Neutral Citation Number: [2024] EWCA Civ 1577

Appeal No: CA-2024-001177
Case No: EX22P00295

IN THE COURT OF APPEAL OF ENGLAND AND WALES (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
FAMILY DIVISION
Mrs Justice Judd

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/12/2024

Before:

SIR GEOFFREY VOS, MASTER OF THE ROLLS
SIR ANDREW MCFARLANE, PRESIDENT OF THE FAMILY DIVISION
and
LADY JUSTICE KING

BETWEEN:

O

Applicant/Appellant

-and-

P

1st Respondent

-and-

Q
(by his children's guardian)

2nd Respondent

Jeremy Hyam KC and **Alasdair Henderson** (instructed by **Sinclairs Law**) for the **Applicant** (the mother)

Deirdre Fottrell KC and **Tom Wilson** (instructed by **Irwin Mitchell LLP**) for the **1st Respondent** (the father)

Allison Munroe KC and **Emma Favata** (instructed by **Tozers Solicitors**) for the **2nd Respondent** (the young person)

Hearing date: 12 December 2024

Approved Judgment

This judgment was handed down remotely at 10:00am on Thursday 19 December 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Sir Geoffrey Vos, Master of the Rolls:

Introduction

1. The young person at the centre of this case is now 16 years old. He was born female and started to identify as male in 2020 at the age of about 12. Sadly, his parents separated acrimoniously many years ago and now disagree as to the processes that should be followed to address his gender dysphoria. The mother brought these proceedings for a prohibited steps order under section 8 of the Children Act 1989 and for a "best interests" declaration under the court's inherent jurisdiction. By the time the matter came before Mrs Justice Judd (the judge) between 17 and 19 April 2024, the mother was asking for the case to be adjourned pending a 6-month assessment being undertaken in respect of the young person by Gender Plus (a private gender dysphoria clinic). The father was asking for the proceedings to be brought to an end on the grounds that they were causing the young person significant distress. The judge decided that the proceedings should be dismissed. It is that decision that the mother is now appealing.

2. It is useful at the outset to distinguish between three possible issues with which the courts have to deal. First, there is the issue of whether a child under 16 is **competent** to consent to or to refuse medical treatment (see *Gillick v. West Norfolk and Wisbech AHA* [1986] AC 122 (*Gillick*), and more recently, *R (Bell) v. Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [2022] 1 All ER 416 (*Bell v. Tavistock*)). Secondly, there is the issue of whether a child (but also an adult) has mental **capacity** to consent to or to refuse medical treatment (see sections 1-6 of the Mental Capacity Act 2005). Thirdly, there is the issue of what is in a child's **best interests**. This issue arises once the presumption as to the **competence** of a child over 16 to consent or refuse medical treatment is engaged (see section 8 of the Family Law Reform Act 1969 (FLRA 1969), which provides that a child over 16 can give consent in the same way as an adult, and no further consent is required from parents or guardians). Despite section 8, the court still retains the right to override consent given or withheld by a child over 16 on welfare or **best interests** grounds in very limited and well-defined circumstances (see *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 (*Re W*)).

3. This case now concerns mainly, if not only, the third issue that I have described above, namely whether now or in the future the court could or should override any consent given by the young person for cross-sex hormone treatment. It is accepted that, now the young person is 16, no *Gillick* competence question arises (see Sir James Munby at [55] in *An NHS Trust v. X* [2021] EWHC 65 (Fam), [2021] 4 WLR 11, and MacDonald J at [48]-[49] in *GK and LK v. EE* [2023] EWCOP 49). It is also accepted that the young person is "impressive, hardworking and intelligent" and has no mental health problems (see [8], [60] and [62] of the judge's judgment). Accordingly, questions as to the young person's mental capacity (the second issue I have described at [2] above) are unlikely ever to arise.

4. The judge's decision is encapsulated in [61] of her judgment, where she concluded that there was no "realistic basis upon which I would override [the young person's] consent to treatment by a regulated provider or clinician in this country". As a result, she held that there was no legitimate purpose in adjourning the case. The main issue before us is whether the judge was right to reach that conclusion.

