, J's father applied under the Children Act 1989, s 8 ['CA 1989'] and the inherent jurisdiction of the High Court, for the court's intervention by way of declaratory or other relief to ensure that J is not treated with puberty blockers and/or cross-sex hormones (testosterone) without the court's approval, which, the father claimed, should only be given on the basis that it is demonstrated to the court's satisfaction that such treatment is in J's best interests. J's mother is the first respondent and J, who was joined as a party, gives direct instructions to his legal team with his CAFCASS guardian advising the court separately.

Some relevant definitions

14. It is helpful at this stage to clarify certain relevant terms:

> '**Gender incongruence**' is the term used to describe a discrepancy between an individual's natal sex and gender identity. It can give rise to symptoms of gender dysphoria.
>
> '**Gender dysphoria'** is a condition where individuals experience distress because of a mismatch between their perceived gender identity and their natal sex (their sex at birth). This condition causes a strong desire to live their daily life as they perceive their gender identity to be, rather than that assigned to them at birth.

Gender Recognition Act 2004, s 25(1) defines ‘gender dysphoria’ as ‘the disorder variously referred to as gender dysphoria, gender identity disorder and transsexualism’.

Gender dysphoria is defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* in the following way.

> “In adolescents and adults gender dysphoria diagnosis involves a difference between one’s experienced gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:
>
> 1. A marked incongruence between one’s experienced/ expressed gender and primary and/or secondary sex characteristics
>
> 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics
>
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
>
> 4. A strong desire to be of the other gender
>
> 5. A strong desire to be treated as the other gender
>
> 6. A strong conviction that one has the typical feelings and reactions of the other gender.
>
> In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months:
>
> 1. A strong desire to be of the other gender or an insistence that one is the other gender
>
> 2. A strong preference for wearing clothes typical of the other gender

3. A strong preference for cross-gender roles in make-believe play or fantasy play

4. A strong preference for toys, games or activities stereotypically used or engaged in by the other gender

5. A strong preference for playmates of the other gender

6. A strong rejection of toys, games and activities typical of one's assigned gender

7. A strong dislike of one's sexual anatomy

8. A strong desire for the physical sex characteristics that match one's experienced gender."

'**Puberty blocking treatment'** or **'pubertal suppression treatment'** is the prescription and administration of gonadotropin-releasing hormone analogues (GnRHA) designed to suppress or reduce the rate at which physical attributes caused by puberty develop. Puberty blocking treatment has historically been prescribed in practice to those suffering with gender dysphoria or to children who commence puberty at a very young age.

'**Stage 1 treatment'** is the stage at which pubertal suppression treatment is administered.

'**Cross-sex hormone treatment'** is the process by which an individual receives hormone treatment altering their natural levels of testosterone or oestrogen hormones. A person with gender dysphoria may seek to undergo cross-sex hormone treatment in order to obtain physical features attributed to their desired gender. Therefore, a natal male would receive oestrogen hormone treatment and a natal female would receive testosterone hormone treatment.

'**Stage 2 treatment'** is considered to be the stage at which cross-sex hormone treatment is commenced.

The established legal context

15. The parties are, in effect, in agreement as to the legal framework within which the current issues would ordinarily fall to be determined. It is, thus, only necessary to give a brief description of the overall legal context relating to consent to medical treatment for those aged between 16 and 18 years.

16. Prior to the age of 16 years, where a child is assessed as having sufficient maturity and understanding to consent to a particular course of medical treatment, and is therefore 'Gillick competent' in accordance with the principles established in *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, the treating clinicians are able to rely upon the child's consent to proceed without the need to obtain consent from a parent.

17. Where a child under the age of 16 years is not assessed as being Gillick competent, consent to medical treatment can be given by a parent with parental responsibility for him/her. Ordinarily, each parent with parental responsibility may act alone. The CA1989, s 2(7) provides that:

> 'Where more than one person has parental responsibility for a child, each of them may act alone and without the other (or others) in meeting that responsibility; but nothing in this Part shall be taken to affect the operation of any enactment which requires the consent of more than one person in a matter affecting the child.'

