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Case No: FD26P00414

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/11/2026

Before:

SIR STEPHEN COBB, PRESIDENT OF THE FAMILY DIVISION

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Between:

An NHS Foundation Trust — **Applicant**

- and –

MBV — **Respondents**

BV
(A Child by his Children's Guardian, Allison Baker)

- -

Re BV (Medical Treatment: Disorder of Sexual Development)

- -

Katie Gollop KC (instructed by **Sintons**) for the **NHS Trust**
Pravin Fernando (instructed by **David Gray Solicitors LLP**) for **MBV**
Malcolm Chisholm (instructed by **Cafcass Legal**) for **BV**

Hearing dates: 27-28 October 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 25 November 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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SIR STEPHEN COBB, PRESIDENT OF THE FAMILY DIVISION

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Sir Stephen Cobb P :

Introduction

1. The application before the court concerns BV, a child aged just 19 months old. In this judgment, I shall use the personal pronouns 'he' and 'him' when referring to BV, these being consistent with the gender in which he is being raised.

2. BV was born with a Disorder of Sexual Development ('DSD[1]'), or mixed gonadal dysgenesis; this manifested at birth as ambiguous or mixed gonadal and genital anatomy, in that BV was born with both male and female genitalia, namely a phallus, a descended gonad, an intra-abdominal gonad, with uterine and vaginal structures. From the earliest days of his life, he was assigned the male gender; this was the family's strong preference at that time and was in line with advice from medical professionals in the hospital where he was born. BV has been raised throughout his life so far by his mother as male.

3. Children with BV's diagnosis present as medically and socially complex; the most difficult immediate (and to some extent enduring) decision for a parent and clinician is the sex of rearing. Currently, the majority of patients with this diagnosis are, as BV is, raised as male. That said, BV has other medical (chromosomal) conditions of note, including Turner Syndrome which are commonly associated with females.

4. The application was issued in late-June 2026 by the NHS Trust ('the Trust') for the area where BV was born and currently lives. The Trust sought the following relief from the court, exercising its inherent jurisdiction:

    i) That it would be lawful and in BV's best interests for surgery to be performed on BV, in three stages, to correct a proximal hypospadias on his penis (a condition and procedure which is explained and described further below: see §§38-42);

    ii) That it would be lawful and in BV's best interests that he should undergo surgery to remove his vagina, fallopian tube and underdeveloped ovaries, hemi-uterus, and an intra-abdominal dysgenic gonad. A question arose as to whether this surgery should take place now, or whether this surgery should be delayed until BV is of an age and understanding to contribute to the decision.

[1] I note that in some places, DSD stands for '<u>Difference</u> of Sex Development', but Mr A has used the term 'Disorder' throughout his evidence and I adopt this term.

5. When the application was issued, the Trust, represented throughout by Ms Gollop KC, argued that the hypospadias surgery (§4(i) above) should take place forthwith, but that the more extensive surgery (§4(ii) above) should be deferred until BV is of an age when he is able to understand the benefits and burdens of such surgery, and contribute to the decision for himself. The Trust's position was founded upon two key points: (a) the female organs are essentially silent at this stage, and invisible to the outside world; there is no medical reason or necessity to remove them; and (b) hysterectomy is irreversible, and if the procedure were to be carried out now, BV would forever be denied the chance to decide to carry a child in later life. The Trust explained that it felt ethically compromised by this difficult situation. However, at the conclusion of the hearing before me, and having heard the oral evidence, the Trust modified its position, and expressed itself, through Ms Gollop, to be neutral on whether the operation (at §4(ii)) takes place now or is deferred.

6. BV's mother ('MBV' or 'the mother'), represented by Mr Fernando, is firmly of the view that BV should undergo the surgery identified at §4(ii) at this stage, to remove his female organs and 'normalise' his anatomy (in addition to the surgery at §4(i)); the mother has struggled with the ambiguity of BV's gender and is fearful of the social and cultural implications if BV proceeds any further through his childhood with both sets of sex organs.

7. BV's father plays no part in BV's life, nor has he played any part in this legal process. His name does not appear on BV's birth certificate; he does not have parental responsibility. I made an order at an earlier stage that the court papers should not be served on him, and I explain my reasoning for this at §§13-20 below.

8. BV, through his Children's Guardian (appointed under rule 16.4 Family Procedure Rules 2010: 'FPR 2010') cautiously supports the position taken by the mother, and advocates that BV should undergo the operation referenced at §4(ii) above at this stage.

9. Thus, it will be seen that by the end of the hearing before me there was clear support for the surgery to take place now, from the mother and on behalf of the child, and there was no opposition to it. Taking account of the views of the parties, and having undertaken my own independent best interests' analysis, I am satisfied that it is indeed in BV's best interests that he should undergo the full range of surgery identified at §4(i) and 4(ii) at this stage, or as soon as clinically indicated. I notified the parties of my decision on 5 November 2026, and at that stage I made an order declaring that it shall be lawful and in BV's best interests for him to be provided with the following nursing, medical and surgical care and treatment as soon as it can be arranged:

    a) Surgery to correct his condition of proximal hypospadias, that surgery to be performed by his treating surgeon in conformity with a two or three stage plan, depending on the treating surgeon's clinical judgment.

    b) Surgical removal of the hemi-uterus, fallopian tube, vagina, and internal gonad (if clinically appropriate upon further examination).

    c) All necessary ancillary nursing, medical and surgical care and treatment as is necessary to facilitate the surgery.

This judgment explains my reasons.

Transparency and anonymisation

10. Before descending into the detail of the case, I must address the anonymity and transparency issues, evident from the form in which this judgment is published.

11. Transparency Orders were made in this case at the inception of proceedings on 29 June 2026 (Poole J), and thereafter on 6 July 2026 and 19 October 2026 (Cobb P). For the purposes of publishing this judgment, I propose to extend the Transparency Order, and vary paragraph 6 of the 19 October 2026 order, which will have the effect that the applicant Trust shall remain anonymised, as shall the identity of the treating clinicians. The clinicians shall be referred to as:

    i) Mr A, a Consultant Paediatric Surgeon and Urologist;

    ii) Dr B, a Consultant Paediatric Endocrinologist;

    iii) Dr C, a recently retired Professor in Paediatric Endocrinology.