5. Before this court the mother contended that there was a legitimate purpose in adjourning proceedings, because: (i) the legal and regulatory landscape for gender dysphoria treatment was changing rapidly, (ii) the final report of Dr Hilary Cass's *Independent Review of Gender Identity Services for Children and Young People* (the Cass Review) was only published on 10 April 2024, a week prior to the hearing before the judge, (iii) Government was continuing to take steps in response to the Cass Review, and (iv) Gender Plus was a private provider, whose practices and procedures were diverging from the approach followed by the National Health Service (NHS). In these circumstances, it behoved the court to keep an eye on a case of this kind in a time of flux. The mother also argued, though not strenuously, that cases concerning treatment for gender dysphoria should be regarded as being in in a special category requiring judicial oversight wherever there was less than complete unanimity. If necessary, the mother submitted that this court should depart from its recent decision in *Bell v. Tavistock*.

6. The father and the Guardian, on the other hand, contended that the judge had been right to close these proceedings down for the careful reasons she gave. The young person's welfare and best interests demanded that course. The proceedings had already been going on for more than 2 years and they would, if they continued, be disruptive to the young person's life and cause him significant and unnecessary distress.

7. I have decided, although not without hesitation, that the judge was wrong to refuse to adjourn the mother's application. In normal circumstances, as explained in *Bell v. Tavistock*, questions of *Gillick* competence are for doctors. Moreover, questions of policy relating to treatments for gender dysphoria are for the NHS, the medical profession and the regulators. Where, as here, there is no question of the young person's competence or capacity, the judge had good reason for thinking that the young person's best interests were served by allowing the treatment process to take its course, without the oversight of the court. On careful reflection, however, I think that two factors combined here to make it clearly appropriate for the court to keep the proceedings alive at least until the young person's assessment by Gender Plus has been completed and can be considered, if necessary, by the court in circumstances where there continues to be genuine disagreement between the parties. First, Gender Plus, as a private provider, could not satisfy all the recommendations made in the Cass Review, including, in particular, the recommendation that every case proposed for medical treatment should be considered by a national multi-disciplinary team. Secondly, the Cass Review had only just been published when the judge heard the application, and it was already clear then (and has been demonstrated since) that Government would be taking various (perhaps then unknown) steps to implement it in ways that the court could not predict, but which might (in the future) affect an appropriately objective view of where the young person's best interests lay.

8. I shall explain my reasons in a little more detail below in the following sections: (i) essential factual background, (ii) the Cass Review, (iii) the judge's decision, (iv) relevant statutes and authorities, (v) discussion, and (vi) conclusion.

Essential factual background

9. The judge set out the factual background. I do not intend to repeat all she said. In particular, I do not think it is necessary to set out the details of the Guardian's meticulous reports and the various medical reports upon which she relied. The

following abbreviated summary of essential events is taken from [3]-[13] of the judgment.

10. In 2020, the young person informed his parents that he was transgender. His father accepted the situation, but his mother did not. The young person's relationship with his mother deteriorated. Since 2021, he has been living with his father. The mother arranged counselling for the young person and therapy for the young person and the parents between late 2020 and 2022.

11. The mother's court application was made in August 2022, originally asking the court to prevent the father from arranging for the young person to access treatment for gender dysphoria. In October 2022, the mother arranged for the young person to undergo an autism assessment, which showed that he had some limited autistic traits. The local authority's assessment in November 2022 noted that the young person had suffered disruption and trauma because of parental acrimony and gender dysphoria. The young person's GP wrote to the court in December 2022 saying that the young person had gender dysphoria but no clinical evidence of mental health problems.

12. Thereafter, the mother agreed that the young person should join the waiting list for NHS treatment, but she did not agree to private treatment. The young person and the father wanted to pursue treatment with an offshore private clinic, Gender GP. Eventually, the judge made an agreed interim prohibited steps order in respect of private treatment (which remained in place as at the April 2024 hearing before the judge). The parents engaged unsuccessfully but consensually with an Improving Child and Family Arrangements (ICFA) service. That intervention failed because both the parents continued to hold strongly opposing views, and the young person remained anxious to be treated.