18. Where a young person is over the age of 16 years, but, being still under the age of 18 years, is still a minor, the default position with respect to capacity to consent to medical treatment is established by FLRA 1969, s 8:

> '8 **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.'

19. If a young person over the age of 16 years, who would otherwise be able to consent to medical treatment in accordance with s 8, does not have the mental capacity to do so, the provisions of the Mental Capacity Act 2005 will apply so that (as provided by MCA 2005, s 2(1)):

> '… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in functioning of, the mind or brain.'

20. At the present hearing, the court has been greatly assisted by Ms Emma Sutton KC, acting with Mr Jeremy Hyam KC for the father, who has prepared a detailed account of the relevant legal framework that applies to decision making under the MCA 2005. Ms Sutton's exposition of the law is not significantly challenged by the other parties and, in circumstances where the issue of J's capacity does not currently fall to be determined, it is not necessary to set those matters out in this judgment.

21. Ultimately, if the court holds that such a young person lacks capacity in relation to a particular matter, the court will go on to determine the matter in question in accordance with the young person's best interests.

22. Even where there is no issue of mental capacity, FLRA 1969, s 8 does not afford complete and unfettered autonomy to a minor who is over the age of 16 years. It has

been held that the limited, but important, purpose of s 8 is to provide statutory protection for treating clinicians against a claim for trespass to the person if they proceed with medical treatment to an over 16-year-old on the basis of their consent [*Re W (A Minor) (Medical Treatment – Court's Jurisdiction)* [1993] Fam 64]. Importantly, FLRA 1969, s 8 does not totally exclude the inherent jurisdiction of the High Court with respect to minors. In *Re W* the Court of Appeal [Lord Donaldson MR, Balcombe and Nolan LJJ] held that the inherent jurisdiction remains available for a court to intervene and override consent given by an over 16-year-old where the consequences of the young person's decision are of sufficient gravity to justify the court's intervention. Examples of the level of gravity necessary are where the young person is likely to suffer severe permanent injury or irreversible mental or physical harm.

23. Consideration of the decision in *Re W*, and the jurisprudence that has developed under it, is an important element of the father's wider case and, in any event, underpins the court's power to make an interim restraining order with respect to the further involvement of Gender GP in the coming months.

24. The fact that their child has attained the age of 16 years does not revoke a parent's parental responsibility. A parent may therefore consent to medical treatment on behalf of their child beyond the age of 16. However, the ability of a parent to exercise parental responsibility in this regard may be controlled by the court by deploying the power to make orders under CA 1989, s 8. In particular a prohibited steps order or a specific issue order:

> '"a prohibited steps order" means an order that no step which could be taken by a parent in meeting his parental responsibility for a child, and which is of a kind specified in the order, shall be taken by any person without the consent of the court;

> "a specific issue order" means an order giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child.'

Resort to CA 1989, s 8 with respect to a child over the age of 16 is, however, restricted to exceptional circumstances by CA 1989, s 9(6):

> 'No court shall make a section 8 order which is to have effect for a period which will end after the child has reached the age of sixteen unless satisfied that the circumstances of the case are exceptional.'

25. In the present case, J's mother has undertaken not to take any step for the time being to consent to, or otherwise support J in, obtaining further prescriptions of testosterone from Gender GP, other than paying a small monthly fee to keep the current referral to that clinic open. Were it not for that undertaking, it is accepted that the court could prohibit her from acting in that way by means of a s 8 prohibited steps order on the basis that the current circumstances are 'exceptional'.

It is against this accepted legal framework, which I have done no more than summarise, that the father's wider legal case is set.

