Neutral Citation Number: [2021] EWCA Civ 1888

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT (FAMILY DIVISION)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 December 2021

Before :

THE PRESIDENT OF THE FAMILY DIVISION
LORD JUSTICE PETER JACKSON
and
LADY JUSTICE NICOLA DAVIES

- -

Case No: B4/2021/0962

Mrs. Justice Theis
FD21P00281

- -

E **Appellant**

and

NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST **Respondent**

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- -

Simon Achonu of **Richard Cook Solicitors** for the **Respondent/Appellant**
Victoria Butler-Cole QC and **Arianna Kelly** (instructed by **Hill Dickinson LLP**) for the **Applicant/Respondent**

Hearing date : 9 November 2021

- -

Case No: CA-2021-000019

Mrs. Justice Judd
FD21P00654

- -

F **Appellant**

and

SOMERSET NHS FOUNDATION TRUST **Respondent**

- -

- -

Simon Achonu of **Richard Cook Solicitors** for the **Respondent/Appellant**
Parishil Patel QC and **Francesca Gardner** (instructed by **Bevan Brittan LLP**) for the **Applicant/Respondent**

Hearing date : 9 November 2021

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Approved Judgment

E & F (Minors: Blood Transfusion)

Sir Andrew McFarlane, President:

1. This is the judgment of the Court.

Introduction

2. These are appeals brought by two young persons from orders made by judges of the Family Division in which it was declared under the inherent jurisdiction that, although the young persons were competent to decide whether to consent to or refuse medical treatment in the form of blood transfusion, it would nevertheless be lawful for their doctors to administer blood to them in the course of an operation if that became necessary to prevent serious injury or death.

3. The appellants are E, a girl who was aged 16 years 8 months at the time of the decision under appeal, and F, a boy who was aged 17 years 5 months at the time of the decision in his case. Each of them has been baptised as one of Jehovah's Witnesses and conscientiously rejects blood transfusions as an article of faith. Each was considered by their doctors to have the capacity to make decisions about their medical treatment, i.e. to be *Gillick* competent (see *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] AC 112). They had made their decisions independently and had the support of their parents.

4. Some decisions about medical treatment have to be made in the certain knowledge that a medical crisis has arisen. That was not the position here. The declarations were made in relation to the treatment that could be given *if* a crisis arose. That was statistically unlikely to happen, but if it did, the consequences were potentially very serious. Happily, no crisis arose in either case, transfusion did not occur, and both young persons were soon safely discharged from hospital.

5. In that sense, the declarations never formally came into effect. E and F are nevertheless aggrieved that their autonomy was overruled, and distressed by the process that occurred. In their applications for permission to appeal they advanced two main arguments. The first was that the State, acting through the court, has no power to overrule the capacitous decision of a mature minor, and in particular a young person aged 16 or 17. The second was that any such power was wrongly exercised in their cases. Permission to appeal was refused in relation to the first argument because it is settled law that the court has the power to intervene in the best interests of a minor even if the effect is to overrule a decision that would be conclusive if the young person had made it after reaching the age of 18. The real question, with which this judgment is concerned, is not whether the power exists, but how it should be exercised.

6. It is however important to acknowledge that in these cases the court is not simply concerned with the 'wishes' or 'views' of the *Gillick* competent young person, but with a treatment decision that would be effective in the absence of intervention by the court. We will therefore refer to the young person's 'decision' so that this important distinction is not overlooked.

The facts in E's case

7. In the late evening of Saturday 8 May 2021, E started to feel pain in the right side of her stomach. At 6.30 a.m. on Sunday 9 May, she attended her local general hospital

with her mother. Appendicitis was diagnosed and she was transferred to another hospital that morning. At the second hospital she was told that she did not have appendicitis, and was discharged on the basis that she would return the following day for an ultrasound scan. The pain continued and E returned to hospital with her father on the morning of Monday 10 May. After the scan took place, she was told that she had acute appendicitis and needed urgent surgery. The surgery would involve a diagnostic laparoscopy (a low-risk examination procedure), followed by a laparoscopic appendectomy (removal of the appendix by keyhole surgery), but if that was not possible, by an appendectomy by open procedure.

8. During the course of the day, the risks and benefits of the operation were explained to E in detail by a consultant surgeon, Dr D and a consultant anaesthetist, Dr A. Dr A described the chances of severe surgical bleeding intraoperatively as being in the order of 1:1000 or 1:2000. Dr D said that the possibility of needing a blood transfusion was "extremely rare" and that without one there was "a very theoretical possibility" of E bleeding to death. E provided her written consent to the surgery but stated in writing that she did not consent to blood transfusions.

9. Other things being equal, E's operation would probably have taken place within a few hours, according to protocol. For two reasons that did not happen. In the first place, another person's surgical procedure took longer than expected, so her operation was put back to 9 p.m. and then it became too late to operate. Secondly, the doctors decided that they needed to clarify the question of whether they could administer a transfusion if that became medically necessary. E's father and the doctors discussed the issue with a member of the local Hospital Liaison Committee for Jehovah's Witnesses. Throughout this period, E was kept 'nil by mouth' so as to be ready for surgery, and continued to be in pain. In the early hours, she was started on intravenous fluids.

10. On the morning of Tuesday 11 May 2021, the hospital trust filed an urgent application in the High Court in which it asked the court:

> "To consider whether it is in [E]'s best interests/declare that it is lawful for her to receive a blood transfusion in the event this is clinically required during appendectomy, notwithstanding her refusal, advanced decision and her parents' refusal due to their deeply held religious convictions as Jehovah's witnesses."

11. The doctors considered that a delay of some hours was acceptable, despite the raised risk of infection from the appendix rupturing, but they determined that if a court decision could not be obtained by 5 p.m. the operation would go ahead then. In the event, the decision was given in time and at about 6 p.m. E had a successful laparoscopic appendectomy without blood transfusion. She returned home on Wednesday 12 May.

The hearing and decision in E's case

12. The Trust's application was heard by Mrs Justice Theis by video link, starting at 2 p.m. on 11 May. The Trust was represented by Ms Arianna Kelly, who provided a position statement that included some reference to the law. E and her father attended the hearing unrepresented. Cafcass Legal had been alerted and attended through Ms Shabana Jaffar, solicitor, and Ms Angela Adams, Cafcass officer.

