



Neutral Citation Number: [2021] EWHC 65 (Fam)

Case No: FD20P00690

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
(In Open Court)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18 January 2021

Before :

SIR JAMES MUNBY
(Sitting as a judge of the High Court)

In the matter of X (A Child) (No 2)

Between :

A NHS TRUST
- and -
X

Applicant

Respondent

Miss CLAIRE WATSON (instructed by Hill Dickinson LLP) for the Applicant
Mr SHANE BRADY (instructed by Richard Cook Solicitors) for the Respondent
Ms VICTORIA BUTLER-COLE QC and Mr ALEXANDER RUCK KEENE (instructed
by Cafcass Legal) for the Advocate to the Court Cafcass Legal

Hearing dates: 18-19 November 2020

Judgment Approved by the court
for handing down

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Sir James Munby :

1. It is clearly established in English law that an adult (that is, someone who has reached the age of 18) is presumed, unless proved otherwise, to have capacity to decide whether or not to accept medical or surgical treatment. It is equally clear that a capacitous adult has an absolute right to accept or refuse treatment, for reasons good or bad or, indeed, for no reason at all, and even if the consequence of refusal is the certainty of very serious harm or even death. The decision of a capacitous adult is therefore determinative, in the strict sense in which I use the word. Subject only to being satisfied that the capacitous adult's expressed decision is in fact his true decision and not vitiated by the undue pressure of either events or people (as to which see *In re T (Adult: Refusal of Treatment)* [1993] Fam 95) the only function of the court is to give effect to it, whether or not it might accord with his judicially-determined best interests. Indeed, the court is not concerned to evaluate, let alone to impose an outcome determined by, his best interests.
2. It is conventional wisdom that no child (that is, someone who has not reached the age of 18) has such an absolute right, and that even if the child is *Gillick* competent (see *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112) or, having reached the age of 16, comes within the ambit of section 8 of the Family Law Reform Act 1969, the court, in the exercise of its inherent *parens patriae* or wardship jurisdiction, can in an appropriate case – typically thought of as being a case where the consequence of the child's decision is likely to be serious risk to health or death – overrule the child's decision, either, as the case may be, vetoing some procedure to which the child has consented or directing that the child should undergo some procedure to which the child is objecting. That conventional wisdom is founded on the decisions of the Court of Appeal in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64.
3. In the present case that conventional wisdom has been challenged and put to the test. It is said that, whatever was or was not decided in those two cases, this is not the law. Times have changed, it is said. Views as to the proper balance between medical paternalism and patient autonomy have altered, with the balance, it is said, continuing to move against the former and in favour of the latter. The Human Rights Act 1998 has fundamentally changed the legal landscape as also, in this particular context, it is said, has the Mental Capacity Act 2005. And there have been other developments in the law; especial reliance is placed upon what is, on any footing, the very important decision of the Supreme Court of Canada in *AC and Others v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [2009] 5 LRC 557. These are important arguments that require the most careful consideration, not just because of the consequences for X, the child with whom I am concerned, but because of their potential impact on the law generally.
4. It is right that I set out here, verbatim, the way in which the case for X is put on her behalf:

“This case is about whether [X], a young woman declared to be *Gillick* competent and “mature and wise beyond her years”, should be afforded the exclusive right to decide her own medical care in the same way as her peers aged 18 years and older. [She] is not refusing all medical treatment. She is exercising a choice about how she wishes to fight her disease, a choice that is grounded in

her human dignity, self-determination, bodily autonomy, and religious conscience. The Applicant seeks to deny [X] her autonomy, requesting a two-year “rolling order” which authorises doctors to repeatedly impose a medical procedure on [X] which she finds deeply repugnant. The Applicant further asks that the “rolling order” remain effective right up to the point [X] reaches the arbitrary chronological age of 18.

The Applicant’s actions and request for a two-year “rolling order” comprise severe and profound violations of [X]’s rights guaranteed at common law, under the Mental Capacity Act 2005, and Articles 3, 5, 8, 9 of the European Convention on Human Rights ... taken alone and in conjunction with Article 14.

[X] requests this Court reject the Applicant’s application in the strongest and clearest of terms and declare that [X], as a person with decisional capacity who is “mature and wise beyond her years”, has the exclusive legal right to decide her own medical care, including refusal of consent to blood transfusions.”

That is a powerful plea which demands both respect and the most careful and anxious scrutiny.

5. The Applicant’s response, in short, is that the law is settled and the court is bound to apply the legal principles set out by the Court of Appeal in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1993] Fam 64, any change to the law being essentially a matter for Parliament, and that the “rolling order” sought is both permissible and appropriate.
6. Because I am concerned in this judgment only with points of law, I can take the relevant facts very shortly. X was born in January 2005. She is a baptised Jehovah’s Witness. Unhappily, she suffers from serious sickle cell syndrome. On occasion this produces a crisis when, in the opinion of her treating clinicians, a blood transfusion becomes an imperative necessity.
7. On 31 May 2020 such a crisis blew up (there had been a previous crisis in 2015 resolved without court order) which led to an urgent hearing out of hours before Gwynneth Knowles J on 3 June 2020. She gave judgment the same day: *Re X* [2020] EWHC 1630 (Fam). Applying the principles as summarised by MacDonald J in *Cardiff and Vale University Health Board v T (A Minor)* [2019] EWHC 1671 (Fam), paras 12-18, a case involving a baby whose mother, a Jehovah’s Witness, was refusing consent to a blood transfusion, Gwynneth Knowles J made an order that that the hospital be permitted to transfuse X with red blood cells. There was no consideration at that stage as to whether X was *Gillick* competent. In the following months there were two more crises each of which was resolved with alternative medical management not involving blood transfusions.
8. The next event was in October 2020 and the matter came in front of me, under what I described as the pressure of considerable medical crisis, on 29 October 2020: *Re X* [2020] EWHC 3003 (Fam). On this occasion, X was represented by counsel, Mr Shane Brady. It was common ground that X was *Gillick* competent and Mr Brady wished to argue that, as a matter of law, her refusal of consent was determinative. I found myself in a most unhappy position, which I summarised as follows (paras 8, 10, 14):

“8 Mr Brady’s argument, which is powerful and demands much fuller response than I can give it today, is that to impose this form of treatment on X is to impinge impermissibly upon her autonomy as, I emphasise, a *Gillick* competent child of almost 16. He submits that the law has moved on, not merely in consequence of the Human Rights Act 1998, but in more general developments, so that the position which had seemingly been reached by the Court of Appeal in the two cases of *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1993] Fam 64 in the early 1990s no longer reflects the law as it is. Those are powerful arguments which deserve full analysis and proper consideration. Unhappily, we do not have time for that today in the light of Dr C’s medical evidence ...

10 It seems to me that I have, for the purposes of today, to approach this matter on the basis of the law as it currently appears to be ...

14 Mr Brady, in an enormously helpful and detailed skeleton argument for which I thank him, has put together arguments suggesting that this view of the law is in need of urgent re-analysis and review, partly in the light of the Human Rights Act 1998, partly in the light of more general recent legal developments, and partly in the light of the very important decision of the Supreme Court of Canada to which he powerfully drew my attention: *AC v Manitoba* [2009] SCC 30, [2009] 2 SCR 181. These are arguments which require to be dealt with, but it is quite impossible for me, within the timescale that Dr C’s evidence sets out, to engage properly with these arguments today. It seems to me that I have no realistic choice, but to take the law as being that which was laid down by the Court of Appeal in the two cases I have mentioned, the best part of 30 years ago ...”

9. Accordingly, I made an order (para 15) authorising the giving of the blood transfusion as desired by the treating clinicians. I went on, however, to make clear my concerns (paras 18-21):

“18 ... It is a matter of profound concern to me that, for whatever reason, this case has come back before the court, having previously been before the court in May ..., in a tremendous rush and in circumstances approaching medical crisis. Now, there is no point in seeking to explore why that has happened, let alone to apportion blame, but it has had the profoundly adverse consequence, the profoundly troubling consequence, that the court has not been able to deal with it in the way in which, ideally, the court would wish to deal with it.

19 It would be nothing short of intolerable if I were simply to make the order I have made and left the matter to await the next potential crisis, because my understanding of the medical evidence is that a crisis of the sort which has erupted in recent days, like the crisis which erupted in May of this year, may be a recurrent feature of X’s condition. It seems to me imperative that the court, sooner rather than later, and before we have the next crisis, is able to give proper attention to Mr Brady’s very important submissions so that the next time, if there is a next time and the case comes back to court, there will be a clear legal

framework available for the resolution of the next crisis. I would like the parties to consider how best we could deal with that.

20 There is also ... the question of whether the court should make, as it were, an order covering similar eventualities over the next two years until X reaches the age of 18. That is a matter which needs to be dealt with urgently and as part of this urgent hearing which I have in mind. However, it does seem to me something which is going to require careful argument because, as I indicated during the course of arguments, whereas, at present advised, I have little doubt the court has power to make such an order, I will require considerable persuasion that it is proper for the court to make such an order in this kind of case.

21 It does seem to me that the proper way forward to avoid this unfortunate scramble to justice, because that is all we have been able to achieve today, is to make sure that these important issues that Mr Brady very properly wants to raise, can be dealt with in early course at a hearing where there has been adequate time for preparation, adequate time for argument and adequate time for judicial reflection.”

10. Accordingly, the order I made provided that the matter was to be listed for a further hearing with a time estimate of 2 days:

“to determine the following issues: (a) Whether following the enactment of the Human Rights Act 1998 and other developments in the law, the consent to or refusal of medical treatment by a capacitous / *Gillick* competent minor under the age of 18 should be determinative; (b) Whether it is in [X’s] best interests to have further “top up” blood transfusions in the event of further serious deterioration in her medical condition and if clinically indicated during this admission and/or subsequent admissions until she reaches the age of 18.

11. Very helpfully, CAFCASS Legal accepted my invitation to act as advocate to the court.
12. When the matter came back for hearing before me on 18 November 2020, the applicant NHS trust was represented, as on 29 October 2020, by Miss Claire Watson. X was again represented by Mr Brady. CAFCASS Legal was represented by Ms Victoria Butler-Cole QC and Mr Alexander Ruck Keene. Counsel’s submissions, both written and oral, were in each case of the highest quality and of very great assistance to me. I am grateful to all of them. At the end of the hearing on 19 November 2020 I reserved judgment.
13. Subsequently, on 1 December 2020, the Divisional Court handed down judgment in *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin). With my permission both Ms Butler-Cole and Mr Ruck Keene and Mr Brady lodged further skeleton arguments, the former on 3 December 2020 and the latter on 4 December 2020. Miss Watson elected not to.
14. X, as I have said, was not yet 16, and the question was raised as to whether it was appropriate for me therefore to be considering what the position might be when she reached 16, at which point, on any view, the relevant legal landscape would change, not least in the light of section 8 of the Family Law Reform Act 1969, which would then come into play for X. Section 8 provides:

“Consent by persons over 16 to surgical, medical and dental treatment.

(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

15. Recognising, of course, the proper reluctance of the court to rule on future or hypothetical questions, I have to say that this seems the plainest possible case for doing so. The medical reality is that X, unhappily, will, in the view of her treating clinicians, require blood transfusions again during the next few years. Unless, perish the thought, she were to die in the meantime, X would be celebrating her 16th birthday in January 2021. In these circumstances, she and her treating clinicians are entitled to know where they stand when the first crisis after her 16th birthday occurs. And, if the experience of the last two hearings is anything to go by, there will not be adequate time to consider this difficult legal question before urgent medical necessity intervenes. I have had full argument on the point. Moreover, although they are conceptually different, the issues in relation to the *Gillick* competent child and the 16-year-old child are, as we will see, closely intertwined in the authorities.
16. So far as X is concerned this case is all about her strongly held religious beliefs. Therefore, before proceeding any further, I must consider how our secular law deals with religion – for I sit as a secular judge in a secular court. For this purpose, I can conveniently go to my judgment in *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677, paras 35-36:

“35 Religion – whatever the particular believer’s faith – is not the business of government or of the secular courts, though the courts will, of course, pay every respect to the individual’s or family’s religious principles. Article 9 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (the European Convention), after all, demands no less. The starting point of the common law is thus respect for an individual’s religious principles, coupled with an essentially neutral view of religious beliefs and a benevolent tolerance of cultural and religious diversity.

36 It is not for a judge to weigh one religion against another. The court recognises no religious distinctions and generally speaking passes no judgment on religious beliefs or on the tenets, doctrines or rules of any particular section of society. All are entitled to equal respect, so long as they are ‘legally and socially acceptable’ (Purchas LJ in *Re R (A Minor) (Residence: Religion)* [1993] 2 FLR 163 at 171) and not ‘immoral or socially obnoxious’ (Scarman LJ in *Re*

T (Minors) (Custody: Religious Upbringing) (1981) 2 FLR 239 at 244) or ‘pernicious’ (Latey J in *Re B and G (Minors) (Custody)* [1985] FLR 134 at 157, referring to scientology).”

17. Article 9 of the European Convention provides as follows:

“1 Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2 Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.”

18. I continued, *Re G* paras 37-38:

“37 ... The protection of Art 9 is qualified in two ways. In the first place, the European Convention protects only religions and philosophies which are ‘worthy of respect in a “democratic society” and are not incompatible with human dignity’: see *Campbell and Cosans v United Kingdom (No 2)* (Application No 7511/76) (1982) 4 EHRR 293, at para 36 ... Secondly, whilst religious belief and thought are (subject to that overriding qualification) given absolute protection by Art 9(1), the ‘manifestation’ of one’s religion in ‘worship, teaching, practice and observance’ is subject to the qualifications referred to in Art 9(2) of the European Convention.

38 The important point for present purposes is that the European Convention forbids the State to determine the validity of religious beliefs and in that respect imposes on the State a duty of what the Strasbourg court has called neutrality and impartiality: see, for example, *Moscow Branch of the Salvation Army v Russia* (Application No 72881/01) (2006) 44 EHRR 912, at para 58, where the court said that:

“The State’s duty of neutrality and impartiality ... is incompatible with any power on the State’s part to assess the legitimacy of religious beliefs.”

19. All this, however, is subject to the paramount consideration of the child’s welfare. As I continued (paras 43-44):

“43 Some manifestations of religious practice may be regulated if contrary to a child’s welfare. Although a parent’s views and wishes as to the child’s religious upbringing are of great importance, and will always be seriously regarded by the court, just as the court will always pay great attention to the wishes of a child old enough to be able to express sensible views on the subject of religion, even if not old enough to take a mature decision, they will be given effect to by the court only if and so far as and in such manner as is in accordance with the child’s best interests. In matters of religion, as in all other aspects of a child’s upbringing, the interests of the child are the paramount consideration.

44 There are many examples of the working out of these principles in the family courts. Sometimes, as in the cases involving blood transfusions for the children of Jehovah's Witnesses, the issue is literally one of life or death (using those words in the secular sense). The tenets and faith of Jehovah's Witnesses will not prevent the court ordering a child to receive a blood transfusion, even though both the parents and the child vehemently object: see, for example, *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386."

I gave other examples (paras 45-46).

20. I stress, because the point is so important, and not just to X, that the court extends precisely the same respect to a Jehovah's Witness as to the adherent of any other religion or religious sect. Plainly, the beliefs of a Jehovah's Witness are "worthy of respect in a 'democratic society'" and they are not in any way "incompatible with human dignity". That principle was recognised as long ago as 1975 in the classic judgment of Scarman LJ in *Re T (Minors) (Custody: Religious Upbringing)* (1981) 2 FLR 239 at 244:

"We live in a tolerant society. There is no reason at all why the mother should not espouse the beliefs and practice of Jehovah's Witnesses."