The Father's wider legal case

26. Although his sole stated goal is to achieve the resolution that best meets his child's welfare needs, the presentation of the father's case has necessarily involved raising significant issues concerning the lawfulness of the treatment of a young person of J's age with puberty blockers and cross sex hormones, and the proper approach that the Court should adopt where disputed issues are raised concerning: -

(i) A young person's competence to consent to treatment;
(ii) The propriety of the diagnosis of gender dysphoria; and
(iii) The propriety of the treatment that was being given to him via an internet provider of gender services that is not regulated by the Care Quality

Commission [‘CQC’] and which operates without the protections provided by provision of such care through specially commissioned NHS services.

27. It is the father’s case that the treatment which was being provided to J by Gender GP was:

a) not in accordance with any recognised guideline;

b) being provided by an online provider without any proper medical supervision;

c) of a kind which would not be available in mainstream NHS service provision pursuant to either the former or current interim NHS service specification;

d) one to which J, at age 15¼ (when he commenced the treatment) and now 16 years, is not competent to consent to having regard to the serious, lifelong and irreversible nature of the treatment and J’s underlying and co-existing diagnoses of autism and anorexia;

e) not in J’s best interests.

The Father’s legal submissions

28. The father, through the submissions of his leading counsel Jeremy Hyam KC, seeks wide-ranging declaratory relief by which the court would, in formal declarations, set out the law that should apply in this and similar cases. Although I have made it plain that the use of declaratory relief in that way would, in my view, be inappropriate, it is helpful in describing the father’s case, at this stage, to set out the declarations that he seeks:

i) That if a parent with parental responsibility for an adolescent such as J (or a medical practitioner) disputes:

   (a) The *Gillick* competence of the adolescent; or

   (b) The diagnosis of gender dysphoria; or

   (c) Proposed treatment with cross-sex hormones ['Stage 2 treatment'] for gender dysphoria

   an application to the court is mandatory even where the young person is over the age of 16 years.

ii) That no treatment with puberty blockers or cross-sex hormones should be administered/prescribed to J, [or any other person under 18] without the prior approval of the court save in the limited circumstances where it is delivered in a specially commissioned NHS setting regulated by the CQC under an appropriate research protocol with appropriate treatment safeguards to ensure:

   (a) fully informed consent is properly obtained from the child;

   (b) that parental rights are respected and all persons with parental responsibility for the child/young person, consent to such treatment;

   (c) that such (parental) consent is freely given and not the product of reverse pressure;

   (d) that treatment is in the child/adolescent's best interests

further or alternatively,

iii) That, to be in accordance with law and to ensure compliance with ECHR, Article 8 rights, Stage 2 treatment with puberty blockers and cross-sex hormones (or cross-sex hormones alone) to J [or any other person under 18] falls within a small group of important decisions made on behalf of a child/adolescent which, in the absence of agreement between those with parental responsibility, ought not to be carried out or arranged by one parent carer although that parent has parental responsibility under CA 1989, s 2(7) and/or

iv) That, notwithstanding a finding of *Gillick* competence, if there is a dispute about diagnosis or treatment (as in J's case), the court should:

   (a) determine the diagnosis;

(b) determine whether the treatment is appropriate, having regard to the adolescent's best interests as the paramount consideration;

(c) make an order authorising or not authorising the treatment in accordance with best interests considerations;

further or alternatively,

v) That to be in accordance with law, and to ensure compliance with Article 8 rights, where a parent or legal guardian does not consent to a person under 18's Stage 2 treatment for gender dysphoria such as J, a medical practitioner who is willing to do so, should not administer treatment to an adolescent who wishes it without court authorisation**.**

29. It is, accordingly, the father's case that treatment with puberty blockers, as was sought, and with cross-sex hormones from January 2023 should not have been commenced in J's case without the prior approval of the court.

30. Having set the father's wider case out for the record, for the present no issue arises which calls for the submissions that have been made as part of that case to be determined. I will therefore move on to say more about the factual background.