13. The only written evidence before the Judge was contained in a 5-page statement from Dr A containing these passages:

> "11. The likelihood of severe surgical bleeding intraoperatively is very small, I could not provide an exact risk but it is about 1:1000 to 1:2000 (ie "rare"). As a team we would minimise the risk of any bleeding through careful standard surgical approach, careful haemostasis using surgical techniques where possible, minimally invasive procedure, careful surgical positioning, a degree of hypotensive anaesthesia, maintenance of normal temperature and electrolytes, and medications such as tranexamic acid where appropriate.
>
> 19. As a clinical team, we feel it is in [E]'s medical best interests to receive blood products in the event these are required in order to keep her alive and healthy. The clinical team is willing and able to administer blood products if these are required, however we are acutely aware of [E]'s wishes and feelings. We therefore invite the Court to determine whether it is in [E]'s best interests to receive blood product treatment if such a treatment would be required in order to save her life.
>
> **Conclusion**
>
> 22. [E] is a 16 year old girl with a long held and firm religious conviction that precludes treatment with any blood products. She therefore refuses blood products under any circumstance. She has clear capacity and understanding in my opinion to make this decision.
>
> 23. [E] requires urgent surgery for presumed appendicitis. There is a rare risk of major haemorrhage, which at its worst could put her life at risk. In this rare circumstance there is the possibility of blood products being the only treatment available to save her life.
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> 24. If a blood product treatment was given in this rare circumstance it would override [E]'s expressed refusal of such treatment, and could have a detrimental effect on her mentally, socially and spiritually.
>
> 25. If a blood product treatment was not given in this rare circumstance it could result in her death.
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> 26. As a clinical team we would like a ruling to determine whether we can accept [E]'s refusal to consent to blood product treatment if such a treatment would be required to otherwise save her life."

14. The hearing began with arrangements being made for the Cafcass representatives to speak by video link to E and her father, a process that took about half an hour. When

it resumed, Ms Kelly confirmed that the Trust did not take a firm position but that it did not feel comfortable proceeding without a referral to the court where E's refusal of treatment might place her life at risk. Dr A gave brief evidence in accordance with his statement. The Judge then heard from Ms Jaffar of Cafcass, who stated that E is a very articulate and intelligent young woman who, despite the visible pain that she was in, had been able to express her views clearly. However, it had been explained to E that in acting on her behalf Cafcass had to put forward what it considered to be in her best interests. The Guardian's view was that it would be in E's best interests to receive blood products if necessary to allow her the fullest opportunity to get back to full health. (To be correct, Ms Adams was not "acting on her behalf". The reality is that Ms Jaffar was speaking on behalf of Ms Adams as Guardian, though not formally appointed as such, and not on behalf of E, who would, had time allowed, have been entitled to separate representation. But nothing turns on this, as the Judge was clearly made aware of E's firm position.) After Ms Jaffar had made some reference to the applicable legal principles, the Judge asked E's father if he wished to say anything; he did not.

15. The Judge then gave a necessarily brief judgment. Having set out the background, the main points of the medical evidence, and E's views, she gave her decision in these terms:

> "11. The Court is required to be able to consider the evidence but essentially to reach a decision that the Court considers is in the best interests of the young person concerned in this case, [E]. It is an objective analysis, weighing the pros and cons in relation to the various considerations that there are.
>
> 12. The Trust, in their document, have summarised, at paragraphs 8 and 9, the relevant parts of the recent cases and I am not going to repeat those matters in this short judgment.
>
> 13. The Trust, for its part, is acutely aware of the very strongly held views by [E] and her parents, and in particular the impact on [E] if the Court does reach a decision that is contrary to her wishes, but they are also clearly of the opinion that the Court needs to weigh very carefully, in the balance, the evidence from Dr [A] that whilst there is a low risk of this happening during the surgical procedure, if it does the consequences are extremely serious.
>
> 14. When looking at the balancing exercise that the Court has to undertake that if permission is not granted for the declaration that is sought and there is a haemorrhage during the procedure, it will have extremely serious consequences for [E].
>
> 15. Alternatively, if permission was given in the event that took place, it would have the opportunity for [E] to be able to continue the life that she has led prior to her admission into hospital and there is no suggestion that is other than a rewarding and enriching life that she has with her family.

> 16. In reaching my decision, I recognise, very much, [E]'s wishes that have been expressed not only by herself but with the assistance of her parents, to Dr [A] but also to Ms Adams and, no doubt, to Ms Jaffar as well. I also recognise that because of her age and her level of understanding, the impact on her and her family of the order that is being requested.
>
> 17. Against that information, the medical evidence is relatively clear. From a clinical perspective this procedure needs to be undertaken, as has been set out in Dr [A]'s statement and his evidence. There is a risk of rupture if the surgery is not carried out, with the consequent risks of widespread infection which may not be able to be readily treated by antibiotics and with the serious risk of there being any sepsis.
>
> 18. The position if [E] does have the procedure is there is a good prospect of it being successful but within that procedure is the relatively low risk of there being a bleed, and the treatment that is needed was outlined in Dr [A]'s evidence. He was clear in his position that if the Trust are not able to use blood products, then that will have fatal consequences for [E].
>
> 19. The Court having weighed up the relevant considerations, I have reached the conclusion that even if with the widest aspects in relation to [E]'s best interests and that despite her expressed wishes and her age and circumstances, that her best interests will be met by this Court granting the declaration that has been sought.
>
> 20. I fully appreciate that this is not the decision that either [E] or her parents want, but I hope that [E], in due course, will be able to understand the Court's role in reaching a decision in these circumstances for the reasons that I have set out.
>
> 21. So, for those very brief reasons, I will grant the declaration that has been sought."

16. The Trust's document referred to by the Judge at paragraph 12 mainly drew attention to the decision in *Plymouth Hospitals NHS Trust v YZ* [2017] EWHC 2211 (Fam); [2018] 1 FLR. 948. That was a case where a 14-year-old who had taken an overdose lacked capacity to make a decision about treatment that was urgently needed to prevent serious damage to her liver. At [12] MacDonald J listed what he described as ten key principles from the authorities, which all concerned severely ill babies.

17. In a statement filed on 1 June, for which permission was granted by this court as E had had no opportunity to put her position in writing at the time of the hearing, she expressed her feelings about part of her discussion with Ms Adams:

> "She then asked me whether I knew that I still have a big future ahead of me, I'm healthy and smart and could have a happy future but if I don't take blood transfusion this might all be taken

> away from me. I felt like this question was a bit threatening as she was questioning whether my faith is not as significant as I think it may be and that if I make a decision I could miss out important parts of my life. I explained to her that if I don't take a blood transfusion I know deep down in my heart that I did the right thing, that God will understand me and know I made a right decision. This decision is more significant than my life."

She further described her feelings when the Judge gave her decision:

> "At that moment I felt very disappointed and dissatisfied, that even though I went through all that trouble, like waiting for my surgery, not eating or drinking and answering all of the lawyers' questions as much as I possibly could, my opinion wasn't taken into account. I tried to do as much as possible but in the end everything I've done wasn't as significant to the Judge as the law. Overall, I felt like me and my beliefs were never going to be taken into account, even though the Judge knew I was mature she still didn't agree with me. I feel like as a 16-year-old girl I can move out of my house, sign documents, but am denied the right to make decisions about my medical treatment which is the most important decision to me."

18. Following the hearing, an order was made in these terms:

> "IT IS DECLARED THAT:
>
> 1. By reason of her age and minority [E] lacks capacity and competence to consent or refuse medical treatment by means of a blood transfusion and/or blood, blood products or clotting products.
>
> 2. Notwithstanding the absence of parental consent to the same, in the existing circumstances it is lawful and in the best interests of [E] that she be administered blood or blood/clotting products should the same be clinically indicated in the opinion of the relevant treating clinicians caring for her at [name] Hospital due to significant blood loss during or subsequent to the planned appendectomy."