    These transparency orders will remain in place until BV's eighteenth birthday.

12. In making such a direction I have borne in mind the competing considerations enshrined in *Articles 8* and *10* of the *ECHR* but consider that such anonymisation is necessary in order to protect BV and his family, in BV's best interests, going forward. These directions are unopposed in this case. In making them I have borne in mind the guidance of the Supreme Court in *Abbasi and another (Respondents) v Newcastle upon Tyne Hospitals NHS Foundation Trust (Appellant)* [2025] UKSC 15, specifically [38], [56-57], [61-63], and [182].

Non-service on the father

13. Although the father does not have parental responsibility for BV, the rules provide (notably, rule 12.3 FPR 2010) that he would nonetheless be an automatic respondent to the Trust's application as BV's 'parent'.

14. At the outset of the proceedings, the mother expressed strong opposition to any engagement of the father in the proceedings; specifically, she expressed a clear and genuine fear that if the father became aware of BV's medical condition, he would disclose this intensely sensitive information to members of the community in which she lives, and that this would be contrary to BV's welfare.

15. The evidence before the court about BV's father derives in the main from the mother; there is some corroborative written evidence from the mother's mother, sister and stepfather (I did not hear from them). Each of those statements provide concerning accounts of the father, albeit from different perspectives. To find further or other corroboration for the family accounts, I have scanned the contemporaneously generated medical records; there are very few references to the father in those records, and this in itself, offers some additional support for the mother's account of the limited role which the father has played in BV's life. Within her evidence the mother specifically alleged that:

i) The father had been abusive towards her during her relationship and was threatening towards her stepfather. He was aggressive and unpredictable when under the influence of alcohol, and he used illicit drugs;

ii) The father played no supportive role during her pregnancy with BV. He attended two ante-natal appointments; he was late arriving to an initial scan, and caused a scene at the 20-week scan, following which he and the mother stopped communicating;

iii) The father has played no role in BV's life thus far. He has met BV only once, when BV was 10 days old, but since then the father has 'disappeared from BV's life completely'. He could have resumed contact (he knows where the mother and BV live) and shown an interest in BV, but has chosen not to do so;

iv) The father is apparently unaware of BV's diagnosis, and unaware of these proceedings; the mother believes that the father would use notification of proceedings as a mechanism to create conflict and cause the mother difficulty;

v) The father will not respect the mother's or BV's privacy; as I earlier mentioned, he poses an unacceptable risk of disclosing into her community information which ought to remain confidential. If the father discloses that information, it will be bound to spread and have a detrimental impact on the mother and BV's life;

vi) The father is not in a position to contribute to decisions as to what is best for BV, as he does not have the knowledge, information or understanding required given his lack of involvement for the last 16 months.

16. I repeat that I am conscious that the father has not had opportunity to respond to the allegations made about him which I have set out above.

17. At a case management hearing on 21 August 2026, I received submissions on this issue from the parties. The Trust was largely agnostic on whether the father should be notified; the Children's Guardian carefully considered the mother's evidence and expressed support for the mother's case, namely that the court should dispense with the requirement to notify the father of these proceedings and serve him with papers. I ruled at that time that the father need not be notified of the existence of these proceedings, nor served with the documents. I then indicated that I would explain my reasoning in this judgment. That reasoning follows.

18. The guiding principles are helpfully discussed (albeit in a different context) by Peter Jackson LJ in *A, B and C (Adoption: Notification of Fathers and Relatives)* [2020] EWCA Civ 41, at [40-44] and [89]:

i) The decision whether to notify a putative father is not governed by section 1 Children Act 1989 as it is not one "relating to the upbringing of a child"; while "child welfare, prompt decision-making and a comprehensive review of every relevant factor, including those mentioned in the checklists, are all central to the notification decision, the decision is not one that is formally governed by the provisions of section 1 of the Children Act 1989" (Peter Jackson LJ in *A, B and C* at [84]);

ii) That said, *Article 8* of the *ECHR* encompasses the right to respect both for private life and for family life where it exists; in this case, I have in mind the right to a private and family life which the mother craves to the exclusion of the father, and the right to a potential family life which the father could acquire if he had the knowledge of BV's existence. In this respect I note:

> "Where it concerns a potential relationship which could develop between a child born out of wedlock and its natural father, relevant factors include the nature of the relationship between the natural parents and the demonstrable interest in and commitment by the father to the child both before and after its birth": see *Lebbink v The Netherlands* No. 45582/99 [2010] ECHR 1418 at [36]);

The existence or non-existence of family life is essentially a question of fact depending upon the existence of close personal ties;

iii) Picking up the last point, in *A, B and C*, Peter Jackson LJ said at [44]:

> "In cases of undisclosed pregnancy and birth, a father or other family member will have had no opportunity to demonstrate commitment to the child and the focus will inevitably be on other factors and a counterfactual assessment of the likely position had the facts been known";

iv) "*The substance of the relationships.*… an assessment must be made of the substance of the relationship between the parents, the circumstances of the conception, and the significance of relatives. The purpose is to ensure that those who are necessarily silent are given a notional voice so as to identify the possible strengths and weaknesses of any argument that they might make. Put another way, with what degree of objective justification might such a person complain if they later discovered they had been excluded from the decision?" (*A, B and C* at [89(6)(3)]);

v) "*The physical, psychological or social impact on the mother or on others of notification being given.* Where this would be severe, for example because of fear arising from rape or violence, or because of possible consequences such as ostracism or family breakdown, or because of significant mental health vulnerability, these must weigh heavily in the balancing exercise" ([89(6)(5)]).