The factual context in more detail

31. J's natal sex at birth was female. His parents separated when he was about 10 years old. Thereafter, J lived with his mother, but spent time with his father. By the age of 12, J's behaviour, which included self-harm and disordered eating, led to a referral to the Child and Adolescent Mental Health Service ['CAMHS']. Around that time, J began expressing himself in the male gender. He changed his name to a male name and his pronouns also to male. At age 13, a diagnosis of Autism Spectrum Disorder ['ASD'] was made and he was also diagnosed with anorexia nervosa. At that stage he was not in education, he was not engaging in treatment for his eating disorder and he was said to be socially isolated. Matters came to a head and in 2020, J was compulsorily admitted

to hospital for 9 months for treatment under the Mental Health Act 1983, s 3 due to severe malnutrition. The CAMHS unit expressly declined to offer counselling with respect to gender dysphoria.

32. Following his discharge from hospital, J, who was by then 14, was said to be improving in terms of his dietary intake. It was at this stage, in late 2022, that J, supported by his mother, first engaged with Gender GP and, at the age of 15 years 8 months, he commenced hormone therapy through the Gender GP service, with testosterone being prescribed by Gender GP but dispensed and administered through J's NHS GP.

33. Records show that prior to prescribing testosterone to J, Gender GP received a self-completed online form. The only 'live' interaction between a professional on behalf of Gender GP and J was an online consultation that he had with an individual based in Manchester, who is registered with the British Association of Counselling and Psychotherapy, and who has a diploma in counselling. The counsellor reported that J 'is well informed about hormones and is aware of the irreversible effects but has no plans to store gametes', that he is 'recovering from his eating disorder and it is going quite well' and that 'I have no concerns, at this time, with him getting the help he needs from hormones'. There is no other record of any professional assessment of J's capacity to consent to receiving hormone treatment. No medical examination, blood testing or other clinical evaluation was undertaken. J has not had any direct communication with a doctor at any stage during the referral to Gender GP.

34. In November 2022, Gender GP records show that a 'Pathway Advisor' recommended commencing treatment with hormones and 'strongly recommended' treatment with a 'puberty blocker' alongside the hormone treatment. Matters progressed and in late December 2022 an email from Gender GP recommended that, as the chosen method of

administration of testosterone was by Nebido, which is a slow-release preparation, Gender GP would start the treatment with a loaded (i.e., increased) dose.

35. The Gender GP prescription is dated 31 December 2022 and signed by a named doctor with a registration number from the Colegio de Medicos de Barcelona and a postal address in Bucharest, Romania. The prescription was accompanied by a letter to J's NHS GP stating that J 'has undergone a full gender appraisal by our team, and we are confident that they fulfil the criteria for medical intervention as per NHS service specifications.' The prescription was for an intramuscular injection of testosterone every 6 weeks. J was given these testosterone injections between January and August 2023.

The proceedings: expert evidence

36. After an extensive, but ultimately unsuccessful, exercise to identify an endocrinologist in the UK who was prepared to accept instruction as a single joint expert in these proceedings, Dr Jacqueline Hewitt, a consultant paediatric endocrinologist based in Melbourne, Australia agreed to accept the parties' instruction to advise the court. Dr Hewitt is a senior lecturer at Monash University and, in addition to her clinical work as a consultant, she undertakes a number of roles in advising government bodies in Australia on issues of sex and gender. The court is very grateful to Dr Hewitt for accepting the instruction in this case and for the very thorough analysis that she has undertaken of J's medical records and, in particular, the involvement of Gender GP in prescribing hormone treatment to him.

37. In her report and oral evidence, Dr Hewitt has been highly critical of Gender GP. As, currently, no party is proposing that J should once again engage with Gender GP, it is not necessary to spell out Dr Hewitt's criticisms in detail. In summary they are:

a) No physical examination by a medical practitioner of J was undertaken by, or for, Gender GP either before prescribing hormones or after;

b) In particular, there was no skeletal bone age x-ray and bone densitometry investigation;

c) The psychological assessment was of 'extremely poor quality' with a single online session conducted by a person who has a counselling qualification but who was not registered with the Health and Care Professions Council;

d) There is no record of counselling regarding the known risks of hormone treatment for gender dysphoria.