19. We do not overlook the pressure under which urgent orders are drafted, but it is essential that orders of this importance accurately reflect the court's decision. Before us, the Trust accepted that there are a number of problems with this order. First, paragraph 1 is simply wrong; it was never disputed that E had capacity to make a decision about transfusion. Similarly, the reference in paragraph 2 to the absence of parental consent is at best questionable in a case where a child is competent to make a decision, though that is an issue that does not need to be further explored in these appeals as the parents supported the young persons' decisions. Finally, the drafting of paragraph 2 does not reflect the essence of the Judge's decision, which was based on evidence that blood transfusion could only be considered if a risk of serious injury or death arose, and then only after all other reasonable treatment options had been attempted.

The facts in F's case

20. At 4.30 p.m. on Sunday 5 September, F lost control of his motorbike on a bend and came off into a field. He was taken to hospital by ambulance, and referred on to another hospital, where he was given two CT scans that revealed a grade 3 laceration involving a quarter to a third of his spleen, the grading indicating an injury of moderate severity. Blood was also seen in the abdominal cavity. However, then and for the remainder of his time in hospital F remained haemodynamically stable, i.e. he was not bleeding internally. He was reviewed by the on-call consultant surgeon and treated conservatively.

21. With an injury of this kind to the spleen, there can be primary or secondary bleeding. Primary bleeding occurs at or shortly after the time of the injury; fortunately, that did not happen in this case. Secondary bleeding may occur later, and particularly within a week or ten days, as a result of a clot loosening, leading to bleeding that can sometimes be catastrophic. If this arises a number of treatments could be attempted, including radiology, the insertion of a coil embolism to stop the bleed, and the removal of the spleen altogether.

22. At 8.30 p.m. on Monday 6 September 2021, the Trust filed an out-of-hours application to the court for declarations that F was competent to refuse or consent to the receipt of blood and blood products but that, notwithstanding his objection and the absence of parental consent, it was lawful and in his best interests for the doctors to provide blood and blood products in the event of an emergency arising from his injury. The application was heard by telephone by Mrs Justice Arbuthnot at 10 p.m. The Trust was represented by counsel, Ms Francesca Gardner, and F by a solicitor. The Trust had filed a 3-page statement from a consultant surgeon, Mr M, who explained that at that stage the prospect of primary bleeding was present but receding, with the risk of secondary bleeding extending over the days and weeks ahead. His statement included these passages:

> "10. … I agree that [F] is capable of making decisions about his treatment."
>
> "13… As a surgeon whose role is to try and save patients my instinct is to do so, but I am acutely conscious of the fact that doing so may be a serious affront to his personal views or it may cause him serious psychological harm.
>
> 14. Equally, he is a child and has the rest of his life ahead of him. I cannot be absolutely clear that he is mature enough to know what his decision means. For that reason I think, on balance, that it is in his best interests to have a blood transfusion should the need arise."

23. Mrs Justice Arbuthnot heard briefly from Mr M and from Mr C, a consultant surgeon instructed at very short notice to give a second opinion on behalf of F. They were in broad agreement about diagnosis and prognosis. Mr M stated that there was less than a 10% chance of F suffering a primary haemorrhage requiring transfusion before 2 p.m. the following day, when a fuller hearing might take place. Mr C considered that the likelihood of a blood transfusion was extremely low if an appropriate treatment plan

was followed. The resulting order recorded that it had been submitted on F's behalf that if a declaration was not made the clinicians would be able to treat him "using their emergency powers in the event of an emergency overnight". In these circumstances, the Judge declined to make the order sought by the Trust. She considered that it was "not necessary, proportionate or appropriate". She directed that the hearing should be continued at 2 p.m. on Tuesday 7 September to allow F time to respond more fully to the application, and to have the opportunity to adduce expert evidence on his treatment and the necessity or otherwise for blood transfusion.

24. We were not addressed in detail about the extent of any "emergency powers", and we do not therefore express a concluded view about the assertion made to Mrs Justice Arbuthnot, and repeated to us on behalf of F, that the doctors could have transfused overnight if the medical need arose. Doctors undoubtedly have a power, and may have a duty, to act in an emergency to save life or prevent serious harm where a patient lacks capacity or cannot express a view, for example because of unconsciousness. However, we very much doubt that such a power exists in respect of treatment that has been foreseen and refused by a capacitous patient. It is doubtful whether such circumstances can properly be described as an emergency.

The hearing and decision in F's case

25. At 2 p.m. on 7 September, the matter came before Mrs Justice Judd by video link. F had not suffered haemorrhage overnight and was able to take part, accompanied by his parents. The parties were represented as before, and Ms Gardner had filed a position statement making reference to the legal framework.

26. The hearing lasted for about three hours. Evidence was given by Mr C and Mr M, and by F and his parents. The Judge then heard submissions and adjourned briefly before giving a judgment.

27. There was substantial agreement between the two medical witnesses. F remained clinically stable and was now described as being in the window of secondary haemorrhage, with the current risk remaining at approximately 10%, but decreasing every day and abating after a number of weeks. Mr C considered that he could be managed with close observation, that his stable condition and healthy underlying constitution meant that he had 'a margin of error' not given to patients with comorbidities, and that the use of blood products was not likely to be necessary. He nevertheless accepted that there remained a distinct risk and that it could arise urgently. Mr M agreed, describing a secondary haemorrhage as "anything from a small re-bleed that's contained to a really quite catastrophic haemorrhage at an alarming rate". If the latter occurred, F would need to be in surgery within 30 to 60 minutes.

28. At the outset of the hearing, it had been suggested on behalf of F that the matter should be adjourned to allow for the opportunity to gather further evidence, but this suggestion, which the Trust opposed, was not pursued through the evidence of Dr C, who conveyed that the clinical picture was now clear.

29. F himself gave evidence. He expressed his appreciation to the doctors and told the Judge this:

> "This accident was distressing for me; it is my first major accident. I am a pretty sensible person, but this was new and distressing. I decided not to have any blood products because of my faith and my relationship with my God and creator. My blood is unique to me, and He created it for me. Anyone else's blood won't be the same. I have thought about this, and I have decided not to have any blood products. So that was my personal decision. It is possible that something could happen in 100 days as the doctor said and I could be rushed in, but my parents and I will do anything to try and keep me safe and I will look after myself and have minimal movement."

30. F's parents gave equally dignified evidence, explaining their support for their son's decision in the predicament that had arisen. They asked about the chances of F having a transfusion but still not surviving. Mr M gave brief further evidence to explain that there could be no guarantees but that transfusions generally save lives.

31. Submissions were then made about the law and the welfare assessment. There was discussion about the length of any order, with the Trust reducing its initial suggestion of 100 days to 21 days.