19. From the later decision of MacDonald J in *A Local Authority v B (Dispensing with Service)* [2020] EWHC 2741 (Fam), I bear in mind the following propositions (taken from [32]):

> "… in determining the local authority's application for an order dispensing with service of these proceedings on the father, I am satisfied that I should apply the following legal principles in deciding whether to exercise my power to

> dispense with service of proceedings for an order under the inherent jurisdiction on a father with parental responsibility:
>
> i) The starting point is that a father should be able to participate (in a wide sense) in proceedings concerning his child. The court should start with full participation then consider partial participation and then, only as a device of last resort, the father's exclusion from the proceedings.
>
> ii) The court's task is to identify the nature and extent of the harm in contemplation. The court should be rigorous in its examination of the risk and gravity of the feared harm.
>
> iii) There is no requirement that a significant *physical* risk be demonstrated. Harm and risk comes in many guises.
>
> iv) When evaluating the risk of future harm, there is no minimum requirement. The court must be alert both to the risk and to the magnitude of the consequences should the risk eventuate, and must also consider whether and to what extent that risk can be managed by the court's control of its own processes. The greater the harm the smaller need be the risk.
>
> v) The court is not determining a question with respect to the upbringing of the child so the welfare of the child, whilst an important consideration, is not paramount.
>
> vi) Authorities in the Strasbourg jurisprudence put a high bar on excluding a parent with parental responsibility. In this context, where a parent has parental responsibility or a right to respect for family life under Art 8, a high degree of exceptionality must be demonstrated by strong countervailing factors to justify their exclusion from participation in the proceedings.
>
> vii) It must be remembered that exceptionality is not, in itself, a test or a short cut and a fair balance must be struck between the factors that are present in the individual case."

20. I distil the reasons on which I have based my decision to dispense with service of the proceedings on the father, and in declining to give him party status, into the following six points as follows:

    i) Had it been possible for the Trust and the mother to reach an agreed position on medical treatment without need for proceedings, the father would have had no role in that decision making for BV, as he does not hold parental responsibility;

    ii) There is an extremely small number of people who currently know about BV's condition: the mother, her sister, the maternal grandmother and step-grandfather. Not even the mother's current partner knows; he does not

ordinarily take part in nappy changing; I was told that he is illiterate and is unable to read or understand correspondence from the hospital which periodically arrives in the home;

iii) It was clear to me that if the father were to be notified of these proceedings, the mother would in all probability withdraw from the litigation altogether and would not herself participate in it. As BV's main carer, it was crucial that the mother be actively engaged. If the mother withdrew, there was a real risk that the court would be denied the chance to investigate this issue of medical treatment at all;

iv) I was concerned that if the father knew of the medical situation, the mother would feel it necessary to move away from her home area, even though this would have the consequence of taking her away from her small, tight-knit and important support network. The mother has emphasised feeling 'terrified', 'at rock bottom', and highly anxious about the prospect of the father being served with these proceedings. She says that she has had to take time off work because she has been struggling to cope;

v) On a wider plane, while acknowledging the father's prospective *Article 8* rights I was of the clear view (which remains) that it is not in BV's interests for his father to be served with the materials generated by this process, given his low level of commitment to BV, and his lack of any relationship with him. I accept the mother's evidence of the risk that if the father were notified of the issues arising within this application, it is unlikely that he would be discreet about the information and would let slip key details to the community in which the mother and BV live, with (certainly as the mother sees it) associated risks of bullying and ostracism for BV;

vi) The decision before the court has no bearing on BV's father's legal parentage or his ability to have a relationship with BV in the future.

Outline facts

21. These facts are largely taken from the evidence of the mother.

22. The mother currently lives in a one-bedroom upper storey flat. She has been there for around eight years; she has vocational qualifications and a job which she enjoys. She works three days per week. In her own words, she described the community in which she lives thus (I reproduce it in full, because it informs to some degree her position in these proceedings):

> "I live on what I would describe as a rough council estate. Everybody knows everybody else's business. People seem to know where you work, who you are seeing, what car you drive and what is going on in your life even when you have never told them. Because of that, I have always kept myself to myself. I do not tell people my business and never have … In my experience, people talk. News travels fast and gossip spreads quickly. Reputation matters to a lot of people and

> once something is being talked about, it soon becomes everybody's business".

23. The mother and father had a short relationship, lasting only a few weeks in the summer of 2024. The pregnancy was unplanned, and the mother says that she was surprised to discover that she was pregnant. The mother described the relationship with the father as 'toxic' and characterised by arguments. During the pregnancy, the mother was advised (based on the evidence of more than one ultrasound scan) that she was carrying a girl.

24. BV was born at 37 weeks. It was immediately apparent that he had a phallus measuring 2-2.5cms, within normal limits for newborn male, but which was abnormal in appearance; the mother was informed that there was uncertainty about her baby's sex characteristics and that unexpectedly the baby had male characteristics. The discordance between what the mother believed she was expecting, and her newborn baby, shocked the mother and her family and caused them a significant degree of distress. The mother refused to handle or cuddle her newborn baby; in her evidence she said this: "I struggled to cope when he was first born. I didn't do skin to skin, didn't feed him. Didn't look at him due to the fact I was shocked".

25. On the day of his birth, BV was examined by Dr C, a professor of paediatric endocrinology who assessed his genitalia as Prader 3. The Prader scale is a clinical tool used to measure the degree of virilisation of the external genitalia, ranging from typical female genitalia (stage 0) to typical male genitalia (stage 6). Prader 3 indicates significant virilisation. However, ultrasound imaging showed evidence of Mullerian structures (i.e., internal female reproductive system). BV's condition is rare; it is caused by chromosomal mosaicism (46XY/45XO). In the last twenty years, Dr C says that he has seen only about ten such cases. Most babies with BV's degree of virilisation have been assigned the male sex, and that appears to be the current trend. However, at the time of his birth, and to date, it was in principle viable for BV to have been assigned the female sex or no sex given his presentation.

26. On the day of BV's birth, the medical team felt under pressure, given the mother's distress, to assign a sex for the child, rather than waiting as they would have preferred; the mother did not wish to leave the hospital with a baby of unassigned sex. Mr A said:

> "Generally where a baby is born with abnormal genitalia, such as [BV] has, we would recommend gathering other information before assigning a sex. Family distress was considered sufficient justification to make and communicate a gender assignment recommendation before all the desired information was available".

