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THE PROVISION OF HEALTHCARE TO YOUNG AND DEPENDENT CHILDREN: THE PRINCIPLES, CONCEPTS AND UTILITY OF THE CHILDREN ACT 1989

Abstract

This article undertakes a thorough analysis of the case law concerned with the provision of healthcare to young and dependent children. It demonstrates how, despite the procedural changes introduced by the Children Act 1989 at an early stage in this body of case law, cases have continued to be brought to court by way of applications for the court to exercise its inherent jurisdiction or in wardship rather than using the orders introduced by the Act. In determining these cases, the court is focused upon its protective duty to the vulnerable but proceedings appear to be adversarial contests between the claims of adults to know what is best for the child in which the medical view normally prevails. Through consideration of the principles and concepts of the Children Act of parental responsibility, working together, the welfare principle and placing the child at the centre of care, this article demonstrates their utility, as yet to be fully realised, in relation to the responsibilities of parents, professionals, public authorities and the courts concerned with the provision of healthcare to young and dependent children.

Keywords: Children Act 1989; Children's Healthcare; Parents, Healthcare Professionals, Public Authorities, Courts

I COMMON LAW AND THE CHILDREN ACT 1989

There had been a small number of cases concerned with the provision of healthcare to children¹ when the Children Act 1989 (hereafter Children Act) came into force in October 1991. Despite the changes introduced by the Act to child law, the approach adopted in those early cases to decision-making and the resolution of disputes over children's healthcare has endured. Healthcare professionals are required to secure consent to the medical treatment of a child from someone authorised to give consent, holders of parental responsibility, to avoid liability in civil and criminal law for battery.² The courts have maintained the framing of this as the parental right to decide.³ Although, consistent with the concept of parental responsibility, this is a right asserted against others, in this case the healthcare professionals who also have an interest in the treatment provided, rather than the child. Should healthcare professionals, who are also under a duty to act in the best interests of the child, consider that parental decisions about a child's medical treatment are contrary to the child's interests the matter must be referred to court for determination. Despite the provisions for court orders regarding the upbringing and welfare of children introduced by the Children Act, the vast majority of cases are referred to court in applications for the court to exercise its inherent jurisdiction. Rather than consider the principles of parental responsibility or apply the welfare principle and checklist, these cases are decided by the court fulfilling its protective duty to the child through an independent assessment of the child's best interests. Disagreements are thus framed as disputes which must be resolved in court; the parental right to decide replaced by judicial decree. Judgments provide guidance as to how a court may approach a dispute between those with parental responsibility and healthcare professionals about a child's medical treatment but not upon the legal duties of those primarily responsible for the provision of treatment and care.

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¹ Considered below in text at n.11-22.

² *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 178.

³ *Ibid.*, 193.

Questions about a child's medical treatment were clearly envisaged as falling within the scope of the provisions of the Children Act, which was described in the Commons by the then Leader of the House, Sir Geoffrey Howe, as 'a comprehensive and integrated statutory framework to ensure the welfare of children'.⁴ Much was written in anticipation of the Children Act coming into force.⁵ This literature recognised that children's medical treatment came within its scope without directly addressing how its principles and concepts applied to the specific issues raised by the provision of healthcare to children. For example, writing in 1991, in the Archives of Disease in Childhood, Stephen Cretney sought to explain the full implications of the legislation for paediatricians but only in relation to their court-related work.⁶ More recently, with specific reference to the concept of parental responsibility, McFarlane LJ observed that many had not, at least until recently, 'grasp[ed] the importance and the utility of the concept'.⁷ I argue that this is the case for the application of the principles and concepts of the Children Act more generally as they apply to the provision of healthcare to children.

The Children Act sought to create a 'single statutory framework which would reflect a coherent set of legal concepts and principles',⁸ bringing together public and private law relating to children to create a comprehensive set of rules for child law. It provides for private law orders to settle disputes between parents over the upbringing of children, services to help parents with children in need and compulsory powers for intervention where parental care places the child at least at risk of significant harm. Andrew Bainham has reflected upon hybrid cases

⁴ Hansard, HC Debate, vol. 158, col. 1075 (26 October 1989).

⁵ The non-exhaustive list includes John Eekelaar & Robert Dingwall, *The Reform of Child Care Law: A Practical Guide to the Children Act 1989*, 1990; Michael Freeman, *Children, Their Families and the Law*, 1992; Nick Allen, *Making Sense of the Children Act*, 1990; White, Carr and Lowe, *The Children Act in Practice*, 1989; Andrew Bainham, *Children – the new law: the Children Act 1989*, 1990; A. Jane Bridge, Stuart Bridge, Susan Luke, *Blackstone's Guide to the Children Act 1989*, 1990.

⁶ Stephen Cretney, 'Implications of the Children Act 1989 for paediatric practice' (1991) 66 Archives of Disease in Childhood 536-541.

⁷ The Right Honourable Lord Justice McFarlane, 'Making Parental Responsibility Work' [2014] Fam Law 1264-1276, 1270.