32. Giving judgment, the Judge rehearsed the background and the evidence, and observed that there was no disagreement between the doctors. As to the law, she directed herself in this way:

> "8. The court may make a declaration that it is lawful for the doctors to give treatment using blood or blood products. The paramount consideration for the court is the best interests of the child. The starting point is to look at it from the perspective of the patient. The court must follow its own assessment of the child's best interests. The views of the child must be considered and given appropriate weight, given his age and understanding. Decision makers must look at welfare in the wider sense, not just medical, but social and psychological. The court must consider the nature of the medical treatment in question; what it involves and its prospects of success; what the outcome of that treatment is likely to be, and they must consult others who are looking after the patient, and those who are interested in his welfare.
>
> 9. I take these propositions from the law as set out by Ms Gardner in her document, with particular reference to the case of *Manchester University Hospital Trust Fixsler and* Others [2021] EWHC 1426 where MacDonald J refers to the case law in detail."

33. The Judge then considered F's views:

> "10. Here I am looking at the age, understanding and competence of a young person, a young man who is 17 and a half, and only six months off his 18th birthday. He is intelligent and articulate and so it follows that I give his views very great weight indeed.

> Having said that, the views of a child, even one of 17 and a half, are not determinative. In the end, they form part of the best interests consideration. Of course the closer a young person gets to their 18th birthday the more and more weight his views must be given."

She quoted fully from F's evidence and noted that if he had been 18, his treatment would have entirely been a matter for him. She also noted his right to respect for his private life and religion.

34. The Judge then stated her decision:

> "14. Although I do think that this is a very difficult decision, bearing in mind the legal framework and the factual background of this case, I have come to the conclusion that I should make the declaration sought by the Trust for a period of 21 days.
>
> 15. In coming to my decision, I bear in mind and take into account the fact that the doctors have said that they will not treat [F] with blood or blood products unless other reasonable avenues have failed and that his life is at risk.
>
> 16. My reasons for making the declarations are as follows:
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> 1. Although the views of an intelligent person of 17 carry very great weight they are not determinative;
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> 2. [F] has been presented with this is as a real issue after suffering a serious accident and with very little time to consider it. Although I entirely accept that he is a thoughtful young man and this is not a frivolous or ill-considered position, even an adult would struggle to grapple with the ramifications of something like this after a serious accident and with only two days to really think about it actually happening to him.
>
> 3. If [F] was not to receive blood products in circumstances where the doctors consider them necessary, it could mean the loss of an otherwise healthy and happy young man. Mr M told me that successful treatment for [F] would leave him able to have a normal life.
>
> 4. I can indeed foresee that this treatment may distress [F] because of his strongly and firmly held religious faith, (I take very much into account his words to me). I can also foresee that it could be difficult for him in the long term. I have thought very carefully about what he had said, in particular that he would "think about it every day". Despite this, I do not know that it is so, that this will be how he feels about it, and I suspect he does not know either. It is possible he will feel less concerned about it than he feels now, and it might

> well be that his distress if he was to receive blood products would lessen over time. [F] is still in his formative years. Nonetheless, I do bear in mind what he says about it now and that it might be difficult for him, and that is something that I have had to balance on the scales when coming to make my decision.
>
> 5. I also appreciate that giving [F] treatment against his wishes would be a violation of his personal autonomy. The fact is, however, that a person of 17 is still not yet an adult. His wishes have received very serious consideration by the doctors and this will continue to be the case. This court is giving very serious consideration to his wishes too, but ultimately I think it would be unlikely that this violation to his autonomy would remain distressing to [F] for a significant length of time. I understand it might be difficult now to feel that adults are patronising and making decisions for him, but he knows that he can make decisions for himself when he is 18 and that he does have personal autonomy and dignity.

17. Given the balance between the possible loss of a healthy young life with a full potential lifespan ahead on the one hand, and the risk of [F] having to suffer a violation of his strongly held religious beliefs on the other, in my judgment the preservation of life should take precedence. In my view it is in [F]'s best interests for the Trust to be able to treat him with blood if it becomes necessary. This is a young man with his whole life in front of him. I am looking at his best interests in the round, that is from a religious, medical, social, and psychological perspective, taking account of the fact that I know he comes from a family of Jehovah's Witnesses.

18. I have heard this case and made the declaration now, because the risk of haemorrhage now is not insignificant, even if the risk that it will have to be treated with blood products as a consequence is lower. I do not think I should adjourn the case to give the family more time to prepare, as I believe that that leaves [F] in a situation of risk.

19. I will, however, make the order 21 days to cover the immediate situation until shortly after it is expected [F] will be discharged from hospital. If the Trust wish then to apply for a further declaration, they would have to make another application to the court and justify it.

20. In the interim, it will be open to [F] to apply to discharge the order before the expiry of 21 days if he wishes to do so, bearing in mind that this hearing had to be conducted so urgently and the restrictions and the limitations on the hearing in these circumstances. I also expect the order to reflect the statement of

> the doctors that they will treat [F] in this way only if it became absolutely necessary."

35. The resulting order provided:

> "IT IS DECLARED THAT:
>
> 1. The Respondent is competent to refuse or consent to the receipt of blood and blood products.
>
> 2. Notwithstanding the Respondent's refusal to accept blood products, it is lawful and in the Respondent's best interests for the Applicant to provide blood and/or blood products to the Respondent in the event of an emergency arising from the injury sustained on 5 September 2021, provided that all other reasonable treatment options have been considered and exhausted.
>
> 3. The terms of the order at paragraph 2 shall be discharged at 4pm on 28 September 2021 without further order of the court."

36. After the proceedings, F made an uneventful recovery, and he was discharged home on Friday 10 September.

The arguments on appeal

37. The case on behalf of E and F had been fully and effectively set out in writing by their counsel, Mr Shane Brady, who has represented young Witnesses in a number of recent medical cases. Unfortunately, Mr Brady was unable to attend the hearing before us, but his place was taken at short notice by Mr Simon Achonu, who presented the appeals with conspicuous ability. We are grateful to them both for their assistance.

38. Although certain matters, described below, are specific to their individual appeals, the central argument made by E and F is that the court's decisions were wrong for these reasons:

(1) To override the decision of a capacitous young person is an affront to their dignity. Increasing age brings increasing respect for personal autonomy and self-determination. By s. 8 Family Law Reform Act 1969, Parliament has provided that a person aged 16 and 17 has the right to consent to any recommended medical treatment, and the House of Lords has held in *Gillick* that even individuals under 16 can make their own decisions in certain circumstances.

(2) Risk is an inherent part of daily life and young persons are exposed to many risks – riding bikes, dangerous sports, viruses – but the law does not intervene in such matters.