13. The judge met the young person in August 2023, forming the view that he was intelligent, well informed, engaging and articulate.

14. In October 2023, the mother sought and obtained permission to instruct a Consultant Endocrinologist and a Child and Adolescent Psychiatrist to provide expert advice as to the young person's capacity and the effect of giving or delaying hormone treatment. Neither expert opinion was obtained. No Consultant Endocrinologist in this country was prepared to give expert evidence. A Consultant Psychiatrist was identified, but the young person refused to agree to his medical records being disclosed. The young person was unwilling to engage in an assessment which was not part of an assessment towards a treatment pathway.

15. The Guardian prepared an addendum report about the young person's living arrangements and relationships. He reported that the young person's partner is also a transgender male, who happens also to be his stepmother's child, living in the same household.

16. In January 2024, the first private gender dysphoria hormone clinic in the UK (Gender Plus) gained registration from the Care Quality Commission. Such registration is not required or available for its associated Gender Plus assessment clinic. Shortly before the hearing, the young person had his 16th birthday. As I have said, 7 days before the hearing, the Cass Review was published.

17. Gender Plus explained its assessment methodology, proposing six appointments over a period of six months, five of which would be online, before deciding whether the young person should be referred to the Gender Plus hormone clinic for hormone treatment for further decisions to be made.

18. The following relevant events before and since the hearing are worthy of mention: (i) the Cass Interim Review in 2022 led to the closure of the Tavistock clinic that had been in issue in *Bell v. Tavistock*; (ii) on 12 March 2024, NHS England published a clinical policy concluding that there was not enough evidence to support the safety or clinical effectiveness of puberty blockers to make the treatment routinely available (outside a research protocol); (iii) as the judge recorded at [58], NHS Scotland had announced before the hearing that persons under 18 would not be prescribed cross-sex hormones; (iv) on 21 March 2023, NHS England published a clinical commissioning policy laying down stringent eligibility and readiness requirements to be met before cross-sex hormones could be administered to those over 16; (v) on 9 April 2024, NHS England wrote to all NHS gender dysphoria clinics asking them to defer offering first appointments to those under 18 "as an immediate response to Dr Cass's advice that 'extreme caution' should be exercised before making a recommendation for [cross-sex hormones] in [children]"; (vi) on 10 April 2024, the Cass Review was published; and (vii) on 11 December 2024 (the day before the hearing before the Court of Appeal), the government announced that the temporary embargo on the use of puberty blockers would be made indefinite (subject to a review in 2027).

The Cass Review

19. The Cass Review has received wide publicity. Like the subjects it covers, it is controversial. Strongly held views have been expressed on both sides of the debate. Nothing I say in this judgment should be construed as expressing support for one side or the other.

20. I would prefer not to pick out parts of a detailed 387-page report. The Cass Review merits consideration in its entirety. For the purposes of this case, however, the mother has highlighted that the Cass Review has called into question the quality of the evidence on which hormone treatments for adolescents are based. Dr Cass says at page 13, for example, that "[t]he reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress". Moreover, Dr Cass highlights new evidence about brain maturation continuing into the mid-20s, whilst it was originally thought to finish in adolescence (see Chapter 6). Dr Cass recommended that puberty blockers should only be available within a research protocol, and that recommendation has, as I have said, now been implemented.

21. Despite what I have said, recommendations 8, 9 and 26 of the Cass Review are of particular relevance to this case:

> Recommendation 8: NHS England should review the policy on masculinising/feminising hormones. The option to provide masculinising/feminising hormones from age 16 is available, but the Review would recommend extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18.

> Recommendation 9: Every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team (MDT) hosted by the National Provider Collaborative replacing the Multi Professional Review Group (MPRG).
>
> Recommendation 26: The Department of Health and Social Care and NHS England should consider the implications of private healthcare on any future requests to the NHS for treatment, monitoring and/or involvement in research. This needs to be clearly communicated to patients and private providers.