38. Dr Hewitt's principal criticism of Gender GP's intervention, however, relates to the dose of testosterone that was prescribed. She explained that the dosage of intra-muscular injection of testosterone [Nebido] at 1000mg/4ml every 6 weeks was at the level that one would administer to an adult only after a course of treatment that would have started at a much lower dose but built up to 1000mg/4ml over the course of two or three years. Not only did Gender GP prescribe this top-end dosage to a testosterone-naïve child, but they did so by directing a 'loading' (double) dose at the commencement of the treatment. Dr Hewitt advised 'with confidence' that 'there is no professional society of paediatric endocrinologists internationally who would consider this anything other than a highly abnormal and frankly negligent approach'. She stated that 'in Australia, the treatment provided by Gender GP would be unlawful'.

39. Over the time following her initial instruction and her main report in September 2023, Dr Hewitt has been concerned about the very high level of testosterone that continued

to be registered during regular testing of J's blood. In October 2023, Dr Hewitt advised that the level of testosterone in the blood was 'dangerously high' and that, apart from the potential for adverse long-term consequences of such a level, J was 'presently at risk of sudden death due to thromboembolic disease', meaning the potential for the hormone to cause thickening of the blood. Subsequently, J's blood was assessed by Dr Russell Keenan, a consultant paediatric haematologist at Alder Hey Children's Hospital, Liverpool, who advised that the results were effectively normal when compared to reference points relevant to an adult male (which Dr Keenan considered was the appropriate comparison in this case).

40. Although the risk of immediate harm as a result of changes to his blood was no longer seen as a pressing factor, Dr Hewitt continued to express surprise that, as the months have gone by, the level of testosterone recorded in J's system has remained very high. In her evidence to the court in February 2024 she explained that after a dose of testosterone, the level would be elevated for a time but then fall to a 'trough level' of 10-15 nanomoles/litre after 10 to 14 weeks. For J the readings had been in the mid 20's nm/L throughout the autumn and up to mid-January 2024. For Dr Hewitt this was an 'unusual' and 'unexpected' picture which initially caused her to question whether there had been any further (surreptitious) top-up dose administered. A test in early February 2024 recorded a fall to 15.7 nm/L.

41. Having reviewed the literature, during a break in her evidence, Dr Hewitt observed that as she had never before (in her 20 years in the field) seen such a 'massive dose' of testosterone administered to a young person, her settled view was that the prolonged record of high levels of testosterone seen here could have been caused by the series of high overdosing that had taken place so that there had been an accumulation of the

hormone in the body, with the baseline trough level never being reached before the next dose was given.

42. One factor, of a range that she gave, that particularly concerned Dr Hewitt was the impact that a large dose of testosterone might have on the development of a patient's bones. Put in lay terms, by overdosing on hormones, skeletal development is accelerated from its normal pace of growth during puberty with the result that the point is brought forward at which the growing plates at the end of the bones 'fuse' and stop growing. When that happens, the individual stops growing with the potential for them to end up as an adult with a shorter, smaller, frame than would otherwise have been the case with a normal span of bone growth.

43. Dr Richard Eyre, who is a consultant child and adolescent psychiatrist working in the Oxford Health NHS Foundation Trust, was instructed as a single joint expert to advise the court on J's capacity and his mental and emotional wellbeing. Dr Eyre is not a specialist in gender dysphoria, and he does not undertake the referral of patients for hormone treatment himself. The court is grateful to Dr Eyre for the report and three addendum reports that he has provided and for the two occasions on which he has given evidence. During the course of his involvement, Dr Eyre has reviewed the medical records and has met J and J's parents on a number of occasions.