(3) It was wrong in law for the courts to have intervened in these cases. The starting point is a strong presumption in favour of a young person's capacitous decision. The decision should be respected unless there are very strong reasons for rejecting it. The presumption can only be rebutted where on a balance of probabilities the

decision would cause serious harm or death. If it is not rebutted, the decision must be followed. For these propositions, reliance is placed upon these decisions:

Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64 per Balcombe LJ at pages 87-89

Re X (A Child) (No.1) [2020] EWHC 3003 (Fam); [2021] 2 FLR 88, per Sir James Munby at [13]

Re X (A Child) (No.2) [2021] 4 W.L.R. 11, per Sir James Munby at [2, 30, 61]

An NHS Trust v A and others [2014] EWHC 1445 (Fam), per Mostyn J at [6, 9, 15]

AC v Manitoba (Director of Child and Family Services) 2009 SCC 30; [2009] 2 S.C.R. 181 per Abella J at [82, 84, 88].

(4) Here, the presumption was not rebutted. The risks were remote and the young persons' decisions were reasonable and safe ones. It was wrong in law to override them on a 'just-in-case' basis.

(5) The Convention rights under Articles 8 and 9 are plainly engaged. Interference can only be justified in pursuit of a legitimate aim where it is necessary in a democratic society.

39. Turning to arguments specific to E's case:

(1) The error in paragraph 1 of the order, which declares that E lacks capacity, is symptomatic of the inadequate respect paid to her views.

(2) On the central issue, the Judge started from the wrong place. She should have applied the presumption in favour of E's decision and asked whether there were very strong reasons to override it. She should have given adequate consideration to the rarity of the feared event. The authority cited by the Trust (*Plymouth Hospitals NHS Trust v YZ*) concerned a person who *lacked* capacity and contains a list of factors that gives no priority to the decision of an older teenager.

(3) E, who had been in pain for a considerable time, had her operation delayed by the court process while the risk of a burst appendix was growing. In the end she went into surgery with the fear of her wishes being overridden. What message, Mr Achonu rhetorically asks, does this process send to a young person in her position?

(4) On the facts of the case, the requirements of Articles 8 and 9 were not satisfied. This was a totally unnecessary order.

40. As to the arguments specific to F's case:

(1) On the facts, the Judge was wrong to say that there were no differences between the doctors. Mr C spoke of managing the situation hour by hour without using blood products.

(2) As occurred in E's case, the Judge took the wrong legal approach. She set off on the wrong track by referring to the decision in *Manchester University NHS Foundation Trust v Fixsler* [2021] 4 WLR 95. In that case, which concerned the withdrawal of medical treatment from a 2-year-old child, MacDonald J again listed principles that apply to children who are not *Gillick* competent. The Judge did not cite the more relevant authority of *Re W*, to which both parties had referred. Accordingly, she did not give presumptive precedence to F's decision and she did not ask whether there was a good reason to override it.

(3) Instead, in her decisive welfare analysis at paragraph 16, the Judge mainly focused on a critical examination of F's wishes, implying that she did not treat it as a matter of such great significance to override them.

(4) The court could have deferred its decision. Instead, it left F with a 21-day order hanging over him.

41. Responding on behalf of the Trusts, Ms Victoria Butler-Cole QC and Mr Parishil Patel QC, respectively leading Ms Kelly and Ms Gardner, submitted:

(1) The argument that a capacitous decision should prevail as a matter of principle amounts to an argument (for which permission has not been given) that the inherent jurisdiction should not exist in the case of 16- and 17-year-olds. Parliament has not given complete autonomy to this group, as seen in the fact that an effective advance decision under the Mental Capacity Act 2005 cannot be made before the age of 18.

(2) The test is welfare as applied to the facts of the individual case. The assessment must be based on principle but there can be no presumptions, starting points or glosses overlaying the welfare test. It focuses on the patient as an individual and takes account of all the circumstances, medical and non-medical: *Aintree University Hospitals NHS Foundation Trust v James* [2014] AC 591 at [23].

(3) There is no *Bolam*-type test that protects decisions that are reasonable or safe from the medical point of view. In any event, there is no body of medical opinion that would regard it as safe not to transfuse if a crisis arose in these cases.

(4) The preservation of a young person's life is inevitably a consideration of the greatest importance, as noted by Nolan LJ in *Re W*.

(5) The Appellants' argument on risk breaks down because it confuses two different situations. One is where treatment may remove the risk of an unlikely event happening at all. The other is where the unlikely event has happened and the risk exists, as in the present cases. The fact that there is a low chance of it occurring is irrelevant because if it eventuates the consequences may be extremely serious. The analogy with ordinary daily risks does not work: the true analogy is with someone who has had an accident and does not call an ambulance.

(6) In neither case was there the option of waiting before making a decision.

(7) Neither judge was misled by the authorities cited to them, which contain nothing objectionable.

(8) In F's case, a detailed reference to the transcript shows that the Judge was right to say that there was no medical disagreement.

(9) Neither decision was wrong. In cases as sensitive and difficult as these, an appellate court should be very slow to conclude that a judge who has correctly identified the law was wrong: *Aintree* at [43].

42. In each appeal, the parties applied for permission to file further medical evidence. In E's case, the application concerned two reports commissioned on her behalf from Professor M.F. Murphy, Consultant Haematologist and Professor of Blood Transfusion Medicine, University of Oxford, the second provided in response to a report commissioned by the Trust from Professor Gordon Carlson, Consultant General and Colorectal Surgeon and Honorary Professor of Surgery, University of Manchester. On behalf of F, a report was provided by Dr C, who had given evidence at both urgent hearings but had not had the opportunity to put his opinion into writing. By the time of the appeals, the hospital medical records of E and F had also been gathered.

43. Among the issues debated in the reports, particularly in E's case, were the latest research and practice on the management of patients by alternative treatments to blood transfusion and the identification of any risks that may arise from transfusion. Although it was not entirely clear that the criteria for the admission of further evidence on appeal were satisfied, we admitted this evidence. There had been very little opportunity for the parties to provide it at the prior hearings and there was no opposition from any quarter. We were also mindful of the undoubted expertise of the authors and the importance of the issues. As it transpired, and as can be seen from the summary of the arguments we heard, nothing turned on the availability of a richer evidential picture. The essentials of the two cases were before the courts when they made their decisions.

Exercising the inherent jurisdiction in respect of capacitous young persons

44. As we have stated, the inherent jurisdiction is available in all cases concerning minors, namely persons under the age of 18. That has always been so and any change must be a matter for Parliament. Recent attempts by Mr Brady to persuade judges at first instance to take a different view have failed in *Re X (A Child) (No.2)* and in *A Teaching Hospitals NHS Trust v DV (A Child)* [2021] EWHC 1037 (Fam) (Cohen J); in these cases, as in the present cases, permission to appeal on that basis was refused by this court.

45. When the court is being asked to exercise its inherent jurisdiction, there are in our view three stages. The first is to establish the facts. The second is to decide whether it is necessary to intervene. If it is, the final and decisive stage is the welfare assessment.

46. The inherent jurisdiction is a protective power and one of the court's central concerns at the fact-finding stage will be to identify the risk in question. Colloquially, 'risk' can be used to mean the risk *of* an event occurring (its probability) or the risk *from* the event occurring (its consequences). One must keep this distinction in mind when making and interpreting statements about risk.