The judge's decision

22. The judge's reasoning was encapsulated at [56]-[64] of her judgment.

23. She said first that, whilst the findings of the Cass Review might turn out to be very significant, she did not think they justified her departure from *Bell v. Tavistock* and from Lieven J's decision in *AB v. CD and Tavistock* [2021] EWHC 741 (Fam) (*AB v. CD*), which the Court of Appeal approved in *Bell v. Tavistock*.

24. The judge said at [57] that her starting point was section 8 of the FLRA 1969, which allowed the young person to consent to his own treatment, whether or not his parents agreed, even though the inherent jurisdiction might on occasion override the decisions of a competent minor (almost always where a young person was refusing life-saving medical treatment). The judge later noted at [59], however, that the boundaries were not closed and referred to the President's decision in *EF v. LM and J* [2024] EWHC 922 (Fam) highlighting concerns about Gender GP, commenting as follows:

> Situations such as those could potentially lead to a judge being persuaded it was appropriate to intervene. In this case, however, [the young person] does not have any mental health problems, nor does it appear that he is personally the subject of coercion in his home or socially although I am not sure I share the Guardian's confidence that [the young person] is able to consider all the evidence about gender dysphoria and the treatment available in a balanced and unbiased way (something that is beyond many adults). The father is prepared to give an assurance that he will not facilitate [the young person] seeking treatment through Gender GP or any other offshore agency whilst he remains under 18 and so seeking treatment offshore does not apply.

25. The judge recorded at [58] some of the recommendations of the Cass Review that I have mentioned, and in particular the inability of Gender Plus to comply with recommendation 9.

26. Before the judge concluded, as I have said, that there was no realistic basis upon which she would override the young person's consent to treatment by a regulated clinician in this country, she said, correctly I think, at [60]:

> The controversy over treatment of young people (whether privately or through the NHS) for gender-related distress or dysphoria is a matter of public interest, but it is something which should fall to be considered by medical and associated professions and their regulators, or if need be, the government. Although Gender Plus is a private provider the hormone clinic requires continued registration. Those

> who treat [the young person] could be liable in negligence if they do not provide a proper standard of care or fail to abide by guidelines without good reason.

27. The last sentence of [60], however, expresses the view that the mother's submission that "safeguards to date have not been sufficient for many young people" were a matter for regulation and professional standards rather than a judge.

28. At [62], the judge made it clear that she thought that it was in the young person's best interests to bring the proceedings to an end. Her reasons were as follows:

> The Guardian's evidence is that he is a very mature child and that his views are very much his own. His attitude has hardened very considerably over the last few months. The proceedings themselves … are causing him to become more entrenched in his views about treatment and increased his anger towards his mother. … I can see a danger that the battle itself could distract [the young person] from focussing on the advantages and disadvantages of any proposed treatment, and what he wants for himself throughout his life. … It is vital that he engages fully in the assessment that is being offered to him and prepares himself to make some very important decisions if he is offered medical intervention thereafter. Given the advice from the Cass Review any doctor will have to exercise great caution before prescribing hormones to a minor, and so it seems quite likely he will have to wait for another two years, but that time will go fast. He needs calm and dispassionate advice over the coming months and years, and the ability to recognise it as such.

29. On that basis, the judge discharged the interim orders including the one preventing private treatment, and accepted the father's undertaking not to fund or facilitate offshore treatment whilst the young person was under 18. She declined to make any broader declaration about the court always requiring oversight of private clinics prescribing puberty blockers or hormone treatment to persons under 18. She invoked Lord Phillips MR's *dictum* at [77] in *R (Burke) v. General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 (*Burke*) as to the dangers of a court grappling with issues which are divorced from the specific facts of a case.

Relevant statutes and authorities

30. Section 8(1) of the FLRA 1969 provides that:

> 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 her 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.

31. Section 2(1) of the Mental Capacity Act 2005 provides that:

> For the purposes of this Act, 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 the functioning of, the mind or brain.

32. Section 3(1) of the Mental Capacity Act 2005 provides that:

> For the purposes of section 2, a person is unable to make a decision for himself if he is unable: (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).