44. As the issue of capacity is not currently a live one, it is not necessary to do more than summarise Dr Eyre's conclusions which are that:

    a) J qualifies for a diagnosis of gender dysphoria as all six key characteristics are present;

b) J's diagnosis of autism spectrum disorder is not such as to render him unable to make decisions about his treatment for gender dysphoria within the meaning of the MCA 2005. In Dr Eyre's view, he is able to understand and weigh up issues and factors relating to treatment;

c) Although in the past J has suffered acutely from anorexia, he is now not in the same severe state, with the result that Dr Eyre did not consider that he displayed a rigidity of thinking and symptoms of anxiety that would have otherwise been the case as a result of the combination of anorexia and ASD. Dr Eyre would not now diagnose J as anorexic;

d) Social anxiety disorder has featured prominently in the past. Now, whilst J finds social situations difficult, this does not prevent him going out. The testosterone treatment had had a positive impact in building J's confidence and reducing anxiety.

45. Dr Eyre's overall view is that, currently, J's gender dysphoria and the need to access treatment does not overwhelm his ability to give proper consideration to the negative aspects of treatment or prevent him from looking at other treatment options. Dr Eyre considers that the combined effect of all four of the identified conditions from which J has suffered/is suffering from does not render him unable to make a decision about treatment for gender dysphoria within the meaning of the MCA 2005. He understands the nature of that condition and its impact on identity, and he has had the recent experience of receiving treatment.

The current position of the parties

46. The options for J's future treatment and care in the context of gender dysphoria are severely limited. As is well known, the previous NHS provision via the Tavistock Clinic is no longer available and planned replacement services have yet to commence taking patients. During the course of these proceedings, particularly after receipt of Dr Hewitt's worrying advice that J may be at risk of imminent death, concerted attempts were made to engage the NHS in offering assessment and, if advised, treatment for J. These efforts were unsuccessful in achieving more than basic blood testing. The reality, reluctantly accepted by the parties and the court, is that, currently, there is no relevant NHS service available for J. Apart from turning once again to Gender GP, which no party currently favours, the only other option that has been identified is for J to engage with the newly opened Gender Plus clinic in London, where an assessment, over some six months, will aim to identify what, if any, treatment that clinic can offer to him. J's testosterone level, whilst beginning to fall, currently remains high and the expectation is that it may well remain above the 'trough' level, at which a further dose might be indicated, throughout the Gender Plus assessment period.

47. It is against the current background, where the options are so limited that they essentially boil down to one, namely for J to undertake the Gender Plus assessment, that the parties' positions at the conclusion of the most recent hearing were cast.

48. In setting out their current position, counsel addressed a list of issues that had been included in the court's order dated 10 January 2024:

> (i) Whether J has capacity to give informed consent to puberty blockers (if still sought by J) and/or testosterone treatment for his gender dysphoria.
>
> (ii) Even if J does have such capacity, whether to undergo such treatment absent a full assessment process for gender dysphoria including a consideration of J's physical and mental health needs (which on the evidence to date has not been carried out) is contrary to J's best interests and should not be sanctioned by the Court in exercise of its inherent jurisdiction.

(iii) Whether as a matter of law or good practice a child's consent, and/or the parental consent of one parent alone is sufficient to authorise such treatment for a person such as J … without the approval of the Court.

(iv) A declaration whether any other treatment or treatments (e.g. menstrual suppression) are or are not in J's best interests pending a full global assessment of J's mental and physical health needs by an appropriate service.

(v) Whether the Court should give guidance, and if so, the content of that guidance, on how cases such as the present should be dealt with by the Court having regard to the specific issues that have arisen in this case.

49. With respect to these issues, the father's position is:

i) The court should rule now on J's capacity to consent to any further treatment from Gender GP;

ii) Even if J does have capacity to consent to further treatment at Gender GP, the court should override his consent by exercising the inherent jurisdiction (as identified in *Re W*) and that decision should be taken at this stage;

iii) The court should rule now on the father's wider legal case and hold that, irrespective of the consent of a capacitous child and/or one parent, treatment with puberty blockers or hormones should only be authorised with the approval of the court;

iv) The court should make the declaration sought at this stage; and

v) General guidance should be given for deployment in other similar cases.

50. With respect to assessment by Gender Plus, J's father's position is that, whilst he does not consider that that clinic is an appropriate provider, he recognises that it is unrealistic to argue against them carrying out the proposed assessment.