The medical team felt that a male gender was the best fit given the presence of a phallus, a testicle, substantial androgen hormones, and the likely impact of androgens on brain development.

27. From the outset, the family was clear that raising BV as non-binary was not an option which they were willing to consider. They were strongly against the idea of a conservative approach to treatment and waiting to see what the child's own opinions

would be in terms of gender and surgery. Nursing staff on the ward at the time of one of the investigations noted that the mother was visibly upset and angry and was overheard calling BV 'a freak'.

28. On 30 June BV underwent cystoscopy and laparoscopy, but the mother would not agree to biopsy of the internal gonad in case it showed ovarian tissue; this demonstrated the strength of the mother's need for BV to be male. The mother was advised that there would be a 'time critical' point for the removal of the hemi-uterus which would be before the onset of menstruation.

29. In December 2025, when BV was about 10 months old, his case was discussed at the Clinical Ethics Advisory Group (CEAG) of the Trust so that they could consider the treatment dilemma. The CEAG endorsed the treating teams view at the time that it was in BV's best interests for surgery to take place to remove the female genitalia and that this should take place as soon as possible. They concluded:

> "While delaying surgery would preserve future choice for [BV] it risks severe psychosocial harm and safeguarding issues and the Group agreed early staged surgery is the least harmful option under current circumstances, provided decisions are documented, safeguarding oversight continues, and a disclosure plan for the child is developed".

The CEAG considered that this decision was dictated by BV's social context; they accepted that if the social context had been different the management suggested may have been different. The treating team considered that surgery may be justified as they were concerned about maternal rejection, family breakdown, BV being denied nursery and normal childhood experiences; they wished to promote his family life.

30. The mother has made it clear to anyone and everyone that should the court not support him having any surgery during his infancy she would give up work so that she could hide away with BV in order to protect him from adverse responses from people; she said that she would separate from her current partner, with whom she is expecting her second child in February 2027. She would move home.

31. However, after the CEAG decision was communicated, the clinicians responsible for treating BV had second thoughts about the timing of treatment; Mr A told me that they developed "significant misgivings" about undertaking any irreversible interventions on BV. They found the mother's ardent wishes challenging, and felt that they "did not know which way forward was best" for BV. They were accordingly advised that a court application should be made. That application was issued in June 2026.

32. In early October 2026, the endocrine Multi-Disciplinary Team (MDT) held a meeting; the notes of that meeting record that the group discussed the existence of an NHS England 'moratorium' on irreversible gender surgeries in children and this contributed to the clinicians' concerns. After further investigation, it was established that there was no such moratorium, but the MDT nonetheless considered:

> "… the removal of the hemi-uterus and vagina. Removal of these structures would constitute an irreversible loss of reproductive potential and would prevent BV from having

> the possibility of carrying a pregnancy in the future should BV subsequently identify as female and wish to pursue this option through assisted fertility techniques. The MDT therefore felt that there should be a clear clinical justification that removal of these structures is in BV's best interests before proceeding with such an irreversible intervention".

33. BV is an active and sociable boy; he is now much-loved by his mother, and doted upon by his maternal family. The Guardian reported that BV "feels safe, comfortable and reassured in the care of his mother, his maternal grandparents and his maternal aunt". During the hearing, and quite by chance given that the mother participated in the hearing on the second day from home, where she was caring for BV, I was able to see him on camera, watching television and eating a yoghurt.

Medical situation

34. As I have earlier emphasised, the mother and maternal family have been firm, from BV's first day, that they wished him to be raised as a boy and treated as a boy. BV has been assigned the male sex.

35. To put this in perspective, from a pure anatomical perspective, BV could in fact be raised either as male or female. It seems that if female, he would be infertile because female fertility relies on ovarian tissue being present, and no ovarian tissue has been identified. However, if the female organs were to be retained, BV could, perhaps, have the choice to try to become pregnant using donor eggs. That said, BV does not have a normal uterus, and it will not be known whether the hemi-uterus has the capability of carrying a pregnancy until BV is older. In terms of sexual function, if BV was subject to feminising surgeries, and there is no post-surgery vaginal stenosis and clitoral sensation is preserved, then BV could probably have adequate sexual function as a female.

36. Dr B was unable to tell me whether BV has a male brain or a female brain. This would probably only become clear when he comes to understand gender. She does not know whether he sees himself as a male or female at this stage.

Treatment options

37. The medical evidence before the court reveals three essential treatment options for BV:

    i) Non-intervention/deferral of intervention – this pathway involves delaying elective surgeries until BV is old enough to participate in decision-making and can decide for himself which anatomical features accord with his gender identity.

    ii) Masculinising Surgery (if raised male) – this would include:- i. Hypospadias Repair – two or three stage surgery which corrects the position of the urethra on the phallus. The hypospadias repair gives the phallus a more normal appearance and enables urination while standing. ii. Removal of dysgenetic intraabdominal gonad. iii. Removal of vagina and hemi uterus.

iii) Feminising surgery (if raised female) – this would include:- i. Feminising genitoplasty - separating the urethra and the vagina with a clitoral reduction. ii. Biopsy and likely removal of left descended gonad. iii. Biopsy +/- removal right intra-abdominal gonad which may have testicular tissue.

I turn to discuss these in a little more detail.

Hypospadias

38. As I have earlier mentioned, BV was born with a phallus; this was abnormal in appearance with the urethral opening at the base of the underside of the phallus rather than the tip. There was a descended gonad on the left side but no gonad on the right side. Endoscopy undertaken when BV was a few months old revealed a short common channel which branched in one direction towards the bladder and in the other towards a normal sized vagina with a cervix of normal appearance.