33. *Re W* remains good law. It authoritatively explained the meaning of section 8 of the FLRA 1969 in the judgments of Lord Donaldson MR and Balcombe and Nolan LJJ, which repay consideration. They explained the distinction between *Gillick* competence and section 8 that I have drawn attention to at [2] above. The case concerned a person under 18 who refused treatment for anorexia nervosa. It is sufficient for our purposes to cite the headnote in the report of *Re W* as follows:

> … on its true construction [section 8] did not confer on a minor who had attained the age of 16 an absolute right to determine whether or not he received medical treatment but enabled him, for the limited purpose of protecting his medical practitioner from prosecution or from any claim in trespass, to give consent to such treatment as effectively as if he were an adult; that, although a minor of any age who had sufficient maturity might consent to treatment, his refusal to give consent could not overrule consent given by the court; that in exercising its inherent jurisdiction the court would take particular account of the minor's wishes, the importance of which increased with his age and maturity, but would override them where his best interests so required.

34. *Bell v. Tavistock* was a judicial review case, where no unlawfulness was actually alleged. The Divisional Court had made a declaration as to appropriate medical practice in the treatment of gender dysphoria. The Court of Appeal (Lord Burnett LCJ, Sir Geoffrey Vos MR and King LJ) held that it had been inappropriate to make any such declaration, since the judicial review in question did "not require the courts to determine whether the treatment for gender dysphoria is a wise or unwise course or whether it should be available through medical facilities in England and Wales" [3]. Such policy decisions were for the National Health Service, the medical profession and its regulators and Government and Parliament.

35. At [85], the Court of Appeal said that that the Divisional Court had not been "in a position to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers. The [Divisional Court] was not deciding any specific case and fell into the error identified by Lord Phillips in *Burke*". The Court of Appeal explained that the test of *Gillick* competence was for the doctors, not the judges [76]. At [48], *Bell v. Tavistock* approved Lieven J's decision in *AB v. CD* to the effect that "unless the parents were overriding the wishes of the child, the parents of a child patient could consent to puberty blockers on their child's behalf … without the need for a "best interests" application to the court". That was, of course, decided before puberty blockers were banned (see [18(ii) and (vii)] above). *Bell v. Tavistock* also approved Lieven J's rejection of the suggestion that the prescription of puberty blockers was in a special category of medical intervention which always required the sanction of the court.

36. It will be noted that *Bell v. Tavistock* cautioned against making decisions about factual circumstances that might occur in the future and were not before the judge, but were being considered in the abstract. I would repeat that warning now.

Discussion

37. It can be seen at once that this case is very different from both *Bell v. Tavistock* and *AB v. CD*. Moreover, since *Bell v. Tavistock*, the regulatory landscape has changed considerably. *Bell v. Tavistock* concerned puberty blockers, which have, as I have said, now been banned in England and Wales. *Bell v. Tavistock* concerned *Gillick* competence in respect of a child under 16, and this appeal concerns the simple question of whether a "best interests" application in respect of a young person who is over 16 should be kept alive as a precaution in case it might become necessary for the court in the future to consider it again. The circumstances in which that might become necessary, according to the mother, include the event that the young person makes a decision to accept treatment with cross-sex hormones in advance of his reaching adulthood. The mother might at that stage ask the court to declare whether such treatment was or was not, at that time, in his best interests, in the factual circumstances available at that future time. The judge balanced the distress and damage being caused to the young person by the lengthy ongoing proceedings against the benefits of the court continuing to keep an eye on the young person's welfare.

38. As I have already said, I have decided that the judge was wrong to refuse to adjourn the mother's application in the unusual circumstances of this case. The judge did not, I think, place enough weight on the rapidly changing regulatory environment and the situation of private providers like Gender Plus in the light of the recommendations made by the Cass Review.