The Strasbourg Court, unsurprisingly, has adopted precisely the same approach: *Jehovah's Witnesses of Moscow v Russia* (Application No 302/02) (2011) 53 EHRR 141.

21. Before leaving the case there is one other point to be derived from *Re G*. I posed the question (para 79), What is the task of the judge, what are the judge's aims and objectives, when acting as a "judicial reasonable parent" (Lord Upjohn in *J and Another v C and Others* [1970] AC 668 at 722)? I provided three answers to the question (paras 80-81), the third being the one relevant for present purposes:

"80 ... Thirdly, our objective must be to bring the child to adulthood in such a way that the child is best equipped both to decide what kind of life they want to lead – what kind of person they want to be – and to give effect so far as practicable to their aspirations. Put shortly, our objective must be to maximise the child's opportunities in every sphere of life as they enter adulthood. And the corollary of this, where the decision has been devolved to a 'judicial parent', is that the judge must be cautious about approving a regime which may have the effect of foreclosing or unduly limiting the child's ability to make such decisions in future.

81 The point arises in its most obvious and extreme form where the issue before the court is whether to require a teenager to submit against their wishes to life-saving medical treatment. There, as Nolan LJ once observed (*In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 94), the duty of the court is to ensure so far as it can that children survive to attain the age of 18 at which an individual is free to do with his life what he wishes."

22. I need to elaborate the point I made in *Re G* para 43 as to the great attention the court will always pay to the wishes of a child old enough to be able to express sensible views, even if not old enough to take a mature decision.

23. The profoundly important principle for which Mr Brady contends is not simply to be ignored in the case of *Gillick* competent children, or for that matter in the case of children who are not *Gillick* competent or of incapacitous adults. On the contrary, both section 1(3)(a) of the Children Act 1989 and section 4(6)(a) of the Mental Capacity Act 2005 require the court to “have regard to” (in the one case) or to “consider” (in the other) the person’s “wishes and feelings”. And the same applies when the court is exercising the inherent jurisdiction, whether in relation to a child or to an incapacitous adult.
24. This is not, I emphasise, some empty piece of rhetoric, nor is the obligation thereby imposed on the judge merely mechanical or formulaic. The court must be rigorous in its analysis and consider the issue with anxious scrutiny. The focus must be on the particular facts and circumstances of the individual case, for here, as so often, context is all. I venture to repeat what I said in *In re M (Statutory Will)* [2009] EWCOP 2525, [2011] 1 WLR 344, para 35:

“the weight to be attached to P’s wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P’s wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P’s wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic.”

Very similar views were expressed by Hayden J in *Re N; M v (1) Mrs N (By her Litigation Friend the Official Solicitor) (2) Bury Clinical Commissioning Group (3) A Care Provider* [2015] EWCOP 76, [2016] COPLR 88, para 28.

25. In the case of a *Gillick* competent child, just as in the case of an incapacitous adult, there is a particularly important aspect of this which has to feed into any welfare analysis of best interests: the possible impact on P of knowledge that her wishes and feelings are *not* being given effect to. Thus, in *Re MM; Local Authority X v MM (by the Official Solicitor) and KM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, para 124, a case under the inherent jurisdiction relating to an incapacitous adult, I said:

“The nearer to the borderline the particular adult, even if she falls on the wrong side of the line, the more weight must in principle be attached to her wishes and feelings, because the greater the distress, the humiliation and indeed it may even be the anger she is likely to feel the better she is able to appreciate that others are taking on her behalf decisions about matters which vitally affect her – matters, it may be, as here, of an intensely private and personal nature.”

This reflects the important observation of Hale LJ in *Regina (Wilkinson) v Broadmoor Special Hospital Authority and others* [2001] EWCA Civ 1545, [2002] 1 WLR 419, at para 64:

“The wishes and feelings of the incapacitated person will be an important element in determining what is, or is not, in his best interests. Where he is actively opposed to a course of action, the benefits which it holds for him will have to be carefully weighed against the disadvantages of going against his wishes, especially if force is required to do this.”

26. That the particular context and circumstances are crucial in the case of medical or surgical treatment, is illustrated by *Re X (a child)* [2014] EWHC 1871 (Fam), (2014) 139 BMLR 143, paras 9-10, which concerned the proposed abortion of the child of a girl who was not yet 14 and did not have *Gillick* capacity. I said this:

“9 I leave on one side cases where the mother has for whatever reason so little appreciation of what is going on as not to be able to express any wishes and feelings. This, I emphasise, is not such a case. The point is very simple and profoundly important. This court in exercise of its inherent jurisdiction in relation to children undoubtedly has power to authorise the use of restraint and physical force to compel a child to submit to a surgical procedure: see *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180 and *Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam), [2007] 2 FLR 1083. I say nothing about how this power should appropriately be exercised in the case of other forms of medical or surgical intervention. In the case of the proposed termination of a pregnancy, however, the point surely is this. Only the most compelling arguments could possibly justify compelling a mother who wished to carry her child to term to submit to an unwanted termination. It would be unwise to be too prescriptive, for every case must be judged on its own unique facts, but I find it hard to conceive of any case where such a drastic form of order – such an immensely invasive procedure – could be appropriate in the case of a mother who does not want a termination, unless there was powerful evidence that allowing the pregnancy to continue would put the mother’s life or long-term health at very grave risk. Conversely, it would be a very strong thing indeed, if the mother wants a termination, to require her to continue with an unwanted pregnancy even though the conditions in s 1 of the 1967 Act are satisfied.

10 A child or incapacitated adult may, in strict law, lack autonomy. But the court must surely attach very considerable weight indeed to the albeit qualified autonomy of a mother who in relation to a matter as personal, intimate and sensitive as pregnancy is expressing clear wishes and feelings, whichever way, as to whether or not she wants a termination.”

27. Now this is all very well, but the vital fact remains that in all these cases the judge has, ultimately, to decide the case by reference to the child’s or incapacitated adult’s best interests. So, the vitally important question remains: Is the decision of a *Gillick* competent child determinative in the same way as the decision of a capacitated adult? If not, are there any, and if so what, circumstances in which the decision of a *Gillick* competent child *is* determinative? The question could hardly be more important, for on the answer depends whether the *Gillick* competent child is autonomous in the same way as a capacitated adult is autonomous. No doubt, if a child is *Gillick* competent, her wishes and feelings and decision will, on any view, carry significantly more weight than those of a child who is not *Gillick* competent, but that does not meet Mr Brady’s

point which is that the *Gillick* competent child is autonomous and her decision is in all circumstances determinative.

28. Understandably and appropriately the arguments ranged far and wide; it is not necessary for me to deal with every point raised though I have carefully considered and had regard to them even if not specifically referred to here.
29. I have been referred to, though taken specifically to only a very small part of, a substantial volume of academic legal literature, medical literature, social sciences literature and comparative jurisprudence. Much of this is of absorbing interest but most of it is of only limited use; I have referred to it where it assists. So far as concerns the academic legal literature it is important to note that the Academy, academia, does not speak with one voice.
30. At the outset, one thing is seemingly clear, namely that in some non-medical contexts the decision of a *Gillick* competent child which is not objectively foolish or irrational will be determinative: see, for example, *Re Roddy (A Child) (Identification: Restriction on Publication)* [2003] EWHC 2927 (Fam), [2004] 2 FLR 949, and *AS v CPW* [2020] EWHC 1238 (Fam), [2020] 4 WLR 127; consider also *Mabon v Mabon* [2005] EWCA Civ 634, [2005] Fam 366. Likewise, it would seem that in relation to some invasive medical procedures (whether or not involving surgery) the decision of a *Gillick* competent child will be determinative: see *Re A (A Child)* [2014] EWHC 1445, [2014] Fam Law 1229 (a case where a *Gillick* competent girl 13 years old was held to have the right to decide for herself whether or not to have an abortion). The issue here, however, is whether and to what extent this is qualified, so that there are cases where the *Gillick* competent child's decision in relation to some invasive medical procedure is *not* determinative.
31. I am not concerned here to explore what is meant by *Gillick* competence, nor the criteria by which it is to be assessed, for I take it as read for the purposes of this judgment that X is, as I have already said, *Gillick* competent. I merely record that the starting point is, of course, the seminal decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and that the most recent, and very illuminating, analyses are those of Cobb J in *In re S (A Child) (Child Parent: Adoption Consent)* [2017] EWHC 2729 (Fam), [2019] Fam 177, [2018] 2 FLR 111, and of the Divisional Court in *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin). For present purposes it suffices to note what the court said in *Bell* (para 126):

“... the question as to whether a person under the age of 16 is *Gillick* competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person's individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information.”

They added (para 145):

“*Gillick* makes clear that any decision is treatment and person specific.”

32. There is no need for me to explore the reasoning in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. For a judge at first instance the starting point is

necessarily the decisions of the Court of Appeal in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64. Although these authorities, as others that I will refer to, also deal with the question as to whether or not the decision of a *Gillick* competent child or a child who is 16 or over can be overridden by the child's parents in exercise of their parental responsibility (as to which see section 3 of the Children Act 1989), that issue does *not* arise in the present case and I say no more about it. My concern here is with the different, albeit to an extent related, question whether the decision of such a child can be overridden by the court. Nor, I make clear, am I concerned here with medical treatment in accordance with the Mental Health Act 1983, a matter, raising rather different issues, which I do not propose to consider.

33. I was referred to the United Nations Convention on the Rights of Persons with Disabilities, but I say no more about it since it throws no significant light on the issues before me. Likewise, in relation to certain age provisions in the Children Act 1989 to which Mr Brady referred me. Nor, in my judgment, is this an appropriate occasion to consider a point raised by Ms Butler-Cole and Mr Ruck Keene but not explored in argument: the question whether the appropriate procedure for cases of this kind is by application under the inherent jurisdiction or application for a specific issue order under section 8 of the Children Act 1989. In this connection they referred me to what Mostyn J had said on the subject in *Re JM (A Child); A NHS Trust v M and others* [2015] EWHC 2832 (Fam), [2016] 2 FLR 235, para 24. It suffices to note that, whatever may be the appropriate procedure for a child under the age of 16, there can be no doubt that an application under the inherent jurisdiction is available in relation to such a child and that in relation to a child who has reached the age of 16 the application should, as Mostyn J recognised, be sought solely under the inherent jurisdiction, and not under the Children Act 1989.
34. *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 involved a child, R, who was a little short of her sixteenth birthday. Because R was not yet 16, section 8 of the Family Law Reform Act 1969 did not apply. Therefore, although there was some reference to section 8 the focus of the judgments was on *Gillick* competence.
35. Although the proposition that the refusal by a *Gillick* competent child of consent to medical treatment was determinative had been accepted by Waite J at first instance, it was specifically rejected by the Court of Appeal. The headnote is both succinct and accurate:

“The judge held that in exercising the wardship jurisdiction he could not override the decision of a “competent” minor to refuse treatment, but that R’s mental condition precluded her from achieving that competence. Concluding that the proposed treatment was in her best interests he accordingly granted the application.

On appeal by the Official Solicitor [contending that the judge was correct in law but wrong on the facts]: —

Held, dismissing the appeal, that the court in the exercise of the wardship jurisdiction was entitled to override a minor’s decision either consenting to or refusing treatment, irrespective of his or her “competence;” that in any event, having regard to the fluctuating nature of her illness, R was not “competent” to

give or withhold her consent, and that the judge’s order had been properly made.”

36. Lord Donaldson of Lynton MR set out (page 22) the Official Solicitor’s submission as being:

“that (a) if the child has the right to give consent to medical treatment, the parents’ right to give or refuse consent is terminated and (b) the court in the exercise of its wardship jurisdiction is only entitled to step into the shoes of the parents and thus itself has no right to give or refuse consent.”

37. He rejected both propositions, summarising his conclusions as follows (page 26):

“There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto.

A “*Gillick* competent” child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian.

... The court in the exercise of its wardship or statutory jurisdiction has power to override the decisions of a “*Gillick* competent” child as much as those of parents or guardians.”

38. On the point with which I am here concerned – namely the power of the court vis-à-vis the *Gillick* competent child – Staughton LJ agreed (pages 28-29):

“The second question is whether the court has power to override the decision of a competent minor who is a ward [he had earlier made clear that he was using the word “competent” “in the *Gillick* sense”]. Again it can arise in two forms: the court may be minded to consent when the ward does not (which would be the situation here, if I had found on the evidence that the ward is competent to take the decision); or the court may be minded not to consent when the ward does (as in the *Gillick* hypothetical case). I say at once that in my judgment the *Gillick* case did not touch on this question.

It can be argued that a wardship judge, exercising the authority of the Crown as national parent, should have no greater powers than a natural parent. I have a good deal of sympathy with that argument, for I accept as a general principle that good reason must be shown before the state exercises any power to control the decisions of a competent person, whether adult or minor, which only concern his own well-being.

There is, however, a group of decisions mainly of Family Division judges, which supports the opposite conclusion ...

Faced with such a substantial consensus of opinion among judges who have to deal with this problem from day to day, I conclude that the powers of a wardship judge do indeed include power to consent to medical treatment when the ward has not been asked or has declined. If that means that the wardship judge has wider powers than a natural parent (on the extent of which I have declined to

express an opinion), it seems to me to be warranted by the authorities to which I have referred.

Then there is the converse case in wardship, where the ward consents but the court is minded either not to consent or positively to forbid treatment. Does the judge in such a case have an overriding power, which the natural parent of a competent child under the age of 16 does not have by reason of the *Gillick* decision? ... the trend of the cases seems to show that, if the treatment would constitute an important step in the child's life, the court does have that power."

39. Farquharson LJ (page 32) observed that:

"We are not here solely concerned with the developing maturity of a 15-year-old child but with the impact of a mental illness upon her. The *Gillick* test is not apt to a situation where the understanding and capacity of the child varies from day to day according to the effect of her illness. I would reject the application of the *Gillick* tests to an on/off situation of that kind."

40. Before leaving *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11, I should refer to something Lord Donaldson said about section 8 (page 24):

"[Counsel] submits, rightly as I think, that consent by a child between the ages of 16 and 18 is no more effective than that of an adult if, due to mental disability, the child is incapable of consenting."

41. *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 involved a 16-year-old anorexic. Accordingly, the primary focus was on section 8 of the 1969 Act, but the court, not least because its decision in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 had been so heavily criticised in the Academy, also considered again the position in relation to a child who had not reached the age of 16 but was *Gillick* competent.

42. Again, the headnote is both succinct and accurate:

"Held, ... that on its true construction section 8 of the Family Law Reform Act 1969 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; [and] 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."

43. On the meaning and effect of section 8 all three judges were agreed. Lord Donaldson of Lynton MR put it this way (pages 76-77):

"The wording of subsection (1) shows quite clearly that it is addressed to the legal purpose and legal effect of consent to treatment, namely, to prevent such

treatment constituting in law a trespass to the person, and that it does so by making the consent of a 16- or 17-year-old as effective as if he were “of full age.” No question of “*Gillick* competence” in common law terms arises. The 16- or 17-year-old is conclusively presumed to be “*Gillick* competent” or, alternatively, the test of “*Gillick* competence” is bypassed and has no relevance. The argument that W, or any other 16- or 17-year-old, can by refusing to consent to treatment veto the treatment notwithstanding that the doctor has the consent of someone who has parental responsibilities, involves the proposition that section 8 has the further effect of depriving such a person of the power to consent. It certainly does not say so. Indeed if this were its intended effect, it is difficult to see why the subsection goes on to say that it is not *necessary* to obtain the parents’ consent, rather than providing that such consent, if obtained, should be ineffective. Furthermore such a construction does not sit easily with subsection (3) which preserves the common law as it existed immediately before the Act which undoubtedly gave parents an effective power of consent for all children up to the age of 21, the then existing age of consent ...