47. Once the essential factual position is understood, the next question will be whether immediate action is necessary, or whether a decision might better be postponed. In a case where a crisis may not arise and a decision could reasonably be deferred until it

does, there may be advantages in that course. It will depend on the facts, and in particular how realistic it would be to expect a fair and timely decision to be given if a crisis arises.

48. One then comes to the all-important welfare assessment. Over the past forty years and more, the court has exercised its powers in respect of minors and persons over 16 who lack capacity in a broadly consistent manner, the former being exercised by the Family Division of the High Court and the latter by the Court of Protection since the inception of the Mental Capacity Act 2005. It is unnecessary to do more than identify a number of milestone appeal decisions in medical treatment cases to make good this observation: *In Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1424; *Re J (A Minor) (Wardship: Medical Treatment)* [1991] 1 Fam. 33; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64; *In Re T (A Minor) (Wardship: Medical Treatment)* [1997] 1 WLR 242; *In Re A (Minors) (Conjoined Twins: Medical Treatment)* [2001] 2 WLR 480; *Aintree University Hospitals NHS Foundation Trust v James* [2014] 1 AC 591.

49. These cases, spanning persons of all ages, mandate an assessment from the individual's point of view by which the court seeks to identify his or her best interests in the widest sense. The assessment will be driven by circumstances that will vary widely from case to case. Considerations that may weigh heavily in a case involving babies are likely to be of less weight in cases of older children, young persons and stricken adults. The courts have therefore been most reluctant to lay down general principles: *Aintree* at [36].

50. That does not mean that the welfare assessment takes place in a vacuum. The law reflects human nature in attaching the greatest value to the preservation of life, but the quality of life as experienced by the individual must also be taken into account. The views of the parents of a baby or young child are always matters of great importance. Likewise, our common experience leads us to pay increasing regard to the views of children and young people as they grow older and more mature.

51. The cases contain authoritative statements about the sanctity of life, for example in *Re J* at page 46, and in *Aintree* at [35]:

> "The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland*, at p 808, "A profound respect for the sanctity of human life is embedded in our law and our moral philosophy". Nevertheless, they are also all agreed that this is not an absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment."

There are also, as we shall see, forceful observations in other cases about the respect due to the decision of a mature minor.

52. In one sense, an unfettered welfare assessment does not sit easily with presumptions or starting points. But, approached carefully, these are more matters of form than substance. What is important is that the court identifies the factors that really matter in the case before it, gives each of them proper weight, and balances them out to make the

choice that is right for the individual at the heart of the decision. If this process is properly carried out so as to arrive at a sound welfare decision, the court will not be acting incompatibly with rights arising under Articles 2, 3 and 8 (and, here, 9) of the European Convention on Human Rights.

53. Welfare assessments in medical treatment cases concerning young persons with decision-making capacity involve the balancing of two transcendent factors: the preservation of life and personal autonomy. The leading decision in this field is *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64. It concerned a 16-year-old girl in local authority care who suffered from anorexia. The authority obtained an order under the inherent jurisdiction to place her in a treatment unit and treat her without her consent. She appealed on the basis that the court did not have the power to overrule her refusal of treatment but that, if it did, it had used it wrongly. The first assertion, which relied on FLRA 1969, s. 8 was rejected. The second argument also failed. On that point, the headnote reads:

> "… 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;"

54. Lord Donaldson of Lymington MR said this at pages 80G and 81H:

> "I have no doubt that the wishes of a 16- or 17-year-old child or indeed of a younger child who is "*Gillick* competent" are of the greatest importance both legally and clinically, but I do doubt whether Thorpe J. was right to conclude that W. was of sufficient understanding to make an informed decision. I do not say this on the basis that I consider her approach irrational. I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less "*Gillick* competent." They may well have sufficient intelligence and understanding fully to appreciate the treatment proposed and the consequences of their refusal to accept that treatment. What distinguishes W. from them, and what with all respect I do not think that Thorpe J. took sufficiently into account (perhaps because the point did not emerge as clearly before him as it did before us), is that it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become. Where the wishes of the minor are themselves something which the doctors reasonably consider need to be treated in the minor's own best interests, those wishes clearly have a much reduced significance."
>
> "I regard it as self-evident that this [the welfare principle] involves giving them [adolescents] 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."

55. Balcombe LJ said this at pages 88A, 89B and 89G:

> "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. This philosophy is also reflected by some provisions of the Children Act 1989 which give a child, of sufficient understanding to make an informed decision, the right to refuse "medical or psychiatric examination or other assessment" or "psychiatric and medical treatment" in certain defined circumstances: see sections 38(6), 43(8), 44(7) and Schedule 3, paragraphs 4(4)(a) and 5(5)(a). 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 *In re E. (A Minor)* (unreported), 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."
>
> "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."
>
> "I entertain grave doubts that if Thorpe J. had directed himself in the way I have suggested, that W.'s wishes should be respected unless there were very strong reasons for rejecting them, he would have reached the decision which he did. However, as I have said, by the time the case was before us W.'s condition had changed so drastically that, whatever may have been the previous position, the court would have been in dereliction of its duty had it not overridden W.'s wishes and effectively confirmed the order made by Thorpe J. that W. should be treated at the specialist London unit."

56. Finally, Nolan LJ stated at page 93G and 94B:

> "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."
>
> "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."

57. W's appeal was dismissed. As can be seen, her condition had deteriorated since the original decision and the assessment that she had capacity to make treatment decisions at any stage was doubted. However, the court proceeded on the basis of the trial judge's finding that she had capacity. It can also be seen that the situation of young Jehovah's Witnesses was very much in its contemplation. The analysis in *Re W* is therefore of direct relevance to the present cases. Where there was a clear prospect of very serious harm to 16-year-old W, the court had no hesitation in overriding her decision. Each member of the court expressed himself somewhat differently, but in our view there is no real difference in their reasoning. They each asserted the primacy of the welfare principle, while emphasising the importance of the decision of a capacitous young person. Such decisions will doubtless prevail in the great majority of situations, whether or not in the medical context, and the court will simply not be involved. At the same time, each member of the court explicitly referred to cases where the irreparable and disproportionate consequences of a refusal of treatment places the court under a duty to intervene. In our view, this approach remains good law. It survives the Human Rights Act 1988 and the Mental Capacity Act 2005, and it has not been overtaken by subsequent decisions, by the passage of time, or by the evolution of societal values.

58. *Re X (A Child) (No.1)* concerned a 15-year-old Jehovah's Witness to whom doctors wished to give blood to treat serious sickle cell syndrome. Sir James Munby authorised this in the short term, stating the principle in this way at [13]:

> "The overriding obligation of the court is to act in the best interests of X. In the decisions in the Court of Appeal in *In re R* and *In re W*, and there is more recent authority to the similar effect, it has been made clear that, in the final analysis, the court has to take its own decision as to what is in the best interests of a young person and that, in an appropriate case, even if that young person is *Gillick* competent, it may be appropriate for the court to decide, with regret, but nonetheless firmly, not to give effect to the strongly held views and the strongly held religious beliefs of that young person. That is something the court is very slow to do. It is something the court is very reluctant to do and it will do it only – I put the matter descriptively rather than definitively – where there is clear evidence of a serious risk to health or possible death if the court does not intervene."