39. It is proposed that BV will undergo a three-stage hypospadias repair. The aim of the surgery is to create a straight penis with a urethral opening as close to the tip as possible. The foreskin is used as a graft to make the new urethra so the final appearance will be of a circumcised penis. This surgery should enable BV to stand up to pass urine and achieve good sexual function in the future. With his current anatomy, when he voids urine, it will preferentially pass out of the body through the urethral opening. However, that will change once the hypospadias repair is completed. The repair will increase the outflow resistance, as the urine will now have to pass through a longer tube before passing out of the body. This may cause some back flow of urine into the vagina resulting in urine leakage from the penis, leading to incontinence, and (if it pools) some risk of infection. If urine back flow problems did occur, then it would be advisable to remove the vagina in any event, in order to address this problem.

40. The time frame for completing the hypospadias surgeries is 18 months from beginning to end. In the absence of complications, BV would be expected to make a full recovery within one month of the final surgery.

41. There are risks with this operation, most likely bleeding and infection. Mr A has given a good explanation of the precautionary and mitigating steps which can and will, as appropriate, be taken. There are some identified risks that the procedure will not be wholly successful - i.e., leakage of urine, the hole at the tip of the penis can become stenosed (narrowed), the curve of the penis can return; all these conditions are remediable through further procedure.

42. BV will likely need hormone support at puberty – this will depend on the function of his testis at puberty. He will almost certainly be infertile (according to Dr C).

Female organs

43. If BV retains his uterus, pregnancy would only be possible with donor eggs, and, very probably, donor sperm. It could be said that the chances of the adult BV identifying as female, wanting to carry a baby, and having a realistic chance of doing so are individually small and collectively even smaller. But in that scenario, which cannot be dismissed as a zero chance, the loss of this option has a high chance of causing profound negative consequences.

44. BV is unlikely to have properly functioning gonads that can produce oestrogen. Consequently, it is unlikely that he will experience female pubertal development, including menarche, without endocrine support (oestrogen).

45. The proposed vaginectomy and hysterectomy are not reversible; that said, the clinical risks associated with the vaginectomy and hysterectomy are low, whether this is conducted sooner to address urine back pooling issues, or later when BV were to reach the age of puberty. The key reason a hysterectomy is medically indicated when a vaginectomy is performed, is that removal of the vagina means that there is no route for menstrual fluid to be excreted from the body when menstruating.

46. If no complication arises from the hypospadias procedure, it would be Mr A's preference to wait approximately six months following the final stage of the hypospadias procedures before undertaking separate removal surgery with assistance from a gynaecology surgeon. The surgery would actually only take about an hour, if performed whilst BV is still small, and they would expect that this could be done as a day case.

47. Dr C reflected on this whole situation, thoughtfully, as follows:

> "The more I have thought about [BV], the more I have tended to the view that I do not know what is in his best interests. Although we are healthcare professionals we recognise that our patients' best interests are not limited to healthcare considerations. That is particularly the case where the patient is a baby born with DSD diagnosed at birth. We do our best to give the best advice we can arrive at, in full knowledge that we cannot know the future and this is an area where medical science still has much to learn. Making a court application is a big step and it has not been taken lightly. We are asking the court to contribute at this juncture because we feel we are not well placed to balance the family factors with [BV's] needs, or to identify the best holistic way forward for him. With a court decision, we will be able to proceed more confidently and with an improved understanding of why we are taking a particularly course of action".

Chromosomal complications and Turner Syndrome

48. In addition to his ambiguous genitalia, BV has an underlying chromosomal mosaicism; hence the complex medical picture reflected the presence of both a cell line with Y material present and also an XO cell line. Dr B explained that BV exhibits phenotypic characteristics which are similar to Turner syndrome, a rare genetic condition which only affects females. Short stature is common in individuals regardless of their phenotypic sex; BV is currently on the 0.4^{th} centile and is the shortest child in his nursery. It is said that BV may only achieve five foot in height. It is reasonably predicted that if BV continues to follow his current growth trajectory, he will need growth hormone therapy at around four years of age to support his growth. The other features of this condition include webbed neck, shield chest, cubitus valgus, high-arched palate, renal malformations such as horseshoe kidney, and cardiac anomalies

such as bicuspid aortic valve and coarctation of aorta. He will have a complex chromosomal pattern which is associated with a number of issues including inter alia: risk of dysmorphia (not currently evident), tumour formation in the testicle, risk of delay in reaching developmental milestones and an elevated risk of neuroatypicality. His life expectancy is likely to be reduced though he might be expected to live into his 50s or 60s (this will depend on issues such as cardiac status).

49. Dr B considers that it is likely that by reason of the Turner Syndrome line, BV will develop as an "eunuchoid habitus male", that is to say that he will have a more female associated body shape – wider hips and/or male breasts. This cannot be fixed by surgical removal of internal female organs or by provision to BV of male hormones. There is no treatment. It is a consequence of chromosomal make up. Dr C expressed the concern:

> "…. about the extent to which [the mother] and her family have digested these issues, and how they are balancing what his chromosomal condition may mean for his education and later life. The overwhelming medical focus for the family appears to be on the role of genital surgery and we remain conscious of the fact that the family are walking this difficult and unexpected road without the usual support that we strongly recommend."

The law

50. The seminal authority in this area relating to best interests' decision making in the context of the provision of medical treatment to non-Gillick competent children is, I suggest, *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at [39] in which Baroness Hale observed:

> "[39] The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."