The most promising argument in favour of W having an exclusive right to consent to treatment and thus, by refusing consent, to attract the protection of the law on trespass to the person, lies in concentrating upon the words “as effective as it would be if he were of full age.” If she were of full age her ability to consent would have two separate effects. First, her consent would be fully effective as such. Second, a failure or refusal to give consent would be fully effective as a veto, but only because no one else would be in a position to consent. If it is a possible view that section 8 is intended to put a 16- or 17-year-old in exactly the same position as an adult and there is thus some ambiguity, although I do not think that there is, it is a permissible aid to construction to seek to ascertain the mischief at which the section is directed.”

44. I need not follow Lord Donaldson into that part of his analysis. For present purposes I pick up where he said (page 81):

“There is ample authority for the proposition that the inherent powers of the court under its *parens patriae* jurisdiction are theoretically limitless and that they certainly extend beyond the powers of a natural parent ... There can therefore be no doubt that it has power to override the refusal of a minor, whether over the age of 16 or under that age but “*Gillick* competent.” It does not do so by ordering the doctors to treat which, even if within the court’s powers, would be an abuse of them or by ordering the minor to accept treatment, but by authorising the doctors to treat the minor in accordance with their clinical judgment, subject to any restrictions which the court may impose.”

45. Balcombe LJ put the point very clearly (page 86):

“It will be readily apparent that the section is silent on the question which arises in the present case, namely whether a minor who has attained the age of 16 years has an absolute right to refuse medical treatment. I am quite unable to see how, on any normal reading of the words of the section, it can be construed to confer such a right. The purpose of the section is clear: it is to enable a 16-year-old to consent to medical treatment which, in the absence of consent by the child or its parents, would constitute a trespass to the person. In other words, for this

purpose, and for this purpose only, a minor was to be treated as if it were an adult. That the section did not operate to prevent parental consent remaining effective, as well in the case of a child over 16 as in the case of a child under that age, is apparent from the words of subsection (3).”

46. He went on (page 87):

“I am therefore satisfied that there is no interpretation of section 8 of the Act of 1969 – and certainly no “settled” interpretation – which persuades me that my view of the clear meaning of the section is wrong. I express no view on the question whether a young person, whether over the age of 16 or under that age if “*Gillick* competent,” should have complete autonomy in the field of medical treatment. That is a matter of social policy with which Parliament can deal by appropriate legislation if it wishes to do so. What I am clear about is that Parliament has not conferred such autonomy on a 16- to 18-year-old child by virtue of section 8 of the Act of 1969, and that the common law, as interpreted by the House of Lords in *Gillick’s* case does not do so either.”

47. Nolan LJ put the point as follows (page 91):

“we ... decided that the court has the power in its inherent jurisdiction to override W’s refusal to undergo the necessary treatment. In saying that the power exists we were doing no more than to reaffirm the unlimited nature of the court’s inherent jurisdiction over minors, a jurisdiction which empowers and may require the court to override the wishes of a minor, even if he or she has sufficient understanding to make an informed decision.”

48. He went on (pages 92-93):

“it is impossible to my mind to regard section 8 as supporting the general proposition that in the exercise of its inherent jurisdiction the court should allow the child’s decision to determine the matter, whether or not the court thinks that this is in the child’s best interests. If the court took this view, it would be abdicating its responsibility.

Nor, to my mind, is the significance of section 8 enhanced by the decision in *Gillick’s* case ... The general approach adopted by the House of Lords to the weight which should be attached to the views of a child who has sufficient understanding to make an informed decision is clearly of great importance, but it is essential to bear in mind that their Lordships were concerned with the extent of parental rights over the welfare of the child. They were not concerned with the jurisdiction of the court. It is of the essence of that jurisdiction that the court has the power and the responsibility in appropriate cases to override the views of both the child and the parent in determining what is in the child’s best interests. Authoritative and instructive as they are, the speeches in *Gillick’s* case do not deal with the principles which should govern the exercise of this court’s jurisdiction in the present case. In my judgment, those principles are to be found in section 1 of the Children Act 1989. The child’s welfare is to be the paramount consideration: see section 1(1). In giving effect to that consideration, the court is to have particular regard to the factors set out in section 1(3). This subsection ... requires the court to have regard in particular to: (a) the ascertainable wishes

and feelings of the child concerned (considered in the light of his age and understanding); (b) his physical, emotional and educational needs; (c) the likely effect on him of any change in his circumstances; (d) his age, sex, background and any characteristics of his which the court considers relevant; (e) any harm which he has suffered or is at risk of suffering; (f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs; and (g) the range of powers available to the court.

In other words, in the circumstances of the present case the wishes and feelings of W, considered in the light of her age and understanding, are the first of the factors to which the court must have regard, but the court must have regard also to such of the other factors as may be relevant when discharging its overall responsibility for W's welfare."

49. What then of the views of the "Gillick competent" or 16-year-old child? I go first to Lord Donaldson (pages 81-82):

"This is not, however, to say that the wishes of 16- and 17-year-olds are to be treated as no different from those of 14- and 15-year-olds. Far from it. Adolescence is a period of progressive transition from childhood to adulthood and as experience of life is acquired and intelligence and understanding grow, so will the scope of the decision-making which should be left to the minor, for it is only by making decisions and experiencing the consequences that decision-making skills will be acquired. As I put it in the course of the argument, and as I sincerely believe, "good parenting involves giving minors as much rope as they can handle without an unacceptable risk that they will hang themselves." As Lord Hailsham of St Marylebone LC put it in *In re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199, 202, the "first and paramount consideration [of the court] is the well being, welfare or interests [of the minor]" and I regard it as self-evident that this involves giving them the maximum degree of decision-making which is prudent. Prudence does not involve avoiding all risk, but it does involve avoiding taking risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them. I regard this approach as wholly consistent with the philosophy of section 1 of the Children Act 1989, and, in particular, subsection (3)(a)."

50. Balcombe LJ put it this way (page 88):

"Since Parliament has not conferred complete autonomy on a 16-year-old in the field of medical treatment, there is no overriding limitation to preclude the exercise by the court of its inherent jurisdiction and the matter becomes one for the exercise by the court of its discretion. Nevertheless the discretion is not to be exercised in a moral vacuum. Undoubtedly the philosophy behind section 8 of the Act of 1969, as well as behind the decision of the House of Lords in *Gillick's* case is that, as children approach the age of majority, they are increasingly able to take their own decisions concerning their medical treatment. In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment ... Accordingly the older the child concerned the greater the weight the court should give to its wishes, certainly in the field

of medical treatment. In a sense this is merely one aspect of the application of the test that the welfare of the child is the paramount consideration. It will normally be in the best interests of a child of sufficient age and understanding to make an informed decision that the court should respect its integrity as a human being and not lightly override its decision on such a personal matter as medical treatment, all the more so if that treatment is invasive. In my judgment, therefore, the court exercising the inherent jurisdiction in relation to a 16- or 17-year-old child who is not mentally incompetent will, as a matter of course, ascertain the wishes of the child and will approach its decision with a strong predilection to give effect to the child's wishes. (The case of a mentally incompetent child will present different considerations, although even there the child's wishes, if known, must be a very material factor.) Nevertheless, if the court's powers are to be meaningful, there must come a point at which the court, while not disregarding the child's wishes, can override them in the child's own best interests, objectively considered. Clearly such a point will have come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury. An example of such a case was [*Re E (A Minor) (Wardship: Medical Treatment)*] [1993] 1 FLR 386, which came before Ward J on 21 September 1990. There a 15-year-old Jehovah's Witness, and his parents of the same faith, were refusing to allow doctors to give the boy a blood transfusion without which there was a strong risk (on the medical evidence) that the boy would die. Ward J authorised the blood transfusion. In my judgment he was right to do so. In the course of his judgment he said:

“There is compelling and overwhelming force in the submission of the Official Solicitor that this court, exercising its prerogative of protection, should be very slow to allow an infant to martyr himself.”

I agree.”

51. He added (page 89):

“I do not think it would be helpful to try to define the point at which the court should be prepared to disregard the 16- or 17-year-old child's wishes to refuse medical treatment. Every case must depend on its own facts. What I do stress is that the judge should approach the exercise of the discretion with a predilection to give effect to the child's wishes on the basis that prima facie that will be in his or her best interests.”

52. Nolan LJ said much the same (pages 93-94):

“I would emphasise that the only aspect of W's welfare with which we are concerned in the present case is her refusal to undergo a particular form of treatment for anorexia. So far in this judgment I have been principally concerned to explain why, as it seems to me, the court has not only the power but the inescapable responsibility of deciding, in that specific context, what is to be done in the interests of her welfare. I am very far from asserting any general rule that the court should prefer its own view as to what is in the best interests of the child to those of the child itself. In considering the welfare of the child, the court must not only recognise but if necessary defend the right of the child, having

sufficient understanding to take an informed decision, to make his or her own choice. In most areas of life it would be not only wrong in principle but also futile and counter-productive for the court to adopt any different approach. In the area of medical treatment, however, the court can and sometimes must intervene.

It will, I think, be apparent from what I have said that even in the case of normal medical treatment I cannot accept [counsel's] proposition that the child's decision should determine the matter. The determination must always be that of the court. If one is then to try and specify the grounds upon which it would be right for the court to intervene I do not for my part find it particularly helpful to speak in terms of special or extraordinary cases as distinct from normal cases ... One must, I think, start from the general premise that the protection of the child's welfare implies at least the protection of the child's life. I state this only as a general and not as an invariable premise because of the possibility of cases in which the court would not authorise treatment of a distressing nature which offered only a small hope of preserving life. In general terms, however, the present state of the law is that an individual who has reached the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age.

To take it a stage further, if the child's welfare is threatened by a serious and imminent risk that the child will suffer grave and irreversible mental or physical harm, then once again the court when called upon has a duty to intervene. It makes no difference whether the risk arises from the action or inaction of others, or from the action or inaction of the child. Due weight must be given to the child's wishes, but the court is not bound by them."

53. I make no apology for dealing with these two cases at such length and for setting out the key passages *in extenso*, for they are on any view central to what I have to decide. And, Miss Watson submits, they are and remain good law. Pausing to take stock, they, and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 in particular, make two things clear as a matter of law: (1) that in relation to medical treatment neither the decision of a *Gillick* competent child nor the decision of a child 16 years old or more is determinative in all circumstances; and (2) that there are circumstances in which the decision of such a child can be overridden by the court.
54. There is, however, a further important point of principle to be derived from certain observations of Lord Donaldson that I have already quoted but which bear repetition. The context is, of course, that as a matter of generality (though not necessarily in all contexts: see in *In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [2019] 1 WLR 5403), the issue of whether a particular child is *Gillick* competent may arise at any time until the child, having reached the age of 18, has attained majority. At the same time, in relation to medical treatment within the ambit of section 8 (I put the point this way because section 8 does not apply to all medical or surgical procedures: see *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64), section 8 identifies the age of 16 as being crucial. How are the two to be reconciled? Lord Donaldson, in my judgment, provided the answer. I refer first, to his observation in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 (page 77), that in relation to the medical treatment of 16- or 17-year- olds within the ambit of section 8:

“No question of “*Gillick* competence” in common law terms arises. The 16- or 17-year-old is conclusively presumed to be “*Gillick* competent” or, alternatively, the test of “*Gillick* competence” is bypassed and has no relevance.”

I refer, secondly, to what he said in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (page 24):

“consent by a child between the ages of 16 and 18 is no more effective than that of an adult if, due to mental disability, the child is incapable of consenting.”

55. Thus, in the context of medical treatment, with which alone I am concerned, Lord Donaldson’s analysis (which for convenience I shall refer to as the Donaldson analysis) can be summarised as follows: (1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is *Gillick* competent. (2) Once the child reaches the age of 16: (i) the issue of *Gillick* competence falls away, and (ii) the child is assumed to have capacity in accordance with section 8, unless (iii) the child is incapacitous (lacks capacity) in the sense in which one speaks of an adult as being incapacitous.
56. I express the last point this way in recognition of the fact that, as Ms Butler-Cole and Mr Ruck Keene helpfully point out, “capacity” and “incapacity” are used in this branch of the law in two quite different senses, which it is important to distinguish:
- i) In one sense (what they call “legal capacity”) the question is one of personal status, irrespective of any impairment or disturbance of mental functioning. Thus, subject only to statute, a child, as such, lacks capacity at common law by reason of being a child and thus not having reached its majority – what was once referred to as incapacity by reason of non-age. Once upon a time the same applied in many ways to a married woman (feme covert) who, by reason of her coverture, was treated as lacking the capacity she had had as a spinster and only recovered as a widow or on divorce (feme sole).
 - ii) In the other sense (what might be called “mental capacity”) the question has nothing to do with personal status; it is all to do with impairment or disturbance of mental functioning – I use the phrase at this point descriptively, not definitively. As we will see below, the test of mental capacity was a creation of the common law; it is now encapsulated in sections 2(1) and 3(1) of the Mental Capacity Act 2005.

For the purposes of section 8 we are concerned only with legal capacity; the effect of the statute, in relation to its specific subject matter (medical treatment) is, as it were, to reduce the age of majority from 18 to 16 – that, *and no more*. Section 8 is not concerned with and does not operate so as to deem the child to have mental capacity.

57. In the light of this elaboration, we can now refine the Donaldson analysis so it may be summarised as follows: (1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is *Gillick* competent. (2) Once the child reaches the age of 16: (i) the issue of *Gillick* competence falls away, and (ii) the child is assumed to have legal capacity in accordance with section 8, unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005.

58. The Donaldson analysis was applied by the Divisional Court in *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin). Having considered (para 145) the application, in the context of the particular treatment in question, of *Gillick* competence in relation first to children aged 13 or under and then in relation to children aged 14 and 15, the court continued (para 146):

“In respect of a young person aged 16 or over, the legal position is different. There is a presumption of capacity under section 8 of the Family Law Reform Act 1969. As is explained in [in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64], that does not mean that a court cannot protect the child under its inherent jurisdiction if it considers the treatment not to be in the child’s best interests.”

Moreover, as we shall see, the Donaldson analysis is, in effect, replicated in the scheme under the Mental Capacity Act 2005.

59. Mr Brady submits, with support from Ms Butler-Cole and Mr Ruck Keene, that much of all this was obiter. For in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 it was common ground, both at first instance and in the Court of Appeal, that the child lacked *Gillick* capacity. And in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 the Court of Appeal doubted the trial judge’s finding of competence, though it is not at all obvious that this was the basis of its decision. However, be that as it may, as a great judge once said, there are obiter dicta and obiter dicta. As Megarry J explained in *Brunner v Greenslade* [1971] Ch 993, 1002:

“a mere passing remark, or a statement or assumption on some matter that has not been argued, is one thing; a considered judgment on a point fully argued is another, especially where, had the facts been otherwise, it would have formed part of the ratio. Such judicial dicta, standing in authority somewhere between a ratio decidendi and an obiter dictum, seem to me to have a weight nearer to the former than the latter.”