59. In his later judgment in the same case (*Re X (A Child) (No. 2)*), Sir James considered the position relating to longer-term treatment for X. He fully reviewed the legal landscape since *Re W*, and concluded at [84], as we have done, that the decision remains good law. He further addressed the arguments under Articles 2, 3, 5, 8, 9 and 14 the Convention, again concluding at [157] that there is nothing in the jurisprudence to throw doubt upon the continued validity of *Re W*. In response to a submission made by Mr Brady based upon the decision of the Canadian Supreme Court in *AC v Manitoba* he similarly concluded at [99] and [104] that the decision confirmed that in the Canadian context the court always has the last word.

60. *AC v Manitoba* concerned a 14-year-old Jehovah's Witness with Crohn's Disease who was susceptible to internal bleeding. Supported by her parents, she refused transfusion, despite facing a significant risk of damage to her brain and vital organs through oxygen deprivation. Social services intervened on child protection grounds. Transfusion was ordered, and the young person survived and appealed. Her appeal was dismissed. In giving the judgment of the majority, Abella J carefully reviewed the approach taken in other jurisdictions, including ours. At [82] onwards, she made these observations about the interpretation of best interests, which I cite as they were relied upon by the Appellants before us:

> "82 The application of an objective "best interests" standard to infants and very young children is uncontroversial. Mature adolescents, on the other hand, have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is also justified.
>
> …
>
> 84 In my view, any solution to this tension must be responsive to its complexity. As… the English Court of Appeal in *W (A Minor), Re* confirmed, the distinction between principles of welfare and autonomy narrows considerably — and often collapses altogether — when one appreciates the extent to which respecting a demonstrably mature adolescent's capacity for autonomous judgment is "by definition in his or her best interests" (para. 8.54). … *Manual* (loose-leaf), 8.01, at paras. 8.52-8.54. [*The reference is to the Canadian Health Law Practice Manual.*]
>
> 85 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.
>
> 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.

88 … When applied to adolescents, therefore, the "best interests" standard must be interpreted in a way that reflects and addresses an adolescent's evolving capacities for autonomous decision-making. It is not only an option for the court to treat the child's views as an increasingly determinative factor as his or her maturity increases, 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.

89 This approach to "best interests" finds support in the relevant provisions of the *Child and Family Services Act*. The standard a judge is obliged to follow before deciding whether to authorize treatment for a child under 16 in accordance with s. 25(8) is found in s. 2(1) of the Act. That section sets out the primacy of the child's best interests and delineates a number of considerations to be included in making such a determination. These considerations include the mental, emotional and physical needs of the child; his or her mental, emotional and physical stage of development; the child's views and preferences; and the child's religious heritage. No priority is given to one factor over the other.

90 What the blending of these factors will actually yield in any particular case will obviously depend on the particular child and

> the particular circumstances of that child. That is because the best interests standard is necessarily individualistic."

The present appeals

61. We first address the Appellants' central argument that the welfare assessments in their case were wrongly approached and therefore wrongly decided. The submission relies heavily on the statements by Balcombe LJ in *Re W*, in which he stated that the court should not lightly override the decision of a capacitous young person and should approach its decision with a strong predilection to give effect to the child's wishes, respecting them unless there were very strong reasons for rejecting them. Mr Achonu submits that "a strong predilection" amounts to a presumption, and that the scales are therefore very firmly weighted towards the capacitous young person's wishes. "Very strong reasons" should only be found where, picking phrases respectively from *Re W* at 88F, *Re X (A Child) (No. 1)* at [13], and *Re X (A Child) (No. 2)* at [2], "circumstances… will in all probability lead to the death of the child or to severe permanent injury", "there is clear evidence of a serious risk to health or possible death if the court does not intervene" or "the consequence of the child's decision is likely to be serious risk to health or death". In the present cases there was no clear evidence of a probability of death or serious injury.

62. Mr Achonu then refers to the decision in *An NHS Trust v A*, a case in which a 13-year-old wanted a termination of pregnancy. He refers to the statement of Mostyn J at [9] that if A did have sufficient understanding and intelligence to know what a termination would involve, that would be "the end of the matter". This was referred to in passing in *Re X (No. 2)* at [30] as a case where a *Gillick* competent girl was held to have "the right to decide for herself" whether or not to have the operation. Mr Achonu further relies on the statement in *AC v Manitoba* at [84] and [88] that respecting a mature adolescent's wishes is "by definition in his or her best interests".

63. The first difficulty with these submissions is that, as we have seen, *Re W* does not establish a presumption in favour of the mature adolescent's decision, but instead affirms welfare as the overriding principle. It speaks for the young person's decision to be upheld where possible but also speaks of those rare circumstances where the gravity of the consequences and the imperative to preserve life may require the court to intervene.

64. The argument also falls into the familiar error of treating phrases culled from judgments as if they were universal statements of principle. For example, Mr Achonu lays emphasis on statements that there needs "in all probability" to be a "likely" serious risk to health or risk of death if the court is to intervene, and argues that that was not so here, where the likelihood of a crisis was remote. That argument confuses the probability of a risk and its consequences in the way we have warned against. When making a decision in a case where the likelihood of a crisis is low but the consequences may be extreme, the court cannot simply ignore the risk, any more than the doctors can. Acting responsibly, it has to contemplate the position where a crisis has arisen and to identify the treatment that would then be called for. It has then to weigh that future scenario, unlikely as it is, against the present impact on the young person of being overruled, though only with provisional effect, on a matter of such personal significance to them. This asymmetry between an unlikely future and a certain present is a feature of cases where a crisis has not arisen and may never arise but, seen in the light we have

suggested, there is no conceptual difficulty in the court making its welfare assessment. At all events, we agree with the Trusts' submission that no helpful analogy exists between the ordinary risks that arise in everyday activities and the special risks that may arise in the context of medical treatment. Everyday risks are a normal part of living, while avoidable medical risks may imperil survival.

65. It is true that in the majority of reported cases in which a refusal of treatment may lead to serious injury or death, the scales have tipped in favour of treatment, but that is not the invariable outcome. A contrary example is supplied by the decision in *DV (A Child)*, where a 17-year-old Jehovah's Witness suffered from cancer that required surgery to his lung. DV had undergone several previous procedures and in 2017 he had been transfused, causing him great distress and leading to him suffering post-traumatic stress disorder. The treating team now applied to the court for a ruling on whether they should give blood products if required during this operation. They did not wish to overrule DV's refusal and Cohen J approved the plan for treatment without blood products despite the risks entailed. At the same time he declined to adjourn to hear the argument, again urged by Mr Brady, that the court had no standing in the matter, and permission to appeal was, as we have said, refused.