51. The relevant case law was helpfully summarised by MacDonald J in *Manchester University NHS Foundation Trust v Fixsler* [2021] EWHC 1426 (Fam) at [56]-[72] (and affirmed by the Court of Appeal in *Fixsler v Manchester University NHSFT* [2021] EWCA Civ 1018). Without reproducing this helpful section in full, the authorities reviewed by MacDonald J establish that, in disputes about treatment for children, the court must undertake a holistic and independent assessment of the individual child's

best interests, giving weight to medical evidence, parental views, the child's perspective, and relevant cultural or religious factors, while recognising that none of these displaces the overriding requirement to identify what is objectively best for that child. Specifically:

i) The child's best interests are the paramount and determinative consideration. In disputes between parents and clinicians over medical treatment for a child, the court's sole task is to determine what is in the child's best interests. The court exercises its own independent judgment and is not deciding between parental wishes and medical opinion as such.

ii) "Best interests" is a broad, holistic concept. The assessment extends far beyond medical considerations and includes all factors relevant to the child's welfare, including medical, emotional, psychological, social, sensory, instinctive, ethical and relational factors. The court must evaluate the child's welfare in the widest possible sense.

iii) The child's perspective is central. The court should, as far as possible, place itself in the position of the child and consider what the child's attitude to treatment is, or would likely be. The child's own views must be considered and given weight according to age and understanding.

iv) The court must balance all relevant factors and reach its own conclusion. Medical evidence is important but not determinative. The court is not bound by clinicians' assessments and must undertake its own balancing exercise, weighing benefits, burdens, prospects of success, quality of life, suffering and other relevant considerations.

v) Parents' views are important but not decisive. Parents' knowledge of their child may be invaluable, and their opinions must be carefully considered. However, the court's focus is the child's objective best interests, not the parents' wishes. The reasonableness of the parents' position is not itself the legal test.

vi) Religious, cultural and ethical values are relevant factors within the best-interests analysis. The child's and family's religious, cultural and ethical background may properly inform the assessment. Concepts such as dignity, sanctity of life, meaning of life and futility may be relevant, particularly in difficult end-of-life cases. However, such factors do not replace the best interests' test and do not provide an alternative legal framework.

vii) Religious or cultural beliefs are factors in the balance, not the lens through which the entire decision must be made. Even where a family's beliefs are deeply held and highly relevant, the court must conduct an overall best interests' evaluation considering all medical and non-medical factors.

52. I apply these principles in the instant case, considering the medical evidence alongside the child's wider social, psychological, emotional or sensory benefits and burdens.

The parties' positions

53. The Trust had submitted at the outset of the hearing that the issue before the court was a relatively narrow one. There was agreement between all parties that BV should undergo staged hypospadias repair. The sole area of dispute had been whether his internal female reproductive structures, namely the hemi-uterus and vagina, should be removed now or whether that irreversible surgery should be deferred until he is older and able to participate in the decision. The Trust had emphasised that those structures are presently asymptomatic, create no current medical difficulty and do not require removal on clinical grounds. The Trust has always accepted that BV's mother is motivated entirely by concern for her son's welfare. It recognises the considerable distress she experienced following his birth and her firmly held belief that removal of the internal female organs will protect BV from stigma, abuse, social exclusion and difficulties within her community. The Trust acknowledges that the mother wishes BV to be unequivocally male and considers surgery necessary to secure that outcome. It had also noted, as the hearing commenced, that the Children's Guardian supports the mother's position, principally because of the harms which the mother believes may follow if surgery is deferred.

54. Against that background, the Trust had contended that the principal ethical consideration was and is the loss of future autonomy which would result from immediate surgery. Hysterectomy and removal of the vagina are irreversible procedures. Unlike hypospadias repair, they cannot later be undone. The Trust relied on the evidence of the endocrinology team that, in the absence of any medical indication for surgery, and in the absence of evidence that BV will lack decision-making capacity as an adolescent, the preferable course had been to preserve his opportunity to make his own decision when older. The Trust had further noted that, although the possibility may be remote, retention of the uterus would preserve a future opportunity for pregnancy which would be permanently extinguished by surgery.

55. The Trust also placed weight on the uncertainties surrounding BV's future development. While he has been raised as a boy and was assigned a male sex of rearing shortly after birth, the clinical evidence is that prenatal androgen exposure does not determine future gender identity and that incongruence between assigned sex and later gender identity is not uncommon amongst children with DSD. The Trust relied upon the current absence of developmental concerns, BV's attainment of age-appropriate milestones, and the opinion of the endocrine multidisciplinary team that there is presently no reason to conclude that he will be unable to make decisions for himself as he grows older.

56. Finally, the Trust drew attention to wider ethical concerns regarding disclosure and transparency. It noted the mother's strongly expressed wish that information about BV's condition remain confidential and, historically, that he is not told about it. The Trust had submitted that any decision to undertake irreversible surgery should be considered in the context of a longer-term plan for informing BV about his condition and treatment. It had argued that postponement would allow further work with the family, provide an opportunity for attitudes to evolve, support future disclosure, and preserve BV's ability to participate in decisions of profound personal significance concerning his body, fertility and identity. For those reasons, the Trust had invited the court to authorise hypospadias repair but to defer any surgery to remove the internal female reproductive organs. As I say, by the end of the hearing, the Trust had revised its position; the mother had given compelling oral evidence of her concerns for herself

and her son if the main surgery did not take place imminently. My sense is that this evidence swayed the clinical team.

57. On behalf of the mother, MBV, it was submitted that the court should declare it to be in BV's best interests to undergo masculinising surgery, including vaginectomy and hysterectomy, without further delay. The mother's case has always proceeded from the premise that BV has been assigned and raised as male since birth following the advice of the treating clinicians, who considered male sex assignment appropriate having regard to his phenotype, androgen exposure, gonadal characteristics and the prevailing clinical practice for children with his condition. The mother has consistently regarded BV as a boy and has always rejected the possibility of raising him with an unassigned or non-binary gender identity.

58. The mother has placed considerable emphasis on the social and psychological realities of BV's upbringing. She contended that he is being raised within a community in which gender is viewed in strongly binary terms and where disclosure of his condition would expose him and his family to stigma, ostracism, ridicule and exclusion. It is said that ambiguity regarding his sex characteristics is intolerable to the family and would materially affect BV's childhood and future opportunities for social integration. The mother maintains that prolonged uncertainty would lead her to restrict BV's social activities and relationships in order to preserve privacy, with consequential detriment to his welfare. She also contends that delay risks undermining her own emotional wellbeing and parenting capacity, matters which are closely linked to BV's welfare given his age and dependence upon her. The Children's Guardian broadly supports this analysis and concludes that refusal of the proposed surgery risks significant harm to BV's lived experience and development.