60. Here, we have two authorities in each of which the Court of Appeal, having had the benefit of vigorous adversarial arguments by Leading Counsel, delivered three lengthy judgments dealing with the points at issue in carefully considered and commanding detail. Indeed, as we have seen, in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64, where the hearing spread over 3 days, the court deliberately reconsidered what it had previously said in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 because of the criticism to which it had been subjected. How sensibly can this be treated as mere obiter? I do not criticise counsel for taking the point, but I have to say that it is the kind of point which probably has more traction amongst the dreaming spires of the Academy than in the robust and ultimately pragmatic world of the court room. We have to remember that the common law developed over the centuries as a process by which practical lawyers sought pragmatic, if principled, solutions to the practical problems thrown up by the unpredictable process of litigation, and that at the root of the process was the system of oral adversarial argument. In *Cordell v Second Clanfield Properties Ltd* [1969] 2 Ch 9, 16, Megarry J, citing the venerable words of Hankford J in 1409, referred to the “purifying ordeal of skilled argument on the specific facts of a contested case” and observed that:

“Argued law is tough law. This is as true today as it was in 1409 ... Today, as of old, by good disputing shall the law be well known.”

Having gone through what I should like to think was the purifying ordeal, what emerged from the essay in the Court of Appeal in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 was surely the tough law of which Megarry J spoke.

61. Both *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 have been much criticised in the Academy (though, as already noted, the Academy here is far from unanimous), but they have been consistently followed and applied by the judges down the years: see, for example, *South Glamorgan County Council v W & B* [1993] 1 FLR 574 (Douglas Brown J: 15-year-old refusing medical examination and assessment); *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180 (Wall J: 16-year-old anorexic refusing treatment); *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810 (Sir Stephen Brown P: 14-year-old Jehovah’s Witness refusing blood transfusion); *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097 (Johnson J: 15-year-old refusing heart transplant); *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam), [2004] 2 FLR 1117 (Johnson J: 16-year-old Jehovah’s Witness refusing blood transfusion); *Re P (A Child); An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam), [2014] Fam Law 1249 (Baker J: 17-year-old child refusing treatment for drug overdose – judge *not* satisfied that child lacked capacity within the meaning of section 3 of the Mental Capacity Act 2005, so made order under the inherent jurisdiction); *Plymouth Hospitals NHS Trust v YZ and ZZ* [2017] EWHC 2211 (Fam), [2018] 1 FLR 948 (MacDonald J: 14-year-old child refusing treatment for drug overdose); *University Hospitals Plymouth NHS Trust v B (A Minor) (Urgent Medical Treatment)* [2019] EWHC 1670 (Fam) (MacDonald J: 16-year-old child refusing insulin treatment for diabetes; order made under inherent jurisdiction); *An NHS Trust v CX and others* [2019] EWHC 3033 (Fam), (2020) 174 BMLR 119 (Roberts J: *Gillick* competent 14-year-old Jehovah’s Witness refusing blood transfusion); and, very recently, *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), (Divisional Court – Dame Victoria Sharp P, Lewis LJ, Lieven J: prescribing of puberty-suppressing drugs to children experiencing gender dysphoria). In none of these cases, it may be noted, did the judges give the slightest indication of any doubt as to whether the decisions in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 were good law or the slightest hint that perhaps the law as stated in them needed reconsideration.
62. I turn to consideration of the Mental Capacity Act 2005.
63. Mr Brady submits that, and I quote, “the Mental Capacity Act 2005 is now a complete code concerning the medical treatment decisions of capable persons aged 16 and older and, as such, has “occupied the field” and has ousted the common law in that discrete area of the law.” He continues, “Thus, a capable person aged 16 or older has the *exclusive right* to decide his or her own medical treatment, as should a capable person under the age of 16 (emphasis in original).” I do not agree that the Act has this effect.
64. Mr Brady placed considerable reliance on section 1(2) of the Act, which provides that:

“A person must be assumed to have capacity unless it is established that he lacks capacity.”

The word “person” is not defined in the Act and therefore might be thought at first blush to apply to any person of any age, and therefore to any child, however young. But section 1(1) provides that this principle applies “for the purposes of this Act”, so to understand section 1(2) one has to turn to other parts of the Act to see what those “purposes” are.

65. By and large the Act is concerned with the powers, duties and responsibilities of the Court of Protection and of the Deputies it appoints to act on behalf of P. The Act does contain various self-standing provisions. For present purposes I need mention only two: those contained in section 5 and in sections 24-26. Section 5 provides, if certain conditions are satisfied, a statutory defence against liability; not merely for those acting as Deputies or otherwise in accordance with directions given by the Court of Protection but also for those who, without any court involvement, have been properly looking after or acting on behalf of P. I need not explore the meaning and effect of section 5 nor, in particular, how it stands in relation to the doctrine of necessity as explained by Lord Goff of Chieveley in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 75, for, in my judgment, section 5, however it is interpreted as operating, throws no light on anything I have to decide. So I say no more about it. Sections 24-26 provide for advance decisions in relation to future medical treatment. I return to them below.
66. In general, the Act extends to those aged 16 or over: section 2(5). This reflects the recommendation in the Law Commission’s 1995 Report, *Law Com No 231, Mental Capacity*, para 2.52 which, as Ms Butler-Cole and Mr Ruck Keene, who have helpfully taken me through the relevant materials, point out, proved uncontroversial. There are exceptions to this. For example, the Court of Protection’s powers under section 16 in relation to P’s property and affairs are exercisable (see sections 2(6) and 18(3)) “even though P has not reached 16, if the court considers it likely that P will still lack capacity to make decisions in respect of that matter when he reaches 18.” In contrast (section 18(2)), the Court of Protection cannot make a statutory will until P has reached 18. And, more directly germane to the issues I have to consider, only a person who has reached the age of 18 can make an advance decision (section 24(1)) or a lasting power of attorney (section 9(2)(c)).
67. The reasons for this limitation were explained in the Law Commission’s 1995 Report, *Law Com No 231, Mental Capacity*. Referring to advance decisions the Commission said this (para 5.18):

“[t]here would be little point in our recommending that an anticipatory refusal of treatment can be made by persons under the age of eighteen since it is now settled if controversial law that the court in its exercise of its statutory and/or inherent jurisdiction (and possibly also any person who has parental responsibility) may overrule the refusal of a minor, competent or not, to accept medical treatment.”

This is plainly a reference to the learning in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64. The Commission gave similar reasons (para 7.20) in relation to what would become lasting powers of attorney.

68. It is fundamental that, except as provided by section 48 (which enables the Court of Protection to make interim orders if “there is reason to believe that P lacks capacity”), the Court of Protection has jurisdiction only in relation to persons who “lack capacity” as that concept is defined and elaborated in sections 2 and 3 (and see also sections 1(3) and 1(4)). For present purposes it suffices to refer to sections 2(1) and 3(1). Section 2(1) provides as follows:

“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.”

Section 3(1) provides as follows:

“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).”

69. The careful qualification to all this reflected by the repeated use of the phrase “for the purposes of this Act” (or, in section 3 “for the purposes of section 2”) indicates clearly enough that this statutory definition of ‘lack of capacity’ is not intended to be of general application outside the four corners of the statute. Except inferentially in sections 9(2)(c) and 24(1), the Act has nothing to say about the *Gillick* competent child. Nor, it may be noted, was section 8 of the 1969 Act repealed by the 2005 Act. On the contrary, as paras 5.18 and 7.20 of the Commission’s Report show, the statutory scheme was crafted against the background of the previous authorities.

70. In their skeleton argument, Ms Butler-Cole and Mr Ruck Keene invite me to consider the relationship between the concepts of capacity under the Mental Capacity Act 2005 and *Gillick* competence, not least, they submit, because these two concepts had not been distinguished at the time that *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 were being decided. They suggest that:

- i) In relation to children under the age of 16, (a) the sole question is whether the child is *Gillick* competent to make the decision in question and (b) the concept of *Gillick* competence has to do the dual work of addressing the child’s decision within the context of both the child’s developmental trajectory and any temporary impairment from which the child may be suffering. As they express it, “In application of that test, those involved will have to consider both where the point is in the child’s developmental trajectory (as impacted, if relevant, by any permanent cognitive impairments) and any temporary factors that may be

impacting upon their decision-making ability in relation to the decision in question (for instance the impact of a temporary mental health crisis or an accident).”

- ii) In relation to children 16 or over, it is not clear whether and how the concept of *Gillick* competence differs from that of capacity under the Act. They invite me to consider whether the demands of the common law as set down in *Gillick* and the demands of the statutory provisions of the 2005 Act might not be reconciled by an approach in relation to medical treatment in which the test is two-fold: (a) does the young person have the 2005 Act capacity to make the decision to accept or refuse the treatment in question, the presumption being that they do so; and (b) if so, does he also have the competence to make the decision, taking into account the nature of the decision in the context of their experience of such decision-making. They commend this approach on the basis that it enables “the concepts of competence and capacity to be doing separate, complementary, work after the age of 16.”
71. In significant part, the pursuit of this will-o’-the-wisp is, with respect, both ahistorical and conceptually problematic. I say this in no criticism of Ms Butler-Cole and Mr Ruck Keene, whose submissions, which in part reflect certain views circulating in the Academy, have been immensely helpful in helping me to focus my thinking and to refine my conclusions. I have to say, however, that some of the thinking in the Academy savours too much of the Thomist schoolmen. In the law, as in other areas of human endeavour, Ockham’s Razor surely has an important part to play.
72. In *Sheffield City Council v E* [2004] EWHC 2808 (Fam), [2005] Fam 326, paras 29-32, and then in a little more detail in *Re MM; Local Authority X v MM (by the Official Solicitor) and KM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, paras 68-81, I sketched out the parallel though intersecting histories during the 1990s of the Law Commission’s emerging thinking on the point and the developing analysis of the judges. The two key judgments were those of Thorpe J in *In re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 and Butler-Sloss LJ in *Re MB (Medical Treatment)* [1997] 2 FLR 426. Thorpe J referred to the Law Commission’s 1993 Consultation Paper 129, *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, and Butler-Sloss LJ to the Commission’s 1995 Report, *Law Com No 231, Mental Capacity*. Indeed, as I noted in *Re MM*, para 70, Butler-Sloss LJ’s formulation was closely modelled on the test set out in the Commission’s proposed Bill. In relation to the Mental Capacity Act 2005 I said this (para 80):
- “there is no relevant distinction between the test as formulated in *Re MB* and the test set out in section 3(1) of the Act, and ... the one merely encapsulates in the language of the Parliamentary draftsmen the principles hitherto expounded by the judges in the other.”
73. Unsurprisingly, there is no reference in any of these cases to *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 or to *Gillick* competence. This is not merely because they all concerned adults; it is because the tests of *capacity* and of *Gillick* competence have nothing very obvious in common, not least because they are rooted in different areas of scientific knowledge and understanding. *Capacity*, or, more precisely, lack of capacity, derives from what Butler-Sloss LJ referred to in *Re MB* as “some impairment or disturbance of mental functioning”, what in section 2(1) of the

2005 Act is referred to as “impairment of, or a disturbance in the functioning of, the mind or brain.” *Gillick* competence, in contrast, is tied to the normal development over time of the typical child and teenager. In the first, one is therefore in the realm of psychiatry. Indeed, it is notorious that Thorpe J’s analysis in *In re C*, from which everything since has flowed, was modelled on the analysis provided in the expert evidence of a psychiatrist, Dr Eastman. In the other, one is not in the realm of psychiatry, rather that of child and adolescent psychology.

74. Is there, nonetheless some ‘read over’ between the two? The only obvious connection is that it is, to put it no higher, difficult to see how a child who lacks capacity applying either the common law test set out in *Re MB* or the statutory test set out in sections 2(1) and 3(1) of the 2005 Act can possibly be *Gillick* competent. This is not because one is using the test of capacity in some way as a surrogate for the test of *Gillick* competence; it is simply because, in the nature of things, the existence of *Gillick* competence as explained in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and subsequent authorities is hard to contemplate in a child who, as a result of some “impairment of, or a disturbance in the functioning of, the mind or brain” is “unable to make a decision for himself” in one or more of the respects identified in section 3(1).
75. In this connection I was referred the decision of Cobb J in *In re S (A Child) (Child Parent: Adoption Consent)* [2017] EWHC 2729 (Fam), [2019] Fam 177, [2018] 2 FLR 111, paras 15-16, 60, cited with seeming approval by the Divisional Court in *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), paras 116-118. For present purposes it suffices to refer to *Bell* (para 116):

“In [*In re S*] Cobb J considered the competence of a mother under the age of 16 to consent to her baby being placed for adoption. Cobb J held that it was appropriate and helpful in determining *Gillick* competence to read across and borrow from the relevant concepts and language in the Mental Capacity Act 2005 but cognisant of some fundamental differences, in particular that the assumption of capacity in section 1(2) of that Act did not apply and there was no requirement for any diagnostic characteristic as there is in section 2(1) of the Mental Capacity Act 2005.”

Although nothing turns on the point for present purposes, I myself would respectfully disagree with this approach. Its premise is that *Gillick* competence is in some way related or even analogous to capacity in the sense in which the expression is used in the 2005 Act. It is not; the two are, as I have said, both historically and conceptually quite distinct.

76. I conclude, therefore, that (except inferentially in sections 9(2)(c) and 24(1), which, after all, reflect the previous common law) the 2005 Act has nothing to say relevant to the medical or surgical treatment of children who are not yet 16; that in relation to children who have reached the age of 16 it has nothing to say except where the child lacks mental capacity as defined in sections 2(1) and 3(1); and, accordingly, that it has nothing to say about children of whatever age who are *Gillick* competent.
77. In relation to the 2005 Act, as before, the Donaldson analysis continues to apply, subject only to the refinement referred to in paragraph 57 above: (1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is *Gillick* competent. (2) Once the child reaches the age of 16: (i) the issue of *Gillick* competence falls away, and (ii)

the child is assumed to have legal capacity in accordance with section 8, unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005.

78. I add one point. In relation to those falling within the scope of the Mental Capacity Act 2005, including those who have attained the age of 16, the courts do not examine separately capacity to consent and capacity to refuse medical treatment. Rather, the courts proceed by examining the question of whether the person has the capacity to make a decision in relation to the treatment. I see no reason why, in principle, the same approach should not be followed when the question is one not of mental capacity but of *Gillick* competence.
79. Inevitably and appropriately, for it had much to say and has much to teach us about the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and about *Gillick* competence, I was taken to the recent decision of the Supreme Court in *In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [2019] 1 WLR 5403. In the final analysis it is of only peripheral importance because fundamentally *In re D* was not concerned with medical treatment, so section 8 was not engaged, and related to the interface between the child's rights and powers and the rights and powers of the child's parents exercising their parental responsibility (see section 3 of the Children Act 1989). Here, in contrast, I am concerned with the interface between the *Gillick* competent child and the court. Thus, neither *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 nor *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 was cited in any of the judgments. There are, nonetheless, important points to be drawn from what the Supreme Court said.
80. First, I can see nothing there to throw any doubt on what I have said in paragraphs 76-77 above. On the contrary, the Supreme Court's reasoning seems to me entirely consistent both with the Donaldson analysis and with my own analysis.
81. Secondly, part of the Official Solicitor's case in the Supreme Court (see para 143) was that:

“If – as the Official Solicitor submits – section 5 MCA 2005 provides a complete framework for the delivery of care and treatment to those aged 16 and above lacking capacity, then he submits that, by operation of conventional principles, it should be seen as ousting the place of the common law ... The Official Solicitor submits that the same analysis applies equally to the (common law) position in relation to those aged 16 and 17 with impaired capacity.”

That submission received no support and was in fact rejected in an important passage in the judgment of Lady Black JSC (para 71):

“I cannot accept the Official Solicitor's case that the 2005 Act constitutes a complete decision-making framework for the care and treatment of those aged 16 and above who lack capacity, not least because there is an obvious overlap between the reach of the Children Act 1989 and that of the 2005 Act, and I can find nothing in the 2005 Act that could be said to indicate a general rule to the effect that, where it applies, it does so to the exclusion of other common law and statutory provisions”

82. Thirdly, Lady Black JSC went on to say (para 90):

“nothing that I have said is intended to cast any doubt on the powers of the courts, recognised in the early cases to which I have referred, and still available today in both the *parens patriae* jurisdiction and under statute, notably the Children Act 1989, to make orders in the best interests of children up to the age of majority, with due regard to their wishes and those of their parents, but not dictated by them.”