66. Finally, on the issue of principle, we do not accept the argument, based on *An NHS Trust v A* and *AC v Manitoba*, that there is a point where the decision of a capacitous young person becomes "determinative" and where respecting such a decision is "by definition in his or her best interests". Again, care needs to be taken with the word 'determinative'. Insofar as it is said to mean that the young person is the ultimate decision-maker, that is not so. Their decision may be the determinative factor in the court's welfare evaluation, but that is in the different sense that it is the factor that has been found to predominate.

67. Nor do the decisions relied upon make good Mr Achonu's argument. In *An NHS Trust v A*, a 13-year-old wanted a termination of pregnancy. The only question for the court was whether she had capacity to consent to the procedure; if she did, the doctors were happy to act on her consent. At [9], Mostyn J accordingly observed that if A had sufficient understanding and intelligence to know what a termination would involve, that would be "the end of the matter". He was not asked to make a welfare decision and his words cannot be taken out of context to suggest that the court had no welfare jurisdiction, however improbable it is to see it being exercised against the wishes of a young person in a case of that nature. *An NHS Trust v A* was referred to in passing in *Re X (No. 2)* at [30] as a case where a *Gillick* competent girl was held to have "the right to decide for herself" whether or not to have the operation, but that observation must be understood in the light of the issue that was before Mostyn J.

68. Mr Achonu further relied on the statement in *AC v Manitoba* at [84] and [88] that respecting a mature adolescent's wishes is "by definition in his or her best interests". One does not have to conduct as full an analysis as was performed in *Re X (No. 2)* to see that the Supreme Court of Canada expressly preserved its powers in respect of 16- and 17-year-olds. Were it otherwise, its decision would not represent the position in this jurisdiction.

69. We now turn to matters specific to each appeal, reminding ourselves of the high threshold for appellate intervention as laid down in *Aintree* at [43].

E's case

70. In this case, the deficits in the order which we have identified were unwelcome but we do not see them as symptomatic of any shortcoming in the Judge's approach to her decision. They were matters that could easily have been resolved by an informal application to amend the order and they are not a reason for allowing an appeal.

71. As to the law that was cited to the Judge, we accept that the decision in *Plymouth Hospitals NHS Trust v YZ*, a case of a young person lacking capacity, was not particularly helpful. It was no doubt felt that a list of the kind that appears in that case at [12] might be of use. Indeed the same ten-point list appears with minor adjustments in *University Hospitals Plymouth NHS Trust v B (A Minor)* [2019] EWHC 1670 (Fam) at [14], a case where MacDonald J overrode a refusal by a capacitous 16-year-old of intravenous infusions for diabetes, and again, with some elaboration, in *Fixsler* at [57], a case about a small child with a catastrophic brain injury. The Trusts' submission to us that there is nothing objectionable about the list is a fair one, but only so far as it goes. The court needs to focus on the factors that really matter in the case before it, and an undifferentiated list does not help in that way. There is a world of difference between a small baby with a brain injury and a capacitous child approaching adulthood. By way of illustration, in the lists presented to the judges who heard these cases, the views of the child appear only as the last item, and in these terms:

> "x) The views of the child must be considered and be given appropriate weight in light of the child's age and understanding."

While there is nothing positively wrong with this general statement, it does not capture the powerful importance that attaches to the decision of a *Gillick* competent young person, whether or not their decision eventually prevails. In such cases, the court's real task, as we have said, is likely to require the weighing of the transcendent factors of preservation of life and personal autonomy. In these cases it would in our view be best for judges to direct themselves by reference to *Re W* and to our present decision.

72. However, returning to E's case, it is apparent that Theis J treated E's decision as a matter of considerable importance, referring to her very strongly held religious views, and going on to place them alongside the medical evidence. She also explicitly acknowledged the low probability of a crisis arising. We are satisfied that she approached the matter correctly in substance, as indeed did MacDonald J in each of the three cases we have mentioned. Accordingly, while there is some substance in Mr Achonu's critique in this respect, it does not undermine the integrity of the Judge's decision in any practical way.

73. Like the Judge we are sympathetic to the predicament in which E found herself, participating in a hearing while waiting for an operation, but a decision had to be made on a matter of such importance and it was made within a very tight timetable. As to Mr Achonu's rhetorical question about the message that the outcome sends to young people, the answer is that the law, in common with all major religious faiths, has a profound respect for the value of human life. Article 2 of the European Convention provides that everyone's right to life shall be protected by law. Once a young person becomes an adult, decisions about whether to accept or reject medical treatment become theirs absolutely, but before that age the court must act upon its objective assessment

of the young person's best interests, even where this conflicts with sincere and considered views.

74. Finally, we do not accept that the Judge's order was unnecessary in Convention terms. With the benefit of hindsight, we know that it never came into effect, but had a crisis arisen it might have saved E's life. Also, we now know that the operation went smoothly by keyhole surgery, but before it began, an open procedure remained a possibility. The Judge took account of the impact on E of overruling her wishes, but she was clearly entitled to conclude that the greater imperative lay in the preservation of life if danger arose. At all events, her decision was certainly not wrong.

F's case

75. We agree with the Trust that there was no relevant difference between Mr M and Mr C. As the treating surgeon Mr M may have been more preoccupied by the possibility of a crisis arising, while Mr C was more sanguine about the prospects for conservative management. However, as we have noted, Mr C nevertheless accepted that there remained a distinct risk and that it could arise urgently.

76. In F's case, a medical procedure was not planned, indeed it was hoped that one would never happen. It was therefore a case where the court needed to ask itself whether it was necessary to make an immediate order. On the out-of-hours application, Arbuthnot J decided that it was not. However, the evidence before Judd J established that surgery might in the worst case be needed within an hour. She therefore understandably decided that a decision could not be postponed because the risk of imminent haemorrhage was not insignificant. Had there been a significantly longer window of time in which to consider how to respond to a crisis, she might have felt it appropriate to make her baseline findings of fact but then to defer a decision until it was needed. As it was, the evidence of urgency justified the making of an immediate decision and the length of the order was in our view reasonable, though undoubtedly felt to be burdensome by F.

77. The submission about the legal self-direction that the Judge gave herself, in this case by reference to *Fixsler*, is similar to that made in E's case, and in our view it leads to the same conclusion. In what was necessarily a swiftly-prepared judgment, the Judge gave herself a generic self-direction that took in a number of matters, including some that would only arise under the Mental Capacity Act, but once again, the substance of her decision fully engaged with the two factors that lay at the heart of the matter.

78. Finally, the judgment of Judd J shows that she very fully considered F's beliefs and the significance of his own decision to refuse treatment. She did refer to the fact that F had had been through a lot and had had a short time to consider his decision; also that if he had to be transfused it might or might not cause him long term harm. We do not consider that in taking account of these matters she was downplaying the deep significance of F's religious faith to him.

79. We therefore conclude that the decision in F's case was one that the Judge was clearly entitled to reach and that it certainly cannot be characterised as having been wrong.

Conclusion

80. For these reasons, we dismiss the appeals.