59. The mother further relied upon the fact that the multidisciplinary DSD team and the Trust's CEAG had originally concluded that early surgery was in BV's best interests. Those bodies considered that, although the procedures were not presently medically necessary, delaying intervention until adolescence could expose BV to physical complications, including problems associated with menstruation and the accumulation of blood within the reproductive tract, together with psychological distress. The CEAG had accepted that the recommendation for early surgery was heavily influenced by BV's social circumstances and family context, concluding that, in the reality of his life, male social gender assignment was fixed and that earlier surgery would simplify future difficulties and support his welfare. The mother submits that she proceeded in reliance on those recommendations and found comfort in the certainty they provided.

60. Whilst acknowledging the Trust's present concern that irreversible surgery would remove BV's future ability to participate in the decision, the mother argued that this concern is overstated. It is submitted that there is no certainty that BV will attain sufficient maturity or competence to make such decisions before intervention becomes clinically necessary, particularly given the developmental and cognitive risks associated with his chromosomal condition. Further, the mother contended that postponement may itself expose BV to psychological harm by requiring him, in adolescence, to confront complexities regarding his anatomy and identity after having lived throughout childhood as a boy. It is also argued that some of the future options relied upon by the Trust are speculative, including the possibility of pregnancy, given the uncertainty surrounding the function of BV's hemi-uterus.

61. Accordingly, the mother submitted that the court's assessment of best interests must extend beyond purely medical considerations and encompass BV's social, psychological and emotional welfare. She contended that the psychosocial factors favouring early surgery are compelling, that they were correctly recognised by both the DSD MDT and the CEAG, and that they outweigh the competing consideration of preserving BV's future autonomy. Against the background of BV's established male upbringing, his family circumstances and the evidence of likely adverse consequences from delay, the mother invites the court to conclude that early masculinising surgery, including removal of the vagina and hemi-uterus, is in BV's overall best interests.

62. The Children's Guardian approached this application by acknowledging the stark choice identified by the Trust: whether to proceed now with the full package of masculinising surgery, including removal of the hemi-uterus and vagina, or whether to undertake only the hypospadias repairs and defer any irreversible surgery until BV is older and able to participate in the decision. The Guardian noted that, although BV is likely to be infertile, the proposed surgery would permanently remove a future reproductive possibility which, while remote, cannot be regarded as wholly theoretical. For that reason, the Guardian submitted that any decision to proceed with irreversible surgery before BV can express his own wishes and feelings must be approached with considerable caution.

63. That said, the Guardian accepted the mother's evidence as genuine and sincerely held. The Guardian described the mother as candid rather than manipulative and identified a deeply rooted fear that, unless BV's female internal anatomy is removed, revelation of his condition within her community would provoke a strongly adverse reaction. The Guardian accepted that the mother fears social stigma and exclusion, and that, in an effort to protect BV from such consequences, she may become inclined to limit his social interactions and keep him isolated from others. At the same time, the Guardian could find no deficiencies in the mother's care of BV, whom she describes as a much-loved child at the centre of his mother's life and that of the wider family.

64. The Guardian further observed that the mother's stance appears to be influenced, at least in part, by the social environment in which she lives, including strongly binary beliefs concerning sex and gender. While recognising the strength of those views, the Guardian recorded that the mother's position leaves little room for the possibility that BV may, in due course, wish to contribute to decisions concerning his own body and identity. Nonetheless, the Guardian accepted that the mother's concerns are genuine and that her wish for surgery is advanced in good faith and with a view to what she believes to be BV's welfare.

65. Notwithstanding her recognition of the importance of preserving BV's future autonomy, the Guardian ultimately recommended that the proposed surgery (at §4(ii) above) should proceed at this stage. Central to that conclusion was her concern about the potential impact on the mother-child relationship if the decision was to be deferred. The Guardian considered that BV's welfare in the coming years will depend heavily on the mother's emotional investment in him and her ability to provide him with consistent support. In her view there is a real risk that postponement of surgery could undermine the mother's wellbeing and parenting capacity, weaken the bond between mother and child, and leave BV vulnerable to feelings of rejection at a crucial stage of his development.

66. The Guardian wished the mother to hear the medical evidence; this was not entirely possible. It was nonetheless clear by the end of the mother's evidence that she (the mother) had formed a wholly unchangeable view as to BV's best interests, informed by as complete an understanding as possible of the consequences of either course, and the Guardian accepted the potent impact of this view on the ultimate outcome.

67. Recognising that the mother takes a very firm view that allows for no input by BV himself later in his development, the Guardian has nevertheless recommended in her report that total surgery should proceed now. Having regard to the evidence filed by the mother so far and which is essentially corroborated by her interactions with Trust staff, the Guardian is particularly concerned about the potential impact upon the mother/child relationship (at his different stages of development) if consideration of total surgery is postponed. BV will undergo a number of significant developmental changes in the years ahead and it will be critical to him that he has the unqualified support of the mother, and that their relationship can flourish and not be undermined by fear.

68. Mr Chisholm argued that the Guardian identifies a real risk that BV's development will be arrested if there is a rift in the mother/child relationship caused by maternal feelings which may be put into suspension until he is, in the mother's words, "fixed". As the Guardian put it in her report,

> "…From a welfare perspective, BV's reality will continue to be predominantly shaped by his mother's care and her degree of emotional investment in him. Delaying surgery may jeopardise her parenting capacity, weakening their bond which post-birth she initially struggled to establish with him. This would clearly be a matter out of BV's control. Should surgery not proceed post proceedings, and detrimentally impact the mother's relationship with BV and her own well-being, he may develop and struggle with a sense of rejection, especially if the quality of his mother's relationship with her second child significantly contrasts with his relationship with her.'

Conclusion

69. This has been, and is, a complex case for the treating clinicians. There is no clear clinical consensus nationally and internationally with respect to this particular form of DSD. This is one reason why BV's case was referred to the CEAG. As I earlier mentioned, after very careful consideration, the CEAG endorsed the treating team's view at that time that it was in BV's best interests for surgery to take place and that this should be undertaken as soon as possible; this decision had been fundamentally dictated by the social context of BV. I recognise that the treating team have vacillated, struggling to know how to look at BV's best interests separately from those of his mother and grandparents. Dr B told me that they do not even know if that is possible or appropriate "but we do know that it is BV who is our patient". I accept that if BV had been in a different social context, then management of his medical situation may have been different. There is no risk-free approach in this case. This application is thus properly before the court.