39. The parents agreed before the judge that it was appropriate for the young person to undergo a 6-month assessment by Gender Plus. But it was clear, as the judge acknowledged, that Gender Plus could not comply with recommendation 9 of the Cass Review as to the need for the case to be discussed by a national multi-disciplinary team of the kind envisaged. It is impossible now to predict the outcome of Gender Plus's assessment (we were told it is in progress, if not complete), nor the consequences that might or might not occur as a result of a potential non-compliance by the private provider with the good practice suggested by Dr Cass. What can be seen already is that the mother, on the one hand, is unlikely to agree with the young person and the father, on the other hand, if the young person is ultimately prescribed cross-sex hormones and gives his consent to their administration. It seems most likely that no question of competence or capacity will arise, but I was struck by the judge's statement at [59] to the effect that she was "not sure [that she shared] the Guardian's confidence that [the young person was] able to consider all the evidence about gender dysphoria and the treatment available in a balanced and unbiased way". In those circumstances, I think that the judge ought to have accorded significantly more weight to the possibility of genuine future disagreement, the rapidly changing regulatory environment and the fact that the services provided by private hormone clinics seem already to be in a somewhat different position from the same services provided by the NHS.

40. I completely understand, as I have said, why the judge thought that the young person's current best interests favoured terminating these long-running proceedings at once, particularly where there was no question of the young person's competence or capacity.

But I disagree with the judge's view, in the rapidly changing regulatory environment that I have described, that she could not envisage any realistic basis upon which the court might, in the future, override the young person's consent to private treatment with cross-sex hormones. I cannot predict the future. The judge may well be right, but I think there is sufficient current doubt as to what is proper and appropriate in this area that it would be a wiser course to keep the proceedings alive at least until Gender Plus's assessment of the young person has been completed and can be considered, if necessary, by the court. I am not persuaded that the young person's present unwillingness to share that assessment with his mother has any bearing on that approach. For the reasons I have given, I think that these are legitimate purposes requiring the case to be adjourned rather than dismissed at this stage.

41. I realise that the young person will be disappointed by this outcome, but I hope that he will come quickly to realise that we have pre-judged nothing. I am just keen that all circumstances can be taken into account in the event that it becomes necessary in the future for this court to consider where his best interests lie. As *Re W* emphasises, one of the most important factors at that stage would be the young person's own wishes.

42. I should say also that, as we decided in *Bell v. Tavistock* in relation to puberty blockers, I do not regard the administration of hormone treatment as being in a special legal category. Of course, the question of whether young people ought to be prescribed cross-sex hormones is different factually from other situations that the court has faced in the past. But the applicable legal principles are now clear, as I have tried to explain. Courts should always be clear as to the legal tests they are applying, whether they be questions of *Gillick* competence, capacity under the Mental Capacity Act 2005 or the "best interests" of a young person where it is suggested that court should override a young person's decision under section 8 of the FLRA 1969.

43. In this case, the court was simply being asked to keep open the possibility that it would, in the future, need to decide whether hormone treatment, to which the young person had consented, was or was not in his best interests. That would be a factual question that the court would be well equipped to decide on the basis of the principles explained in *Re W* and the subsequent cases that have applied it.

Conclusion

44. For the reasons I have given, I would allow the appeal and adjourn these proceedings to allow for the completion of the child's assessment by Gender Plus so that, if necessary, that assessment can be considered by the court. In formal terms, I would adjourn the proceedings with no continuing orders in place, and order that the proceedings may be restored to the judge by either party for further directions to be made.

Sir Andrew McFarlane, President of the Family Division:

45. For the reasons given by the Master of the Rolls, I agree that the judge's order bringing the proceedings to a conclusion must be set aside and replaced with an order adjourning the applications as he describes.

46. It is important to stress that the court's best interests jurisdiction with respect to consent to medical treatment given by a competent person who is over 16, but under 18, is not

a general welfare jurisdiction. As was made plain in *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, the court will only override the consent of a competent young person, who is over 16, where it is necessary for the court to intervene to protect them from 'grave and irreversible mental or physical harm' (Nolan LJ p 94). Each case may turn on its own facts and, whilst the issue of law was not in direct focus in this appeal, I agree with My Lord that the administration of cross-hormone treatment is not in a special legal category in this regard.

Lady Justice King:

47. I agree with both judgments.