83. Before leaving this topic, I must refer to a case on which Mr Brady placed some reliance: the decision of Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC*, [2014] EWCOP 1317. That case related to a 23-year-old adult. There is nothing in it, or in the passages (paras 8, 11, 27ii, 33 and 42) to which Mr Brady specifically referred, which in my judgment throws any light on the issues before me.

84. I conclude therefore that there is nothing in the Mental Capacity Act 2005 which throws any doubt on the continued validity of *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64, nor indeed anything which even begins to suggest the need for any judicial re-evaluation of what they establish.

85. I turn now to consider the decision of the Supreme Court of Canada in *AC and Others v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [2009] 5 LRC 557, on which, understandably, Mr Brady placed much reliance. We do well to pay close attention to what the Supreme Court of Canada has to say, for it is one of the most distinguished courts of the common law world and its decisions in relation to the Canadian Charter of Rights and Freedoms often illuminate similar debates here in relation to the European Convention and other international instruments. The Supreme Court of Canada in *AC* had much to say about the *Gillick* competent child and, indeed, about the science which underlies our understanding of child development, which is powerfully illuminating and which we would do well to ponder. The question at the end of the day, however, is whether the decision in *AC* takes Mr Brady as far as he would have me go. In my judgment, it does not.

86. Mr Brady referred me to various earlier decisions of Canadian courts. None of them, as I read them, is determinative of any of the issues I have to consider, so I can go straight to *AC*.

87. *AC* concerned a 14-year-old girl who was refusing a blood transfusion, as were her parents. The relevant Manitoba legislation, section 25(8) of the Child and Family Services Act (CFSA), provided that a court order could be sought to authorise treatment for a minor, but that if the child was aged 16 or 17 years, an order could only be made if the young person was unable:

“(a) to understand the information that is relevant to making a decision to consent or not consent to the medical examination or the medical or dental treatment; or (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical examination or the medical or dental treatment.”

88. Much of the debate focused on whether the legislation passed constitutional muster under the Canadian Charter of Rights and Freedoms, a topic with which I am not concerned. Understandably, Mr Brady's focus was on the judgment of Abella J, speaking for the majority (Abella, LeBel, Deschamps and Charron JJ) and on those parts of her judgment particularly germane to the issues before me.
89. Having considered (paras 39-45) the common law in relation to adults, Abella J turned (paras 46-69) to consider the common law in relation to minors. She began:

“46 The latitude accorded to adults at common law to decide their own medical treatment had historically narrowed dramatically when applied to children. However, the common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. This is known as the common law ‘mature minor’ doctrine ... The doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person’s level of maturity, with the degree to which maturity is scrutinised intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

47 AC [for whom, I note, Mr Brady appeared – he is qualified in several jurisdictions] argued that the mature minor doctrine means that mature children are, at common law, entitled to make all decisions related to their medical care, including the decision to refuse life-saving medical treatment. This literal interpretation of the ‘mature minor’ doctrine, with respect, miscasts its actual development and application, both in Canada and abroad. It also seriously underrepresents the limits on the ability to accurately assess maturity in any given child.”

90. Abella J then embarked upon a detailed analysis of the English authorities (*Gillick*, *Re R* and *Re W*), saying of them (paras 56-57) that:

“56 [they] currently represent the law for adolescents’ medical decision-making capacity in the United Kingdom. What is important to note is that none of these cases asserted that a ‘mature minor’ should be treated as an adult for all decisional treatment purposes. The Court of Appeal confirmed in *Re R* and *Re W* that a child’s ‘*Gillick* competence’ or ‘mature minor’ status at common law will not necessarily prevent the court from overriding that child’s wishes in situations where the child’s life is threatened. In such cases, the court may exercise its *parens patriae* jurisdiction to authorise treatment based on an assessment of what would be most conducive to the child’s welfare, with the child’s views carrying increasing weight in the analysis as his or her maturity increases.

57 To date, no court in the United Kingdom has allowed a child under 16 to refuse medical treatment that was likely to preserve the child’s prospects of a normal and healthy future.”

91. That was followed (paras 58-63) by an equally detailed analysis of the Canadian authorities. She commented (paras 59, 62):

“58 As in the United Kingdom, where deferring to the wishes of a child under 16 was likely to jeopardise his or her potential for a healthy future, treatment has always been ordered by courts in Canada over the refusal of the adolescent and his or her parents ...

62 Where a child’s decisional capacity to refuse treatment has been upheld, on the other hand, it has been because the court has accepted that the mature child’s wishes have been consistent with his or her best interests.”

92. Abella J then extended her consideration to the United States of America (paras 64-66) and Australia (paras 67-68). In relation to the former she said (para 66):

“As in the UK and Canada, no state court has gone so far as to suggest that the ‘mature minor’ doctrine effectively ‘reclassifies’ mature adolescents as adults for medical treatment purposes.”

In relation to Australia she made a similar observation (para 68):

“And, as elsewhere, Australian courts have determined that their authority to make orders in respect of children’s welfare, including medical treatment, is not limited by the decisions of a ‘Gillick-competent’ minor ... The treatment decisions of even mature children can therefore be overridden by a court exercising its *parens patriae* jurisdiction or the Family Court’s almost identical statutory jurisdiction.”

93. Summarising (para 69) she said:

“What is clear from the above survey of Canadian and international jurisprudence is that while courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the ‘mature minor’ doctrine as dictating guaranteed outcomes, particularly where the consequences for the young person are catastrophic.”

94. After considering the academic literature, both legal and social scientific (paras (70-79), Abella J turned to what is the central core of her analysis and the focus of Mr Brady’s submissions, first, interpreting best interests (paras 80-96) and then, constitutional diagnosis (paras 97-122).

95. As a prelude to his submissions, Mr Brady emphasises that, so he asserts, “all of the judges ... in *AC* ... agreed that capable “older adolescents”, aged 16 and older, should have the *exclusive right* to decide their own medical treatment (my emphasis).” In support of that he referred to what Abella J, speaking for the majority, had said (paras 24, 35, 37, 111), to what McLachlin CJ, concurring in the result, had said (paras 130, 145), and to what Binnie J, dissenting in the result, had said (paras 172, 176, 177, 233). Given that he was dissenting, I can pass over what Binnie J said. And I have to say that it is far from obvious to me that what McLachlin CJ was saying supports Mr Brady’s unqualified proposition. Be that as it may, the crucial judgment is obviously that of

Abella J. It does not, in my judgment, support Mr Brady's contention. I need only go to her conclusion (para 111):

“... Under the Child and Family Services Act the distinction between promoting autonomy and protecting welfare is presumed to collapse at age 16, subject to evidence to the contrary. But *whether a child is under or over 16*, the weight that is accorded to his or her views under s 25 of the Act will ultimately correspond to a court's conclusions about the extent to which the child is capable of making decisions in his or her own best interests.” (emphasis added)

96. To return to her judgment, Abella J acknowledged (para 85) that:

“In the vast majority of situations where the medical treatment of a minor is at issue, his or her life or health will not be gravely endangered by the outcome of any particular treatment decision. That is why courts have determined that medical practitioners should generally be free to rely on the instructions of a young person who seems to demonstrate sufficient maturity to direct the course of his or her medical care.”

But, she went on (paras 86-87):

“86 Where a young person comes before the court under s 25 of the Child and Family Services Act, on the other hand, it means that child protective services have concluded that medical treatment is necessary to protect his or her life or health and either the child or the child's parents have refused to consent. In this very limited class of cases, it is the ineffability inherent in the concept of ‘maturity’ that justifies the state's retaining *an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests*. The degree of scrutiny will inevitably be most intense in cases where a treatment decision is likely to seriously endanger a child's life or health.

87 *The more a court is satisfied* that a child is capable of making a mature, independent decision on his or her own behalf, the greater the weight that will be given to his or her views when a court is exercising its discretion under s 25(8). *In some cases*, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor. *If*, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, *the court is persuaded* that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected. Such an approach clarifies that in the context of medical treatment, young people under 16 should be permitted to attempt to demonstrate that their views about a particular medical treatment decision reflect a sufficient degree of independence of thought and maturity.” (emphases added)

97. I move on (paras 88, 92, 95):

“88 ... it is, by definition, in a child's best interests to respect and promote his or her autonomy *to the extent that his or her maturity dictates*.”

92 ... the quality of decision-making about a child is enhanced by input from that child. The extent to which that input affects the ‘best interests’ assessment is as variable as the child’s circumstances, but one thing that can be said with certainty is that the input becomes *increasingly determinative* as the child matures. This is true not only when considering the child’s best interests in the placement context, but also when deciding whether to accede to a child’s wishes in medical treatment situations.

95 In those most serious of cases, where a refusal of treatment carries a significant risk of death or permanent physical or mental impairment, a careful and comprehensive evaluation of the maturity of the adolescent will necessarily have to be undertaken to determine whether his or her decision is a genuinely independent one, reflecting a real understanding and appreciation of the decision and its potential consequences.” (emphases added)

98. Abella J recognised (para 106) that:

“... a problem arises when a child’s interest in exercising his or her autonomy conflicts with society’s legitimate interest in protecting him or her from harm.”

She reconciled them as follows (paras 107-108, 111):

“107 Given the significance we attach to bodily integrity, it would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions. It is not, however, arbitrary to give them the opportunity to prove that they have sufficient maturity to do so.

108 Interpreting the best interests standard so that a young person is afforded *a degree of bodily autonomy and integrity commensurate with his or her maturity* navigates the *tension between an adolescent’s increasing entitlement to autonomy* as he or she matures *and society’s interest in ensuring that young people who are vulnerable are protected from harm*. This brings the ‘best interests’ standard in s 25(8) in line with the evolution of the common law and with international principles, and therefore strikes what seems to me to be an appropriate balance between achieving the legislative protective goal while at the same time respecting the right of mature adolescents to participate meaningfully in decisions relating to their medical treatment. The *balance is thus achieved between autonomy and protection*, and the provisions are, accordingly, not arbitrary.

111 ... But *whether a child is under or over 16*, the weight that is accorded to his or her views under s 25 of the Act will ultimately correspond to a court’s conclusions about the extent to which the child is capable of making decisions in his or her own best interests. By permitting adolescents under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make treatment decisions is ultimately calibrated in accordance with maturity, not age, and no disadvantaging prejudice or stereotype based on age can be said to be engaged. There is therefore no violation of s 15.” (emphases added)

Abella J concluded her analysis as follows (paras 114-116):

“114 ... the ‘best interests’ test referred to in s 25(8) of the Act, properly interpreted, provides that a young person is entitled to *a degree of decisional autonomy commensurate with his or her maturity*.”

115 The result of this interpretation of s 25(8) is that adolescents under 16 will have the right to demonstrate mature medical decisional capacity. This protects both the integrity of the statute and of the adolescent. It is also an interpretation that precludes a dissonance between the statutory provisions and the Charter, since it enables adolescents to participate meaningfully in medical treatment decisions in accordance with their maturity, creating *a sliding scale of decision-making autonomy*. This, in my view, reflects *a proportionate response to the goal of protecting vulnerable young people from harm, while respecting the individuality and autonomy of those who are sufficiently mature to make a particular treatment decision*.

116 If ss 25(8) and 25(9) did in fact grant courts an unfettered discretion to make decisions on behalf of all children under 16, despite their actual capacities, while at the same time presuming that children 16 and over were competent to veto treatment they did not want, I would likely agree that the legislative scheme was arbitrary and discriminatory. A rigid statutory distinction that completely ignored the actual decision-making capabilities of children under a certain age would fail to reflect the realities of childhood and child development. However, this is not the effect of ss 25(8) and 25(9). As the foregoing analysis demonstrates, a child’s maturity and corresponding interest in self-determination will factor significantly into any determination of his or her ‘best interests’ under s 25(8) of the Act, with the child’s views becoming increasingly determinative as his or her maturity increases.” (emphases added)

99. The simple fact, in my judgment, is that, try as he might, Mr Brady was unable to make good the proposition which he sought to derive from AC. As the several extracts I have quoted from Abella J’s judgment demonstrate, the case is not authority for the proposition that the decision of either a *Gillick* competent child or a child aged 16 or more is always, and without exceptions, determinative in relation to medical treatment. In the final analysis, as I read her judgment, the court always has the last word.
100. As Ms Butler-Cole and Mr Ruck Keene pointed out, Binnie J in his dissenting judgment in AC was clear as to what he thought the majority had decided (para 194):

“the majority’s interpretation of the CFSA does not render rebuttable the presumption that persons under 16 lack the capacity to refuse medical treatment. Under their interpretation of the CFSA, even if a minor under 16 demonstrates his or her capacity, he or she is still not treated in the same manner as a minor who is 16 and over. His or her demonstrated capacity remains one consideration among others (however much its weight increases in correspondence with the maturity level and the nature of the treatment decision to be made) and is in no way determinative. AC’s position throughout this case has been that once it is established that she is an individual with ‘capacity’ the applications judge ought to cede to her the power to decide to have or not to have the blood transfusion. In seeking to set aside the 16 April 2006 order, AC asks for either a constitutional exemption or the nullification of ss 25(8) and 25(9) of the CFSA.

The sliding scale of weight the majority is prepared to give to her views is not responsive to her argument. Her point is: who decides?”

It is hard to imagine that the majority would have let this pass without comment had they thought it misrepresented their position.

101. Be that as it may, the matter does not end there, for I was taken to a number of subsequent Canadian cases: *Carter v Canada (Attorney General)* 2015 SCC 5, [2015] 1 SCR 331 (Supreme Court of Canada), *AB v CD* 2020 BCCA 11 (Court of Appeal for British Columbia), *SP v BP* 2020 ABQB 331 (Court of Queen’s Bench of Alberta), and *PH v Eastern Regional Integrated Health Authority* 2010 NLTD 34 (Supreme Court of Newfoundland). None provides any assistance to Mr Brady. Two are interesting as illustrating subsequent Canadian judicial understanding of just what was decided in *AC*; neither supports Mr Brady’s analysis.
102. In *SP v BP* 2020 ABQB 331, a case involving the question whether a young man just two weeks short of his 18th birthday should be subjected to compulsory counselling, Devlin J said (para 81):

“This Court has already found that BP is a mature minor, of high intelligence, on the cusp of adulthood. Applying the principles in [*AC*], I find that his wishes should be accorded *virtually* the same respect and deference extended to adults.” (emphasis added)

He went on (paras 86-87):

“86 The right to consent to medical treatment extends to children, with some caveats. In *AC v Manitoba* at para 46, the Supreme Court described the contours of those limits [quoting the passage I have already set out].

87 I conclude that there is a high bar to overcome before a Court could find that a mature minor’s refusal of counselling can be overcome ...”

103. In *PH v Eastern Regional Integrated Health Authority* 2010 NLTD 34, LeBlanc J was concerned with mental health treatment for a 16-year-old child in a jurisdiction where the age of majority was 19 but where a 16-year-old was, by statute, presumed competent to consent to their own medical treatment. He said (paras 45-46):

“45 ... It is my opinion that the best interests standard should have application, where the treatment decision is related to the preserving of life of a person who is not legislatively recognized as an “adult”. I am of the opinion that the best interests standard must be applied in line with the level of maturity had by the individual involved as well as the independence of their judgment. My reason for concluding that this is a proper consideration is based upon the rationale used by the Supreme Court of Canada’s majority decision in [*AC*].

