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Case No: FD24P00707

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 February 2024

Before :

MR JUSTICE CUSWORTH

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Between :

Y NHS FOUNDATION TRUST	**Applicant**
- and –	
(1) AN	**Respondents**
(2) BN	

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- -

Ms Stephanie David (instructed by **Hempsons Solicitors**) for the **Applicant**
Mr Ian P Brownhill (instructed by the **Official Solicitor as Advocate to the Court**)
The **First** and **Second Respondents** appeared in person

Hearing date: 10 February 2024

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JUDGMENT

This judgment was handed down remotely at 10.30am on 11 April 2024 by circulation to the parties or their representatives by e-mail and by release to The National Archives.

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

Mr Justice Cusworth :

1. This judgment is written on Saturday 10 February 2024. It follows a hearing that took place during the course of last night, commencing eventually after midnight, and which was conducted remotely after an out of hours application received from the applicant, a NHS Foundation Trust.

2. The application concerns AN, who was born on 14 October 2007, and so is now 16 years and 4 months old. AN is an intelligent young person who is due to sit her GCSE exams in the summer of this year. Very sadly, and completely unexpectedly, AN was diagnosed as suffering from acute leukaemia after presenting at hospital with the symptoms of a cough, fever and chest infection 5 days ago, on 5 February 2024.

3. After one night in hospital, AN discharged herself against medical advice but with the support of her parents. At the time, the doctor concerned was satisfied that AN understood and was able to retain information regarding the diagnosis, was aware of the seriousness of the condition, could weigh up the risks and benefits of being discharged, versus staying in hospital, and could communicate this.

4. On 7 February, Dr X, Consultant Haematologist at the applicant Trust, and a national expert on Acute Lymphoblastic Leukaemia (‘ALL’), visited AN at her home and spoke to her in the presence of her mother. She describes AN in her statement of 9 February 2024, which is before me, as a well-educated young lady who explained that she needed time to come to terms with the diagnosis and asked for several days to do that. She recounted what must have been a very traumatic experience of being given the diagnosis and being told that she would die without treatment. Dr X explained to her the urgency in starting treatment promptly, and why this would usually be done as an inpatient, given the potential for side-effects and life-threatening complications.

5. Dr X explicitly told AN that without treatment she would die of her Leukaemia. AN explained that she was not refusing treatment, but needed time to come to terms with her diagnosis. She didn’t believe that she would become unwell over several days at home. Dr X records her impression that AN had capacity to understand the diagnosis,

and the proposed need for inpatient treatment, and the risks of not having treatment. The doctor agreed to give her limited time at home before seeing her again ideally to admit her for treatment on 9 February.

6. On that day, AN returned to the hospital with her parents for blood tests and a review. Those tests confirmed an elevated White Blood Cell count, a low neutrophil count and anaemia. The diagnosis of Precursor B cell ALL was confirmed, and there was further concern that elevated inflammatory markers suggested a potential for active infection. ALL is described by Dr X as an aggressive, rapidly progressive form of blood cancer that untreated would be expected to result in life threatening complication within a matter of days or weeks. With appropriate treatment, however, there is a very high chance of remission, and a good chance of long-term cure.

7. The hospital's intention was that AN should be immediately admitted for the starting of therapy on an urgent basis. This would include intravenous fluid hydration for the first 48 hours (protecting the kidneys from tumour cell breakdown), and dexamethasone (steroid) tablets to destroy the cancer cells. The doctor explained that, when leukaemia cells are broken down by steroids, breakdown products released into the bloodstream can interfere with kidney function, which therefore requires inpatient admission to enable appropriate blood test monitoring, IV fluids and observations to be performed.

8. After many hours of conversation with the professionals on 9 February, AN remained of the view that she did not want to be admitted for treatment. Dr X, in company with psychologist Dr Z, performed a capacity assessment for AN, and concluded that she did not have clinical/physiological impairment of brain functioning, nor any history of mental health disorder. However, she found that AN was not accepting of her diagnosis, or of the inevitability that she would become unwell in the absence of urgent treatment. This led her in her statement to conclude that AN 'does not display sufficient capacity today to make decisions about her treatment/safety'.