51. J's mother's primary focus is for the court to approve, at this stage, for J to be referred to the new clinic, Gender Plus, for an assessment. During this further period, J's mother will continue to undertake not to approach Gender GP for further treatment, save for continuing to pay the small monthly retainer fee to keep the referral open. If, in the end, the option of Gender Plus does not lead to treatment and there are no other options, the case would have to come back to court for the issue of the further involvement of Gender GP to be determined.

52. J's guardian, Sarah Gwynne, has acted in that role for nearly one year. Whilst, rightly, leaving the issue of capacity and consent to the court, the guardian is clear that it is in J's best interests to access further hormone treatment for gender dysphoria. She favours assessment work now being undertaken by Gender Plus. The joint position put forward by Ms Elizabeth Issacs KC on behalf of J and his guardian was that it is premature for the court to determine any issue of capacity to consent to treatment by either Gender Plus or Gender GP at this stage as the former requires an extensive assessment period and the latter does not currently arise as a live option. Similarly, Ms Issacs submitted that it was not necessary at this stage for the court to engage with the father's wider legal case or to offer general guidance.

Discussion and conclusions

53. The approach that I propose to take, which is in line with that taken at all earlier stages in these proceedings, is to limit the court's involvement in terms of decision making to that which is currently necessary. The law, and the approach of the courts, with respect to issues arising in cases of gender dysphoria is still very much in the process of development. In the absence of intervention by Parliament, the court should be careful to move forward on a case by case, decision by decision, basis so that the approach

under the common law is developed incrementally as may be required, rather than by judicial diktat.

54. It may, in time, be necessary to determine whether J has capacity to consent to further treatment from Gender GP and, if so, it may be necessary to determine the father's plea for the court to prevent him doing so by the exercise of the inherent jurisdiction, but it is not necessary at this stage, and it may never be necessary, to do so.

55. The plan for J for the current period of six months or so is to engage in assessment with Gender Plus. His testosterone levels remain elevated and there is no current need to consider an interim top-up dose. Although J's father is not in favour of resort to Gender Plus, he does not seek to argue against the planned assessment. In the circumstances, no issue currently falls for determination by the court, other than to endorse that agreed/accepted plan. This judgment will, therefore, not deal with the issues listed (i) to (iv) by Mr Hyam (paragraph 49 above). It is also premature for consideration to be given to general guidance, particularly so given the recent publication of the final report of the Cass Review and the need for the parties and the court to consider its content.

56. Although my decision not to move forward and evaluate the wider issues that the father seeks to raise will be a disappointment to him, I am very clear that not to do so is the right approach in law. The court, particularly in a novel and sensitive area such as this, must be particularly cautious not to be drawn into academic discourse and or presume to lay down the law beyond that which is necessary to determine any current dispute. To do so would be to risk trespassing, impermissibly, on the role of Parliament.

57. Before concluding this judgment, it is right to record (by way of preliminary indication, albeit firmly given) that, on the basis of the evidence currently available, if the option of J resorting once again to Gender GP for a further prescription is raised, then there

will be a need to consider very carefully (a) his capacity to consent to that particular option and (b) whether the circumstances are such that the court should exercise the inherent jurisdiction to prohibit him from doing so. There must be very significant concern about the prospect of a young person such as J accessing cross-hormone treatment from any off-shore, online, unregulated private clinic. The evidence relating to Gender GP that is currently available, as analysed by Dr Hewitt, gives rise to additional serious concerns as to the safety of patients accessing cross-hormone treatment from that particular clinic. If a further referral to Gender GP is to be proposed by any party, the court will expect a detailed account from the clinic setting out their proposed course of assessment and treatment.

58. Whilst further evidence may, of course, alleviate the concerns that I have described, on the experience in these proceedings thus far, I would urge any other court faced with a case involving Gender GP to proceed with extreme caution before exercising any power to approve or endorse treatment that that clinic may prescribe.