46 In that case, Abella J, for the majority of the court, found that ... applicable child protection legislation in place in Manitoba that stipulated that a court could authorize medical treatment for a person under 16 years of age considered in that person’s best interests, such a consideration was not an unconstitutional one. The caveat to this is that the best interests standard must

be applied in a manner that takes into increasingly serious account the young person's views the greater the child's level of maturity. This is an analysis that is best analogized with a "sliding scale" type of approach. While this reasoning was applied with regard to a person under of the age of 16, I find that the same reasoning is applicable to those over the age of 16 up to the time the person reaches the age of majority and is recognized by law as an adult."

He went on (para 51):

"In [AC], notwithstanding the presumed competency of the individual involved, the majority of the Court allowed for a sliding scale application of the best interests standard. A person who is aged 16 and has not yet reached the age of majority is in no different a position than a person found to a "mature minor" under 16 years of age in my view. Neither have attained the age of majority notwithstanding a recognition of competency either by statute or common law. As the approach to be applied takes into account differing levels of maturity, I see no issue in accepting that the best interests standard is to be applied for individuals who, at law, are not recognized as being an "adult". The Court's authority to protect the vulnerable using its *parens patriae* jurisdiction accords with this approach for this class of persons."

104. I conclude therefore that there is nothing in AC (or, indeed, in the other Canadian authorities to which I was taken) which throws any doubt on the continued validity of *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64, nor indeed anything which even begins to suggest the need for any judicial re-evaluation of what they establish.
105. I come now to consider the Human Rights Act 1998 and the European Convention.
106. Mr Brady relies upon Articles 2, 3, 5, 8, 9 and 14 of the Convention. I shall consider them in turn, though prefacing what follows with the observation that the combined researches of counsel have revealed nothing in the Strasbourg jurisprudence expressly addressing the issues before me.
107. Article 2: Mr Brady submits that Article 2 is not engaged and points to recent Grand Chamber decisions showing that the ambit of the State's obligations under Article 2 is narrow and is generally limited to the obligation to "provide effective deterrence against threats to the right to life" by third parties and to ensure that health care institutions have appropriate resources and regulations in place so as to avoid or minimize systemic deficiencies that might put life and health at risk: *Lopes de Sousa Fernandes v Portugal* (Application No 56080/13) (2017) 66 EHRR 28, paras 186, 191-192, 194-196, *Nicolae Virgiliu Tănase v Romania* (Application No 41720/13) [2019] ECHR 491, paras 135-136. More specifically, he points to the decision of the Strasbourg court in *Jehovah's Witnesses of Moscow v Russia* (Application No 302/02) (2011) 53 EHRR 4, para 132, that a decision by a Jehovah's Witness to refuse consent to blood transfusions is not "tantamount to suicide", because they seek to "make a choice of medical procedures" and do not "exclude treatment altogether."
108. Be that as it may, nothing in any of this, in my judgment, prevents the State having regard to the preservation of life as a factor that can permissibly be taken into account

in appropriate circumstances in evaluating, for example, whether there has been a breach of Article 3 or whether the qualifications to Articles 8 and 9 come into play.

109. Article 3: Article 3 provides, in unqualified terms, that “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.” Miss Watson relies upon the established Strasbourg jurisprudence that compulsory medical intervention which is a therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading: see *Herczegfalvy v Austria* (Application No 10533/83) (1992) 15 EHRR 437. Ms Butler-Cole and Mr Ruck Keene likewise refer to *Nevmerzhitsky v Ukraine* (Application No 54825/00) (2006) 43 EHRR 32, a case involving an adult hunger-striking prisoner, where the court (para 94) said:

“The Court reiterates that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist.”

110. Ms Butler-Cole and Mr Ruck Keene referred also to *Aggerholm v Denmark* (Application No 45439/18) [2020] ECHR 628, a case concerned with patients “entirely incapable of deciding for themselves”, where the Strasbourg court said (para 83) that “as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.” I need not for present purposes follow up their suggestion that this represents a tightening of the previous approach, limiting it solely to the position of those who are incapable of making their own decisions, for Mr Brady proceeds on a narrower front. Fastening on the phrase “general rule”, he counters with the observation that there must be exceptions to that “general rule” and submits that the present case is a paradigm example. He relies on two cases.
111. In *VC v Slovakia* (Application No 18968/07) (2011) 59 EHRR 29, para 110, the court having noted that “sterilisation is not generally considered as life-saving surgery”, and that “there was no emergency involving imminent risk of irreparable damage to the applicant’s life or health”, went on “since the applicant was a mentally competent adult, her informed consent was a prerequisite to the procedure, even assuming that the latter was a ‘necessity’ from a medical point of view.” In *NB v Slovakia* (Application No 29518/10) [2012] ECHR 99, a case of sterilisation of a 17-year-old whose consent to the procedure had been obtained (para 76) by telling her that “she would otherwise die”, the court, applying *VC v Slovakia*, held (para 74) that “the present applicant’s sterilisation was not a life-saving medical intervention ... that it was carried out without the informed consent of the applicant and/or her representative [and] ... was therefore incompatible with the requirement of respect for the applicant’s human freedom and dignity.” The court added that “The fact that the doctors had considered the procedure necessary because the applicant’s life and health would be seriously threatened in the event of her further pregnancy cannot affect the position.” The court went on (para 77): “For the Court, such a way of proceeding, by removing one of the important capacities of the applicant and making her formally agree to such a serious medical procedure while she was in labour, when her cognitive abilities were affected by medication, and then wrongfully indicating that the procedure was indispensable for preserving her life, violated the applicant’s physical integrity and was grossly disrespectful of her human

dignity.” See also, to similar effect, *IG and Others v Slovakia* (Application No 15966/04) [2012] ECHR 1910, paras 122, 125 (sterilisation of minors).

112. Mr Brady also pointed to the Grand Chamber decision in *Bouyid v Belgium* (Application No 23380/09) (2015) 62 EHRR 32, paras 89, 101, emphasising that “respect for human dignity forms part of the very essence of the Convention” and that “[a]ny interference with human dignity strikes at the very essence of the Convention” and confirming human dignity as a separate substantive ground for finding a violation of Article 3.
113. Referring to the evidence X gave at the hearing before me on 29 October 2020, he submits that there can be no doubt that X has suffered a violation of her human dignity:

“Q ... going back to when you were transfused in ... June 2020, could you explain ... how that made you feel? What was your reaction, your feeling, at the time of the transfusion and afterwards?”

A Well, when I was getting transfused and I saw the blood going through the canula in to my body, I felt, like, really disgusted and, sort of, horrified with myself. Just because I did ... I didn’t feel right with having somebody else’s blood going inside me and afterwards, I ... remember feeling really low in mood. I was really ... very down and I felt very miserable ...

Q ... you were transfused at an earlier time, in [2015] ... how did you feel at that time when you were transfused?

A ... it was very difficult time...that time and it was [last-minute] as well. So, the transfusion happened quite quickly ... I felt ... angry with the doctors and I felt I wasn’t being listened to ...

Q With the evidence of Dr C in mind, and if you were to receive an additional transfusion, a third transfusion, how do you anticipate you would feel?

A Well, I would feel frustrated and even more angry because, you know, it would be the third time that it had happened and, like I said, you know, despite fighting so hard for it not to happen, ... I would feel that nobody really, you know, cares about what I think or what I feel. So, ... I would be angry. I would be frustrated ... And I would ... I feel exhausted and, you know, you know, just miserable and really, really, sad.”

114. He submits that imposing blood transfusions on X – and threatening to do so at any time over the next two years, until she reaches the arbitrary chronological age of 18 – diminishes her human dignity in her own eyes and, picking up language used by the Strasbourg court, arouses profound feelings of “fear, anguish or inferiority.”
115. Now a child is as much entitled to the protection of Article 3 as an adult. Let it be assumed for the purpose of argument, as Mr Brady would have me accept, that to impose on a competent adult treatment to which she is objecting cannot be saved from the reach of Article 3 by claims of medical “necessity”, the fact is that I am here concerned with a child, not an adult, and a child moreover who, whether *Gillick*

competent or 16 or over, is not, as a matter of our domestic law autonomous in the same way as an autonomous adult, and whose decision is not determinative. Moreover, in this case, in contrast to *NB v Slovakia* (Application No 29518/10) [2012] ECHR 991 where, it is to be noted, the distinction was expressly drawn by the court, I am concerned with a potentially life-saving medical procedure. How does Article 3 operate in such a case? I have been taken to no authority directly in point, so approach the question as one of principle.

116. Ms Butler-Cole and Mr Ruck Keene suggest that the answer can be found in certain academic writings. They take me first to an important article by Professor Jane Fortin, *Accommodating Children's Rights in a Post Human Rights Act Era*, (2006) 69 MLR 299, 316:

“On the face of it, article 8 offers considerable protection to anyone objecting to treatment, underpinned as it is by notions of personal autonomy. But whilst such protection is available to an adult, it might be arguable that an infringement of a *Gillick* competent teenager's rights under article 8(1) (by forcing treatment on him) could be justified as being necessary to safeguard his life, as long as it is proportionate to the risks involved in the patient not receiving the treatment. It appears therefore that as long as the treatment is medically perfectly orthodox and life-saving, a domestic court might authorise treatment against the teenager's wishes, without necessarily falling foul of articles 3 or 8 of the Convention.”

117. But that of course, as they acknowledge, takes the argument only part of the way. One still has to ask why Articles 3 and 8 protect the refusal in all circumstances of life-sustaining treatment by capacitous adults, but not necessarily by children. They suggest that the answer is provided in an equally important article by Emma Cave, *Goodbye Gillick? Identifying and resolving problems with the concept of child competence*, (2014) 34 Legal Studies, 103-122, at 111:

“[a]rguably, the interests of minors are served by overriding their immediate decision where a failure to do so would prevent them from developing into functionally autonomous agents. Thus there are strong arguments for applying future-orientated versions of autonomy in cases where the decision would result in death or serious injury.”

118. Where have we seen this idea before? Does it not reflect the thinking of Lord Donaldson of Lynton MR and Nolan LJ in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 as carried forward in *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677 (see paras 21, 49, 52 above)? Interestingly, it has also been recognised by the Supreme Court of Canada. In *AC and Others v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [2009] 5 LRC 557, Abella J (para 88) quoted McIntyre J in *King v Low* [1985] 1 SCR 87, 101:

“It must be the aim of the Court ... to choose the course which will best provide for the healthy growth, development and education of the child *so that he will be equipped to face the problems of life as a mature adult* (emphasis added by Abella J).”

119. Moreover, as Ms Butler-Cole and Mr Ruck Keene point out, the need to balance the autonomy of minors with obligations to protect and support them, not only to make their own decisions, but also to survive to adulthood, is reflected in various provisions of the United Nations Convention on the Rights of the Child, for example, Article 3(2) “States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being ...”, Article 6(1), “States Parties recognize that every child has the inherent right to life”, Article 6(2), “States Parties shall ensure to the maximum extent possible the survival and development of the child”, and Article 24(1) “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” The Convention is not part of our domestic law but it is well-recognised that its provisions can be referred to for elucidating the content of those human rights that are generally recognised throughout the European family of nations, in particular the nature and scope of those fundamental rights that are guaranteed by the European Convention.
120. There is, so far as I am aware, nothing in the jurisprudence of the Strasbourg court recognising, let alone mandating States to enforce, a principle that a child, even a child who, to use our terminology, is *Gillick* competent or who has reached the age of 16, is in all circumstances autonomous in the sense that a capacitous adult is autonomous; nor, specifically, that such a child is autonomous when it comes to deciding whether or not to accept life-saving medical treatment. Indeed, as we will see, such indications as there are in the Strasbourg case-law contradict any such sweeping principle.
121. Accordingly, in my judgment, the application in the present case (and indeed in similar cases) of the principles established in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 does not, of itself, involve any breach of Article 3.
122. Article 5: The protection of Article 5 is not, of course, limited to adults. Putting the point shortly, and without spending time on further analysis, as the Supreme Court confirmed in *In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [2019] 1 WLR 5403, the concept of deprivation of liberty applies to those aged 16 and 17 in materially identical fashion to those over 18. And although, in relation to younger children, the concept of confinement applies in a different fashion, being nuanced to reflect the expectations of society as to the restrictions placed by parents upon their children, that nuancing can only go so far; thus, the concept of confinement engaging Article 5 will apply to children younger than 16, perhaps even as young as 11: see *In re A and others (Children) (Care Proceedings: Deprivation of Liberty)* [2018] EWHC 138 (Fam); [2019] Fam 45, para 43.
123. *In Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam), [2007] 2 FLR 1083, para 16, citing authority, I said:
- “It is ... quite clear that a judge exercising the inherent jurisdiction of the court (whether the inherent jurisdiction of the court with respect to children or the inherent jurisdiction with respect to incapacitated ... adults) has power to direct that the child or adult in question shall be placed at and remain in a specified institution such as, for example, a hospital, residential unit, care home or secure unit. It is equally clear that the court’s powers extend to authorising that person’s

detention in such a place and the use of reasonable force (if necessary) to detain him and ensure that he remains there”

124. It is equally clear, of course (*Re PS*, paras 18-27), that to the extent that such an order involves a “deprivation of liberty” as that phrase is used in Article 5, in contrast to a restriction on “liberty of movement” as that phrase is used in Protocol 4, Article 2, then the court in making such an order must comply with both the substantive and the procedural requirements of Article 5. I am concerned here with the former. Article 5 provides that a deprivation of liberty can be lawful only if the case falls within one or other of sub-paragraphs (a) to (f) of Article 5(1). The only one relevant in this kind of case is (e) which, so far as material permits:

“the lawful detention ... of persons of unsound mind ...”

125. The problem is immediately apparent. How can a *Gillick* competent child be “of unsound mind”? In the present case there are, in my judgment, two potential answers to the problem and two possible reasons why there was here no breach of Article 5.
126. First, I had made no order providing for X to be restrained or prevented from leaving the hospital. Nor did she in fact seek to do so. She acquiesced in – went along with – the order I had made. That suffices to dispose of the issue in the present case.
127. Secondly, if more problematically, there is the ‘carve out’ from the conventional application of Article 5 in the context of immediately necessary life-saving medical treatment considered in *Regina (Ferreira) v Inner South London Senior Coroner (Intensive Care Society and others intervening)* [2017] EWCA Civ 31, [2018] QB 487, and by Lady Arden JSC in *In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [2019] 1 WLR 5403, paras 119-120:

“119 ... Article 5 is not a qualified right and there is no scope for holding that the denial of a person’s liberty engages article 5 but does not amount to a violation because it serves a legitimate aim and is proportionate and necessary in a democratic society. Exceptionally there are situations where the Strasbourg court finds that in effect those tests were met but it can only do so by holding that there is no deprivation of liberty for article 5 purposes. Thus, in *Austin v United Kingdom* 35 EHRR 14, the complainants were demonstrators who had been “kettled” by the police, that is, kept against their will within a police cordon. The Strasbourg court held that there was no violation because the need for the police to maintain order in this situation meant the denial of liberty was not a deprivation of liberty for article 5 purposes. So, too, in [*Nielsen v Denmark* (1988) 11 EHRR 175], the Strasbourg court had held that there was no deprivation of liberty for article 5 purposes.

120 It follows that there will be cases where a person loses their liberty but the acid test in *Cheshire West*, as Lady Hale describes it, does not apply. That conclusion is shown by observing that D’s case is about living arrangements. It is not about a child, or anyone else, needing life-saving emergency medical treatment. For the reasons which the Court of Appeal (McFarlane LJ, Sir Ross Cranston and myself) gave in *R (Ferreira) v Inner South London Senior Coroner* [2018] QB 487, the situation where a person is

taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control (para 89)."