9. Dr X then set out the 3 options which she understood to exist for AN, the first being immediate admission for treatment, and the third being AN going home with no

specific agreement about re-admission. However, whilst under this last outcome the doctor foresaw the likely progression of the disease to fatality in days or weeks, it was the second option which I understood from AN's mother's submissions to me to be one which she could accept. That involved a further delay of admission for several days whilst providing steroids and supportive care medicine for AN to take at home, with a view to daily blood tests being performed and AN being re-admitted to hospital on Monday 12 February.

10. That then was the position when the matter was brought to the court by the applicant Trust yesterday evening. Given that AN's parents, who with her were objecting to admission, had expressed a desire to see the judge, I determined to conduct the hearing remotely to the hospital, despite the late hour. I received a position statement and oral submissions from Ms David of counsel for the applicant, and submissions from AN's mother, BN, in person. AN was present in the room with her mother and could hear and see the evidence and submissions. By the time that the hearing commenced, her father had left to look after her siblings. I was also grateful for the assistance of Mr Brownhill of counsel who appeared for the Official Solicitor, appointed as Advocate to the Court. That unusual situation arose as follows.

11. The application before me has been brought under the inherent jurisdiction. As AN is 16, she remains a minor and so would in those circumstances usually be represented through Cafcass as her guardian. I have been referred to the January 2023 guidance provided jointly by Cafcass and the Official Solicitor dealing with out of hours medical cases involving children. However, given that the issue of capacity has been raised, and in light of AN's age, this may yet become a case that should appropriately proceed in the Court of Protection, in which case the court could appoint the Official Solicitor as AN's litigation friend. In circumstances where no officer of Cafcass was available at short notice, and pursuant to the Attorney-General's Memorandum of 19 December 2001, paragraph 3, the Official Solicitor was satisfied that this was a case where '*there is a danger of an important and difficult point of law being decided without the court hearing relevant argument*', as reconfirmed and explained in the President's Guidance dated 26 March 2015.

12. In addition to submissions from counsel and from AN's mother, whom I have joined as 2nd respondent to the proceedings, I also heard oral evidence via Microsoft Teams from Dr X, and from Dr Z, the psychologist. Dr X's evidence was careful, considered and powerful, in supplementing her statement. Dealing with the possibility of the second option which she had identified in that statement she said this:

'If we gave AN some steroid tablets to take home, this would start to potentially deliver some initial treatments to bring that white cell count down. But it wouldn't be done in a safe and controlled environment. So whilst it may start to treat the leukemia and she may manage to take the medication as an outpatient, the monitoring that goes along with that, that we would ordinarily do to ensure that we're keeping patients safe through that process, wouldn't be happening… Also, given that she's displayed some signs and has some clinical features that raise concern that she has active infection, and she has a compromised immune system, letting her go on tablet antibiotics would be a risky thing to do in that situation, because even with antibiotic therapy at home, her immune system is not well powered even in the face of antibiotics to fight these infections. Intravenous antibiotics are of paramount importance and patients can get very sick very quickly… If she isn't here we can't provide the close oversight and monitoring and minimize risk in terms of any side effects related to that process... we would normally be doing blood tests very frequently and in the 1st 24 to 48 hours we often do blood tests twice a day to make sure that they are stable, and that we are not causing any knock on effects to things like the kidneys and the kidney function is stable,… alongside giving her some fluids to make sure that her kidneys were hydrated and that we were doing everything to minimize the risk whilst those steroids had effect.

13. Asked by Mr Brownhill whether she agreed that '*the only real means of keeping AN safe over the weekend period is for her to remain in an acute setting until she's been stabilized*', Dr X agreed. Finally, asked by me how she felt that AN would react if she was kept in the hospital, notwithstanding her expressed wish to go home, Dr X replied that: '*Although I very much understand that she doesn't want to stay, my impression is that if we advise her that that is required, I think she will*', and '*we will do everything we can to support her, to be ready to receive some more definitive therapy next week'*.

14. Dr Z gave helpful evidence about the services available within the Trust to counsel AN, and explained how as much support as practicable would be made available to support her stay. He agreed with Mr Brownhill's suggestion to him that AN's current reaction might be attributable to '*something stress related, short term and non-psychotic and so a little bit like an adjustment disorder*'.