70. I have considered BV's best interests in the round. I acknowledge that there is no medical necessity for extensive surgery at this point; I further acknowledge the potential benefit to BV of deferring a decision until a point when he can contribute to it. I also take into account Mr A's opinion that the younger the child is when they undergo surgeries of this nature, the less disruptive the surgery and post-operative experience is for them and their families. This is primarily due to the need of a catheter after surgery (5-7 days following the first and second stage of surgery, and 10-14 days following the third stage).

71. The maternal family have been focused on the endpoint (i.e., normalising BV as a male). It is a matter of concern to me that the mother said that she would not send BV to nursery or school until he is 'fixed'; the fact that BV has in fact been to nursery cannot be assured as a plan going forward; the mother was ambivalent about his attendance there. The family find the idea of leaving any female organs in situ until BV is older an intolerable prospect. BV has been presented to their community as a boy, and the family feel that anything that might cast doubt upon this risks BV and his family being ostracised by their community.

72. I have considerable sympathy for the mother in having to deal with this extraordinary situation. Since BV's birth, the mother has been consistent; her opposition to any outcome other than that BV should be male is simply candid, rather than manipulative. Her position lacks guile. There is an unusual clarity to her approach; she is open in her views, and is clear that there is only one real solution. I accept that she has struggled profoundly with the reality of BV's situation; she had been advised from day one that he could and should be reared as a boy, and this she has done. She cannot entertain any notion that he should be viewed as female or as a child of unassigned sex. The Guardian told me that she had been left "with the overriding impression that [the mother] has lived in fear of anyone discovering the truth and that she is desperate for closure".

73. Those aspects of this unusual case to which I attach considerable, indeed the greatest, weight are the potential impact upon BV's future psychological and social development arising from the current ambiguity surrounding his sex characteristics. As BV matures, questions of identity, belonging and self-perception are likely to assume increasing importance; the evidence suggests that prolonged uncertainty may give rise to practical, emotional and social challenges, particularly during childhood and adolescence, when peer relationships and the development of a stable sense of self are especially significant. I do not believe that BV's mother will ever be able to help him with these issues; this is not a criticism of her, it is just an observation about her unshakeable position. My concern is not with BV's difference in itself, but with the possible consequences for his welfare of growing up without sufficient clarity, support, or certainty in this important aspect of his development.

74. The mother has been clear that she would find it difficult to form a secure attachment to BV were this uncertainty to persist. In my judgment, deferring the decision could only be justified if there were a reasonable prospect that, at the critical stage when the issue would fall to be determined, BV would be emotionally, psychologically and developmentally equipped to participate meaningfully in that decision. Yet a childhood lived under the shadow of unresolved uncertainty, marked by qualified maternal attachment, possible rejection (or a sense of rejection), and by continuing maternal anxiety concerning medical matters, is unlikely to furnish BV with the emotional

resilience, psychological security, or developmental maturity necessary to undertake so profound a personal choice.

75. I am of course mindful of the need to distinguish BV's welfare from that of his mother, but in a case such as this their interests are necessarily and closely interconnected. BV is wholly dependent upon his mother for his care, his security, his emotional development and his sense of belonging in the world. While the court must guard against permitting parental wishes to determine the outcome of a best interests' decision, it cannot ignore the reality that the quality of parental attachment and the stability of the child's primary relationships are themselves factors of profound importance to that child's welfare.

76. The mother has been clear that she would find it difficult fully to reconcile herself to BV's condition were the present uncertainty to persist. I do not treat that assertion as a threat or as an attempt to influence the outcome of these proceedings. Rather, I regard it as a frank expression of the struggle which she has experienced from the moment of BV's birth, and which has been consistently reflected in the contemporaneous records and in the evidence before this court.

77. I have therefore weighed, on the one hand, the considerable benefit which might arise from preserving for BV the opportunity to participate personally in this decision at a later stage, together with the possibility, however remote, that he may in adulthood wish to retain female reproductive structures and seek to carry a pregnancy. These are important considerations and I have not underestimated them. Against them, however, I place the realities of BV's present life: he has been assigned and raised as male since birth; he is known to his family and community as a boy; the evidence establishes that continuing ambiguity carries a significant risk of adverse consequences for his social and psychological welfare and, critically, for the stability and security of his relationship with his mother, upon whom he presently depends for everything.

78. I recognise, as Dr B candidly acknowledged, that medical science cannot provide certainty in a case of this kind. Nor can the court. This decision is not founded upon a belief that the future can be predicted with confidence; it is founded instead upon an assessment of what is most likely to promote BV's welfare when all of the medical, psychological, social and relational factors are viewed together. In undertaking that assessment I have been particularly influenced by the evidence that there is no neutral course available. Deferring surgery is not a means of avoiding risk; it is simply the adoption of a different set of risks.

79. Standing back and considering the matter in the round, I am satisfied that the balance comes down in favour of authorising the proposed operative treatment in full now. In reaching that conclusion I attach significant weight to the importance of securing for BV a stable and unambiguous framework within which he can develop during childhood, to the need to support and preserve the crucial attachment between him and his mother, and to the evidence that delay risks compromising those objectives. While I acknowledge the loss of future choice which this decision entails, I am persuaded that, in the particular and highly unusual circumstances of this child, the benefits of proceeding now outweigh the advantages of postponement.

80. For those reasons, and applying the best interests' test in its fullest and widest sense, I concluded that it is lawful and in BV's best interests for him to undergo the staged hypospadias repair and the surgical removal of the hemi-uterus, fallopian tube, vagina and internal gonad (if clinically appropriate), together with all associated and necessary medical treatment. That is why I made the declarations to which I referred earlier in this judgment.