128. This potentially takes us into a difficult and as yet only partially explored part of the legal landscape for, as Ms Butler-Cole and Mr Ruck Keene point out, the position of X and other children in her position, whether *Gillick* competent or having reached the age of 16, is self-evidently not necessarily the same as the position of the patient being considered in *Ferreira* or of a baby. And, as a contrast with *Austin v United Kingdom* 35 EHRR 14, one needs to consider *Commissioner of the Police for the Metropolis v ZH* [2013] EWCA Civ 69, [2013] 1 WLR 3021, paras 82-83; and see the decision of the Commission in *X v Austria* (Application No 8278/78) (1979) 18 DR 154.
129. Referring to the well-established three-part analysis of what amounts to a deprivation of liberty for the purposes of Article 5, Mr Brady submits that the first component – was X denied her liberty for a “non-negligible length of time”? – is plainly satisfied. For a period of approximately three hours on 29 October 2020, medical staff administered blood cells to her based on the order I had made. From her perspective, he says, nothing was “normal” about those three hours when she was transfused against her will. She was fully lucid and conscious, but not “free to leave”. I am not so sure.
130. There is no need for me to decide the point here, and it is better left for decision as and when it arises, but I am inclined to think that in this situation the solution is to be found in the so-called ‘carve out’ – that what we have here is, at most, a restriction on “liberty of movement” as that phrase is used in Protocol 4, Article 2, rather than a “deprivation of liberty” as that phrase is used in Article 5.
131. Article 8: Article 8, like Article 9, sets out rights which are qualified, not absolute:
- “(1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”
132. Mr Brady submits that human dignity, personal autonomy, and self-determination are the bedrock of the Convention. I unhesitatingly agree. He points out, citing authority which there is no need to quote because the principles are so well-established in the Strasbourg jurisprudence, that the concept of “private life” guaranteed by Article 8 “embraces ... a right to self-determination” and includes “personal autonomy and personal development” and “physical and psychological integrity.” Thus, he submits, every capable person has the right to make fundamental personal choices, including the right to exercise control over his or her bodily integrity free from State interference. An imposed medical procedure, he says, is one of the most egregious violations of a

person's physical and psychological integrity. He quotes *YF v Turkey* (Application No 24209/94) (2003) 39 EHRR 34, para 33:

“[A] person's body concerns the most intimate aspect of private life. Thus, a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this right.”

133. None of this is controversial. Indeed, it is fundamental. But the question is the extent to which these principles apply without qualification in the case of a child, even a child who is *Gillick* competent or has reached the age of 16.
134. Miss Watson submits that, whilst X's rights under Article 8, and for that matter Article 9, are undoubtedly engaged, these are not absolute rights and, in a case such as this, have properly to be weighed in the balance as part of the best interests analysis in proceedings under the inherent jurisdiction. This approach, she says, has an objective and reasonable justification and pursues a legitimate aim, namely the care and treatment of a seriously unwell child. Ms Butler-Cole and Mr Ruck Keene put the point succinctly: preserving the lives of children until adulthood is a legitimate aim. I agree.
135. I repeat in this context what I have already said above in paragraphs 116-120 in the context of Article 3. In my judgment, that analysis applies a fortiori in the case of Article 8, where, in contrast to Article 3, the rights engaged are not absolute but qualified by Article 8(2). Moreover, there is support for it in the authorities.
136. In the context of Article 14, Miss Watson referred me to what the Strasbourg court had said in *DG v Ireland* (Application No 39474/98) (2002) 35 EHRR 33, para 115, following *Bouamar v Belgium* (Application No 9106/80), (1988) 11 EHRR 1, paras 66-67. This was a case where the complaint by a child under Article 14 was linked to a complaint under Article 5, so it is not directly in point in relation to Article 8, but the reasoning of the Strasbourg court is nonetheless illuminating:
- “... even assuming that there would be a difference in treatment between minors requiring containment and education and adults with the same requirements, any such difference in treatment would not be discriminatory *stemming as it does from the protective regime which is applied through the courts to minors in the applicant's position*. In the Court's view, *there is accordingly an objective and reasonable justification for any such difference of treatment*. In so far as he compares his situation to that of other minors, the Court considers that no separate issue arises given that it raises the same issue which lies at the heart of the Article 5 complaint in respect of which the Court has found a violation of the Convention.” (emphasis added)
137. Article 8 was directly engaged in *In R (Axon) v Secretary of State for Health (Family Planning Association Intervening)* [2006] EWHC 37 (Admin), [2006] QB 539 (cited in *Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), para 108), where a mother challenged the lawfulness of a document published by the Department of Health entitled *Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* (the 2004 Guidance). Silber J was faced with the argument that the principles in *Gillick* breached a *parent's* rights

under Article 8. After a lengthy analysis of the issues (paras 118-151), he concluded as follows (para 152):

“For all those reasons it follows that first the 2004 Guidance does not engage article 8(1), but even if it does, any infringement of the parent’s article 8(1) rights can be justified under article 8(2) in the light of the matters to which I have referred. Thus the principles in *Gillick* continue to be valid and applicable being unaffected by article 8.”

The sweeping statement in the second sentence has, it seems to me, to be read in the context of the specific reference in the first sentence to the *parent’s* Article 8 rights.

138. More directly germane to the issues with which I am concerned is the analysis of Baker J in *Re P (A Child); An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam), [2014] Fam Law 1249, paras 15-16:

“15 In this case, balancing the competing factors, I have no hesitation in concluding that the balance comes down firmly in favour of overriding P’s wishes. I recognise that this is not to be taken lightly. The wishes of a young person aged seventeen and a half are important. They are, of course, entitled to be taken into account as part of her Article 8 rights under ECHR. On the other hand, those rights are not absolute. Here, they are outweighed by her rights under Article 2 – everyone’s right to life shall be protected by law. The court is under a positive or operational duty arising from Article 2 to take preventative measures to protect an individual whose life is at risk: *Osman v UK* (1998) 29 EHRR 245; [*Rabone and another v Pennine Care NHS Trust (INQUEST and others intervening)*] [2012] UKSC 2, [2012] 2 AC 72; *A NHS Trust v Dr A* [2013] EWHC 2273 (Fam).

16 In those circumstances, this court is under a heavy duty to take what steps it can to protect P’s life which is manifestly in danger tonight. Accordingly, I have made an order including a declaration that it is lawful and in P’s best interests for the medical practitioners having responsibility for her care and treatment to treat her for the effects of her overdose notwithstanding the fact that she is refusing treatment.”

139. Mr Brady submits, in relation to both Article 8 and Article 9, that the domestic rule relied upon by Miss Watson is not, in the sense in which these phrases are used in the Strasbourg jurisprudence, “prescribed by law”, that it does not pursue a “legitimate aim” and is not “necessary in a democratic society.” As to the second and third of these, I have already in substance explained why I do not accept this. In relation to the first, Mr Brady cites the Grand Chamber in *Maestri v Italy* (Application No 39748/98) (2004) 39 EHRR 38, para 30:

“The law should be accessible to the persons concerned and formulated with sufficient precision to enable them – if need be, with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail ... For domestic law to meet these requirements, it must afford a measure of legal protection against arbitrary interferences by public authorities with the rights guaranteed by the Convention. In matters affecting fundamental rights it would be contrary to the rule of law, one of the

basic principles of a democratic society enshrined in the Convention, for a legal discretion granted to the executive to be expressed in terms of an unfettered power. Consequently, the law must indicate with sufficient clarity the scope of any such discretion and the manner of its exercise.”

Many attempts have been made to demonstrate that purely common law rules, to be found only in a mass of case-law, fall foul of this principle but I am not aware of any that have succeeded, nor have similar attacks on the statutory, if largely undefined and unarticulated, rule that the welfare of a child is the court’s paramount consideration. I reject the proposition that the law as set out in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 offends this salutary principle.

140. The application in the present case (and indeed in similar cases) of the principles established in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 does not, of itself, involve any breach of Article 8.
141. Article 9: In addition to what I have already said about Article 9, I need to refer in more detail to what was said by the Strasbourg court in *Jehovah’s Witnesses of Moscow v Russia* (Application No 302/02) (2011) 53 EHRR 4. Mr Brady cited what the court said (paras 135-136):

“135 The very essence of the Convention is respect for human dignity and human freedom and the notions of self-determination and personal autonomy are important principles underlying the interpretation of its guarantees. The ability to conduct one’s life in a manner of one’s own choosing includes the opportunity to pursue activities perceived to be of a physically harmful or dangerous nature for the individual concerned. In the sphere of medical assistance, even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity and impinge on the rights protected under art.8 of the Convention.

136 The freedom to accept or refuse specific medical treatment, or to select an alternative form of treatment, is vital to the principles of self-determination and personal autonomy. A competent adult patient is free to decide, for instance, whether or not to undergo surgery or treatment or, by the same token, to have a blood transfusion. However, for this freedom to be meaningful, patients must have the right to make choices that accord with their own views and values, regardless of how irrational, unwise or imprudent such choices may appear to others. Many established jurisdictions have examined the cases of Jehovah’s Witnesses who had refused a blood transfusion and found that, although the public interest in preserving the life or health of a patient was undoubtedly legitimate and very strong, it had to yield to the patient’s stronger interest in directing the course of his or her own life. It was emphasised that free choice and self-determination were themselves fundamental constituents of life and that, absent any indication of the need to protect third parties – for example, mandatory vaccination during an epidemic, the state must abstain from interfering with the individual freedom of choice in the sphere of health care, for such interference can only lessen and not enhance the value of life.”

142. As Ms Butler-Cole and Mr Ruck Keene observe, the Strasbourg court was careful to make clear that it was considering the position of competent adult patients and, as they submit, it does not automatically follow that it would take the same position in relation to minors. Indeed, as they point out, the court went on in the same case to say in relation to Russian domestic law (para 137):

“... the parents’ decision to refuse treatment of a child may be reversed by means of judicial intervention. It follows that Russian law protects the individual’s freedom of choice in respect to their health care decisions as long as the patient is a competent adult and there is no danger to innocent third parties. These provisions ... were prima facie applicable in the instant case because all the refusals of blood transfusions which had been described in the domestic judgments had been formulated by adult Jehovah’s Witnesses having capacity to make medical decisions for themselves. In the only case involving a minor, the hospital did not apply for judicial authorisation of a blood transfusion, although such a possibility was explicitly provided for in law, which indicates that authorisation was considered unnecessary for medical or other reasons.”

143. In my judgment, the same analysis as I have applied to the claims under Article 3 and Article 8 applies in the same way to the claim under Article 9. Here, as there, preserving the lives of children until adulthood is a legitimate aim.

144. Accordingly, the application in the present case (and indeed in similar cases) of the principles established in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 does not, of itself, involve any breach of Article 9.

145. Article 14: Article 14 provides that:

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

146. The leading domestic authority is the decision of the House of Lords in *R (Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37, [2006] AC 173, where Lord Hoffmann said (paras 14-15):

“14 ... Discrimination means a failure to treat like cases alike. There is obviously no discrimination when the cases are relevantly different. Indeed, it may be a breach of article 14 not to recognise the difference: see *Thlimmenos v Greece* (2001) 31 EHRR 411. There is discrimination only if the cases are not sufficiently different to justify the difference in treatment. The Strasbourg court sometimes expresses this by saying that the two cases must be in an ‘analogous situation’: see *Van der Musselle v Belgium* (1983) 6 EHRR 163, 179–180, para 46.

15 Whether cases are sufficiently different is partly a matter of values and partly a question of rationality.”

147. The case was taken to Strasbourg. The Grand Chamber agreed with this approach: *Carson v UK* (2010) 51 EHRR 13, para 61 (citations omitted):
- “... in order for an issue to arise under article 14 there must be a difference in the treatment of persons in analogous, or relevantly similar, situations. Such a difference in treatment is discriminatory if it has no objective and reasonable justification; in other words, if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. The contracting state enjoys a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment. The scope of this margin will vary according to the circumstances, the subject matter and the background.”
148. As Mr Brady points out, the Strasbourg jurisprudence shows that discrimination under Article 14 can arise in two different ways: (i) when the State treats differently “persons in an analogous or relevantly similar situation”: *Mižigárová v Slovakia* (Application No 74832/01) [2010] ECHR 2018, paras 114-115, and the Grand Chamber decision in *Molla Sali v Greece* (Application No 20452/14) [2018] ECHR 1048, para 133; (ii) when the State treats the same, persons whose “situations are significantly different”: *Thlimmenos v Greece* [GC] (Application No 34369/97) (2000) 31 EHRR 15, para 44.
149. In relation to (i), he submits that there is discrimination with respect to two groups: (a) capable persons age 16 and 17, who, he asserts, are “guaranteed” by the Mental Capacity Act 2005 that their treatment decisions will be respected; and (b) capable persons age 18 and older, who are guaranteed that their treatment decisions will be respected by section 1 of the Family Law Reform Act 1969. With respect to both groups, he says, X is in an “analogous or relatively similar situation” because (and I quote his skeleton argument) “Like persons age 16 and 17 and also like persons age 18 and older, she has decisional capacity to make her own medical treatment decisions, including refusing blood transfusions.” However, he says, unlike persons in both groups X is denied the authority to decide her medical care, including refusing consent to blood transfusion.
150. In relation to (ii), he submits that X is being treated in the same way as incapable children under the age of 16, who are denied the right to decide their medical treatment, even though, he asserts, unlike those persons, she has capacity to decide her medical care.
151. With respect to both types of discrimination, he says, X is treated differently on the grounds of “age” which constitutes “other status” for the purposes of Article 14 of the Convention: *Carvalho Pinto de Sousa Morais v Portugal* (Application No 17484/15) [2017] ECHR 719, para 45. That difference in treatment cannot be justified, he says. It is, he submits, no answer that the State prescribes a fixed age for certain activities, such as voting, driving, marriage, or receipt of government benefits; these are all matters where administrative convenience justifies a fixed age, but administrative convenience, he says, can never justify denying the fundamental right to human dignity, bodily autonomy, self-determination, and religious conscience.
152. Mr Brady’s submissions are on the face of it inherently problematic. As will be appreciated, his analysis of the relevant domestic law is not one that I can accept; and

it is not administrative convenience but something much more fundamental – the protection of the welfare of children – which lies at the root of the impugned provisions.