15. I accept from Mr Brownhill that the law which I must apply here is that which was encapsulated in the judgment of Sir Andrew MacFarlane P in *E & F (Minors: Blood Transfusion)* [2021] EWCA Civ 1888, where he set out the stages necessary to make a determination in a situation such as AN's. He said:

Exercising the inherent jurisdiction in respect of capacitous young persons

44. …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...

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…

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. …our common experience leads us to pay increasing regard to the views of children and young people as they grow older and more mature…

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…

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:… 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… 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…
>
> "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."…

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." …

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."

16. In this case, the factual background is clear and not in dispute. I accept the evidence of Dr X of the risks to AN if she goes home over the weekend and begins her treatment, but without the intravenous fluids that would protect her kidneys and the regular and reliable testing that would come with her admission. There is a clear and very serious further risk to AN's already compromised health if she is not admitted for treatment tonight. And she is currently in a bed in the hospital and allowing treatments to be administered to her.

17. Furthermore, the fact of an existing underlying infection suggests that the prospects of unmanageable damage occurring before the matter can come back before a court remain significant. Given that to be effective, once necessary tests have been administered to AN, after allowing final decisions about her representation to be taken, and then to get her further instructions, a court hearing next week cannot be before Wednesday 14 February, the period of concern for the court is some 5 nights. Unless AN has a change of heart, or there is a further emergency, the question of her admission would next fall to be considered then.

18. In all of those circumstances, this is clearly a case in my judgment where intervention would be appropriate, if justified in the interests of AN's welfare. I do however pay serious regard to her expressed views and wishes and to those of her parents, both in supporting her and for their own part in advocating for a return home for their daughter. She is clearly an intelligent and articulate young person who, despite the most traumatic of circumstances has nevertheless been able to converse at length with her doctors and in so doing impress on them her capacity and her awareness of her situation. It is not a surprise that she has found the final step, of acknowledging the gravity of her diagnosis and consenting to immediate and demanding treatment a hard one to take over such a short period of time. I remind myself that just this time last week, all of the events since her diagnosis were completely unforeseen and unforeseeable. She has in fact coped remarkably well with the most terrible of situations. It is completely understandable that she would like to be at home.

19. In that situation, I have given very careful thought to whether AN's autonomy should be respected, and she should be given the additional time to process her position

which is in effect what she feels that she needs. However, I have come to the very clear view that, notwithstanding her age and her expressed wishes, her welfare needs do dictate that she must now remain where she is and commence inpatient treatment as Dr X urgently recommends. I bear in mind that this is not a young person who is refusing treatment, but rather one who clearly says that she wants to be treated, but simply wishes to delay the commencement of that treatment. The evidence is very clear that such a delay risks seriously compromising the efficacy of the treatment. The potentially extremely serious side effects of the steroids which AN would be taking at home would not be mitigated by the intravenous hydration which could be provided in a hospital setting. Further, chemotherapy, which would otherwise begin at the start of next week, would almost certainly be delayed, increasing further the risk of the cancer proving fatal.

20. In this case, both the likelihood of an infection causing a serious negative impact on AN's health if the treatment outlined by Dr X is not now started, and the extreme consequences of such an impact for AN, are clear. As against those dangers, alongside of course AN's own clearly expressed wish for more time, I have to weigh the very positive potential outcomes if the treatment is commenced immediately without those risks being run. In those circumstances I am clear that the balance falls comfortably in favour of intervention, and in acceding to the Trust's application for an order which will keep AN in hospital where she is now, so that the life-saving treatments which are available can be administered to her.

21. I hope that she will understand this decision and accept the treatments as offered, as Dr X anticipated that she would. I was gratified to understand from Ms David that the Trust do not propose any physical or chemical means of restraint in order to administer AN's treatment, but rather just to ensure that she is not free to leave the hospital, in the expectation that while she is there, she will permit the treatment that she so badly needs.

22. I have given direction to ensure that there is evidence of the up to date position available when the matter comes back on Wednesday 14 February, when I have indicated that I will hear the matter again, remotely, with a time estimate of 2 hours.