153. Miss Watson submits that a *Gillick* competent child (and, indeed, a 16-year-old child) is sufficiently different from a capacitous adult to justify a difference in treatment as a matter of law and that any difference in treatment is not discriminatory because it stems from the protective nature of the procedure applicable to minors. Furthermore, she says, there is an objective and reasonable justification for any such difference in the treatment, namely to uphold the paramountcy principle and to ensure to the maximum extent possible the survival and development of the child. Accordingly, she submits, the approach to applications under the inherent jurisdiction set out in *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 does not discriminate against *Gillick* competent children (or children over the age of 16) in the enjoyment of their Convention rights.
154. She points to *DG v Ireland* (Application No 39474/98) (2002) 35 EHRR 33, para 115, following *Bouamar v Belgium* (Application No 9106/80), (1988) 11 EHRR 1, paras 66-67, as a case where the Strasbourg court found that any difference in treatment between minors requiring containment and education and adults with the same requirements would not be discriminatory because it stems from the protective nature of the procedure applicable to minors. Accordingly, there was an objective and reasonable justification for any such difference in the treatment: “even assuming that there would be a difference in treatment between minors requiring containment and education and adults with the same requirements, any such difference in treatment would not be discriminatory stemming as it does from the protective regime which is applied through the courts to minors in the applicant’s position. In the Court’s view, there is accordingly an objective and reasonable justification for any such difference of treatment.”
155. She relies upon *Re E (A Child)* [2018] EWCA Civ 550, [2019] 1 WLR 594 (the Alfie Evans case), where an alleged violation of Article 14, read with Article 8, was considered by the Court of Appeal in a case where it was proposed to withdraw life-sustaining treatment from a baby whose parents were refusing to consent. Although this concerned alleged discrimination against the parents, rather than the child (who obviously was not *Gillick* competent), Miss Watson relies upon what King LJ said (para 118) when considering the question of reasonable justification:
- “the proceedings under the inherent jurisdiction have in my view an objective and reasonable justification and pursue a legitimate aim, namely the care and treatment of desperately ill children.”
156. Furthermore, as Ms Butler-Cole and Mr Ruck Keene point out, the Supreme Court of Canada in *AC and Others v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [2009] 5 LRC 557, rejected an argument based on discrimination on the grounds of age in alleged breach of section 15 of the Canadian Charter of Rights and Freedoms. As Abella J explained (paras 110-111, citations omitted):
- “110 Age distinctions have frequently been upheld by this court ... They are currently employed to determine when a person can marry, vote, drive, consent to sexual intercourse and sell property. As noted by McLachlin CJ in *Gosselin* [2002] 4 SCR 429 at [31], it must be recognised that ‘age-based legislative

distinctions are a common and necessary way of ordering our society'. In the context of s 15 of the Charter, McLachlin CJ has commented that while 'all age-based distinctions have an element of this literal kind of "arbitrariness"', this alone does not invalidate them '[p]rovided that the age chosen is reasonably related to the legislative goal' (*Gosselin* [2002] 4 SCR 429 at [57]).

111 Age demarcations for allocating presumptions were defended by Jessica W Berg et al in *Informed Consent: Legal Theory and Clinical Practice* (2nd edn, 2001), p 97:

'Most authors in this area agree that age cut-offs should not be used as automatic determinants of de facto capacity for any type of decision *but may function as an indicator to shift presumptions*. Thus, individuals below the age of consent are presumed to lack capacity unless shown otherwise, and those above the age of consent are presumed to have capacity until shown otherwise.' (Our emphasis.)

Under the Child and Family Services Act the distinction between promoting autonomy and protecting welfare is presumed to collapse at age 16, subject to evidence to the contrary. But whether a child is under or over 16, the weight that is accorded to his or her views under s 25 of the Act will ultimately correspond to a court's conclusions about the extent to which the child is capable of making decisions in his or her own best interests. By permitting adolescents under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make treatment decisions is ultimately calibrated in accordance with maturity, not age, and no disadvantaging prejudice or stereotype based on age can be said to be engaged. There is therefore no violation of s 15."

157. I repeat what I have already said in relation to Article 3, Article 8 and Article 9. In my judgment, the application in the present case (and indeed in similar cases) of the principles established in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 does not, of itself, involve any breach of Article 14.
158. I conclude therefore that there is nothing in the jurisprudence of the European Convention which throws any doubt on the continued validity of *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64, nor indeed anything which even begins to suggest the need for any judicial re-evaluation of what they establish.
159. Finally, and standing back from all this, I must address Mr Brady's submission that times have changed and views as to the proper balance between medical paternalism and patient autonomy have altered. Of course, a family court cannot be blind to the changes in society's views and values which are such a striking feature of modern life, and this is well recognised in the authorities. Thus it is now a commonplace that, in addressing the question of what is in a child's best interests and required for the child's welfare, the judge has to adopt the standards of 2021 and not those of 1989 (when the principle was enshrined in the Children Act 1989, let alone those of 1925 (when the principle first received statutory recognition in the Guardianship of Infants Act 1925): see *Owens v Owens* [2017] EWCA Civ 182, [2017] 4 WLR 74, para 40:

“The concept of welfare is, no doubt, the same today as it was in 1925, but conceptions of that concept, to adopt the terminology of Professor Ronald Dworkin, or the content of the concept, to adopt the corresponding terminology of Lord Hoffmann in *Birmingham City Council v Oakley* [2001] 1 AC 617, 631, have changed and continue to change. A child’s welfare is to be judged today by the standards of reasonable men and women in 2017 – not by the standards of their grandparents in 1925 or their parents in 1969 (when the House of Lords decided *J and Another v C and Others* [1970] AC 668; see in particular the speech of Lord Upjohn, 722-723) – and having regard to the ever changing nature of our world, in particular, changes in social attitudes: see *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677, para 33.”

160. But that does not entitle the court to reject the learning – the law – as set out in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64. When put on this plane, what Mr Brady is inviting me to do falls foul, in my judgment, of the salutary principle enunciated, as we have seen, by Balcombe LJ in *In re W*, as quoted in paragraph 46 above:

“I express no view on the question whether a young person, whether over the age of 16 or under that age if “Gillick competent,” should have complete autonomy in the field of medical treatment. That is a matter of social policy with which Parliament can deal by appropriate legislation if it wishes to do so.”

161. I accept, of course, as Mr Brady points out, that the “common law is capable of moving with the times” (*In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [2019] 1 WLR 5403, para 22), and can adjust to “social and legal developments”, including the Human Rights Act 1998 (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] 1 AC 1430, para 81, rejecting the medical paternalism reflected in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871). That is precisely what I have been seeking to explore throughout this judgment. But in that endeavour, Mr Brady has for the reasons I have given, failed. What I cannot do is to overthrow *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 merely because society’s views have changed, even assuming that they have.
162. At the end of this lengthy analysis, my clear and firm conclusion is that the learning in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 emerges unscathed from Mr Brady’s attack. The change for which he contends is a matter for Parliament, not the courts.
163. I shall accordingly dismiss X’s application, made on 17 November 2020, seeking declarations (1) that at the time of the oral argument on 18 November 2020 she had the requisite decisional capacity to exclusively decide her own medical treatment refusing consent to blood transfusions and (2) that upon reaching the age of 16 she shall be presumed in law to have decisional capacity and, as such, the authority to exclusively decide her own medical treatment including refusing consent to blood transfusions.

164. I turn therefore to the second question, which I can take quite shortly. Further argument and the opportunity for further thought and reflection leaves me of the same view as set out in the passage from my previous judgment (*Re X*, para 20) quoted in paragraph 9 above.
165. I have no doubt that the court has jurisdiction to make the kind of contingent, anticipatory or prospective order which Miss Watson seeks: see my analysis in *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)* [2002] EWHC 2278 (Fam), [2003] 1 FLR 292, paras 50-60, citing *Re R (Adult: Medical Treatment)* [1996] 2 FLR 99 and *Re SLS* [2002] EWHC 6 (Fam). Examples of such orders can be found in *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam), [2004] 2 FLR 1117, and, more recently, *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24, *Wakefield Metropolitan District Council and Wakefield Metropolitan Clinical Commissioning Group v DN and MN* [2019] EWHC 2306 (Fam), [2019] COPLR 525, and *Guys and St Thomas's NHS Foundation Trust and another v R* [2020] EWCOP 4, [2020] 4 WLR 96.
166. The real question is whether I should make such an order.
167. Miss Watson submits that I should. She says that there is cogent medical evidence before the court that: X is at risk of developing life-threatening complications of sickle cell disease on some future occasion for which a blood transfusion will be the only effective treatment; in the event of a further life-threatening sickle cell crisis X would be at “significant” risk of serious irreversible harm or death due to complications such as a stroke if she does not receive further blood transfusions; and a blood transfusion has good prospects of successfully treating a further life-threatening sickle cell crisis and improving her overall physical health. She also asserts that X will not resist the administration of a blood transfusion if authorised by the court and restraint will not be required. This is precisely the sort of case, she says, in which an anticipatory order should be made. It would be contrary to X’s best interests to defer an application until a further crisis develops, leading to the need to make a further urgent application to the court with the attendant risk that the court will have to reach a decision under pressure of time and without the advantage of proper representation. Such an order has the benefit of certainty and predictability and will avoid the need for further repeated applications to the court, potentially on an urgent basis if X’s condition deteriorates suddenly.
168. Mr Brady submits that I should not make such an order. I agree, though not necessarily agreeing with all the detail of the points he makes. He has four submissions:
- i) Determining whether or not a particular treatment is medically required is highly fact specific. It cannot be subject to speculation or generalisation, certainly not up to two years in advance. This, he suggests, is particularly true in the case of blood transfusions where, he submits, there are wide, but well-documented, variations in clinical practice. He relies for this purpose on the World Health Organization’s *The clinical use of blood in general medicine, obstetrics, paediatrics, surgery and anaesthesia, trauma and burns*, Geneva, WHO, 2009, available at: http://www.who.int/bloodsafety/clinical_use/en/ and the European Commission’s *Building national programmes of Patient Blood Management (PBM) in the EU—A Guide for Health Authorities*, Brussels, EU, 2017, available at: https://ec.europa.eu/health/blood_tissues_organs/publications_en.

I do not follow him into the detail, though the general point is, I think, well made.

- ii) To grant a two-year “rolling order”, to be implemented based on the say-so of whomever happens to be the treating clinician and whatever their particular transfusion practice, is therefore inappropriate. It runs the risk of privileging “medical paternalism” over judicial protection. I can see the force of this point.
- iii) In the kind of case with which I am concerned, there is the risk of discrimination and religious stereotyping, based on the erroneous assumption that blood transfusions are always necessary whenever recommended by a clinician and that a patient who is a Jehovah’s Witnesses is always wrong to refuse such a procedure. He cites *M(J) v Alberta (Director of Child Welfare)* 2004 ABQB 512, para 43, where Kent J said:

“... the treating physician’s clinical assessment must always be a significant consideration. However, the [State] and the Court must be careful not to presume that the doctor has always recommended the only acceptable treatment and that Jehovah’s Witness parents are always wrong in denying their consent for treatment by way of blood products. Such a paternalistic attitude impairs the parents’ rights ...”

- iv) X and her counsel were given very little notice of the urgent hearing on 29 October 2020, did not have access to the hospital records and had no opportunity to obtain expert evidence. Although counsel did his best at the hearing to probe Dr C’s various assertions, X has not yet had the opportunity to test the medical evidence rigorously – which must be the pre-requisite if there is to be a rolling order for a period stretching over two years.
169. Taken in the round I accept the force of Mr Brady’s submission and agree that there should not be a “rolling order.”
170. Mr Brady seeks a certificate for a ‘leapfrog’ appeal to the Supreme Court pursuant to Part II of the Administration of Justice Act 1969, alternatively permission to appeal to the Court of Appeal. Miss Watson opposes both applications. Ms Butler-Cole and Mr Ruck Keene made no submissions on behalf of CAFCASS as advocate to the court.
171. A certificate can be granted only if the conditions in either section 12(3) or section 12(3A) are fulfilled. The conditions in section 12(3) are that:

“a point of law of general public importance is involved ... and that that point of law either –

- (a) relates wholly or mainly to the construction of an enactment or of a statutory instrument, and has been fully argued in the proceedings and fully considered in the judgment of the judge in the proceedings, or
- (b) is one in respect of which the judge is bound by a decision of the Court of Appeal or of the Supreme Court in previous proceedings, and was fully considered in the judgments given by the Court of Appeal or the Supreme Court (as the case may be) in those previous proceedings.”

The conditions in section 12(3A) are that:

“a point of law of general public importance is involved in the decision and that

—

- (a) the proceedings entail a decision relating to a matter of national importance or consideration of such a matter,
- (b) the result of the proceedings is so significant (whether considered on its own or together with other proceedings or likely proceedings) that, in the opinion of the judge, a hearing by the Supreme Court is justified, or
- (c) the judge is satisfied that the benefits of earlier consideration by the Supreme Court outweigh the benefits of consideration by the Court of Appeal.”

172. Section 12(1)(b) requires that the judge must be satisfied “that a sufficient case for an appeal to the Supreme Court under this Part of this Act has been made out to justify an application for leave to bring such an appeal.” Section 15(3) provides that:

“Where by virtue of any enactment, apart from the provisions of this Part of this Act, no appeal would lie to the Court of Appeal from the decision of the judge except with the leave of the judge or of the Court of Appeal, no certificate shall be granted under section 12 of this Act in respect of that decision unless it appears to the judge that apart from the provisions of this Part of this Act it would be a proper case for granting such leave.”

173. In my judgment, it is clear that neither limb of section 12(3) is fulfilled. My judgment does not “relate wholly or mainly to the construction of” either section 8 of the 1969 Act or the Mental Capacity Act 2005 – it ranges far wider. Mr Brady does not in fact seek to bring the case within this limb. Nor has the central point (are *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 still good law in the light of subsequent developments?) ever been considered, let alone “fully considered,” by any judge, let alone by either the Court of Appeal or the Supreme Court.
174. So far as concerns section 12(3A)(a) it is plain that it is not enough that the point of law is one “of general public importance”; it must also be “of national importance.” Despite the profundity of the ethical and societal issues to which Mr Brady refers, I am not persuaded that the matter is, within the meaning of section 12(3A)(a), of “national importance.” Nor am I persuaded that the matter is “so significant” within the meaning of section 12(3A)(b) as to justify a hearing by the Supreme Court. So far as concerns section 12(3A)(c), Mr Brady points to the additional cost and, more particularly, the additional delay to which X will be exposed in knowing what her rights are, if the matter has to go first to the Court of Appeal before reaching the Supreme Court. That is a powerful point, but it is, in my judgment, heavily outweighed by the considerable advantage the Supreme Court (assuming for this purpose that the case ever gets there) will derive from having the benefit of the Court of Appeal’s considered views.
175. I am also not persuaded that a “sufficient case” has been made out within the meaning of section 12(1)(b). In this respect there is considerable force in the point made by Miss Watson that there are no decisions conflicting with mine to be found in our domestic

courts, in the Strasbourg court or across the common law world and that “it is highly unlikely that on re-examination by a superior court the law as set out in *In re R* or *In re W* would be overthrown.”

176. I therefore refuse a certificate. I turn to the question of permission to appeal to the Court of Appeal.
177. Permission may be granted (CPR 52.6(1)) “only where – (a) the court considers that the appeal would have a real prospect of success; or (b) there is some other compelling reason for the appeal to be heard.”
178. I appreciate the inherent risk that I may yet be proved wrong, but I am not persuaded that an appeal would have a real prospect of success. Mr Brady identifies two matters on which, he submits, my judgment is vulnerable: first, what he refers to as “the greater freedom of the Court of Appeal to overrule or clarify” *In re R* and *In re W*; secondly, my failure “to identify a compelling State justification required by Article 14 ... in conjunction with Articles 3, 5, 8 and 9 ... to justify a law which permits a court to overrule the medical treatment decisions of a competent 16/17 year old ... while prohibiting the court to similarly override the treatment decision of a person age 18 and older.” He submits that “such a distinction, based solely on age, is inherently arbitrary and cannot be justified.” I do not, with respect, accept either proposition as demonstrating a real prospect of success. There is nothing in what I have said to suggest that the Court of Appeal would have “greater freedom ... to overrule or clarify.” As to the second point, Mr Brady has been unable to identify anything in the Strasbourg jurisprudence which supports his proposition; quite the contrary.
179. In relation to the contention that “there is some other compelling reason for the appeal to be heard”, that is a matter which, in my judgment, is better left for determination in this instance by the Court of Appeal rather than the judge at first instance.
180. I therefore refuse permission to appeal. It will be appreciated that the effect of this is that I would in any event have had to refuse a certificate under Part II of the 1969 Act: see section 15(3).