⁸ Brenda Hoggett, *Parents and Children: The Law of Parental Responsibility*, 1993, 9.

under the Children Act provisions, public law cases with private law dimensions and vice versa and cases which transform from public to private or the reverse.⁹ The private/public dimension of cases concerning children's healthcare is of a different nature. There are examples of the courts resolving private disagreements between holders of parental responsibility on elective matters such as children's immunisation or ritual male circumcision where different beliefs negotiated prior to parental separation become a battleground between warring parents.¹⁰ The majority of cases, however, involve a challenge to the decision of parents by the healthcare Trust or local authority on behalf of health professionals who are unable, in all professional conscience, to accept the parental decision about the provision of medical treatment in the best interests of a young and dependent child. Disagreements about children's healthcare therefore straddle private and public domains; the exercise of parental responsibility challenged by professionals, who have legal duties to the child, in the public setting of an NHS hospital where questions arise about public duties to protect the welfare of children.

This article first critically examines the case law concerned with the provision of medical treatment to young and dependent children. The additional issues raised by the healthcare decisions of older children, and cases in which the court is asked to determine the legality of withdrawing or withholding treatment from a child with a life-limiting condition, are beyond the scope of this article; those cases raise further personal, relational, professional, caring, social, ethical and legal issues which require separate consideration. However, where the legal principles established in that wider body of case law are equally applicable they are considered here. Consideration of the case law demonstrates that, despite the procedural changes introduced by the Children Act 1989, the majority of cases are still brought to court by way of applications for the court to exercise its inherent jurisdiction or in wardship rather than by way

⁹ Andrew Bainham, 'Private and public children law: an under-explored relationship' (2013) 25 CFLQ 138.

¹⁰ Considered below in text at n.131-9.

of applications for section 8 orders introduced by the Children Act. The procedure adopted, it is argued, has determined the approach of the court to the resolution of disputes between parents and professionals, in adversarial proceedings of contested claims to know what is best for the child and in which medical best interests normally prevails. The principles and concepts of the Children Act as they apply to the provision of healthcare to children are then considered with respect to parental responsibilities, professional duties, the responsibilities of public authorities and the approach to the court to the determination of disputes. A detailed examination of the principles and concepts of the Children Act of parental responsibility, working together, the welfare principle and checklist and placing the child at the centre of care, demonstrates that their utility is yet to be fully realised in the context of the provision of healthcare to children.

II CHILDREN'S HEALTHCARE BEFORE THE COURTS

The first reported case in which questions concerning the provision of healthcare to a child were determined in legal proceedings was the case of *Re D*¹¹ in 1976. The decision of D's mother and paediatrician to subject D to a sterilisation operation, and hence parental authority and medical paternalism, were challenged in legal proceedings initiated by an educational psychologist from the local education authority. Heilbron J noted that D's 'caring and devoted', if 'over-zealous' mother was genuinely seeking to do her best for her daughter,¹² and praised the exemplary care provided to D through the co-operation of a range of professionals and services. Emphasising the duty of the court to protect D's rights, care for her and prevent future harm, her Ladyship declined to authorise the operation.¹³ The case prompted media debate in which it was argued that decisions about non-therapeutic sterilisation should not be left to doctors and parents but required instead 'strict guidelines', 'stringent safeguards' and

¹¹ *Re D (a minor) (wardship: sterilisation)* [1976] Fam 185.

¹² *Ibid.*, 192.

¹³ *Ibid.*, 194.

‘independent review’.¹⁴ Subsequently, in *Re B (1988)*, Lord Templeman expressed the view that all proposals to sterilise a child should be reviewed by a judge. It was, his Lordship said, ‘a drastic step’ which ‘vitally concerns an individual’ and involved ‘principles of law, ethics and medical practice’ such that it required the authority of the court.¹⁵

When the court was first asked in *Re B (1981)*¹⁶ to determine the medical treatment of a child it was in order to clarify the law. The contemporaneous prosecution of Dr Arthur, who had prescribed nursing care and the administration of a sedative to John Pearson, a baby with Downs Syndrome, following his parents rejection of him, demonstrated that the law sets the parameters of professional conduct.¹⁷ In the context of the debate prompted by *R v Arthur*, the local authority sought a declaration from the court of the legality of respecting the decision of the parents of Alexandra, who also had Downs Syndrome, to decline life-saving surgery. Alexandra was temporarily taken into care after the court authorised procedure in the exercise of the public authority’s protective duties to the child, although a few months later she was returned to her parents’ care.¹⁸ The cases that followed *Re B* but preceded the Children Act, which came into force in its entirety in October 1991, concerned leave to apply for judicial

¹⁴ ‘A wise and compassionate decision’ *The Times*, 18 September 1975; Martin Huckerby, ‘High court forbids sterilization of handicapped girl aged 11’, *The Times*, 18 Sept 1975; ‘Sterilization – the need for safeguards’, *The Times*, 22 July 1975.

¹⁵ *Re B (A Minor) (Wardship: Sterilisation)* [1987] 2 WLR 1213, 1218B-C, E.

¹⁶ *In Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421.

¹⁷ *In Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421 followed the charge but preceded the trial of Dr Arthur. The original charge for murder was reduced to attempted murder, following the post-mortem, for which he was acquitted by the jury, *R v Arthur* 12 BMLR 1, 1981. Dr Arthur maintained throughout that his professional conscience was clear as he had acted as a responsible paediatrician respecting the authority of the parents, Arthur Osman, ‘Conscience is clear, murder case doctor says’, *The Times*, 3 April 1981. A BMJ editorial of the time emphasised the need for socially acceptable standards to guide doctors in the absence of which there was no reason to consider that judges were better placed to decide than parents to reach a humane decision, Editorial Comment, ‘The Right to Live or the Right to Die’ (1981) 283 BMJ 569.

¹⁸ Michael Freeman, *The Rights and Wrongs of Children*, 1983, ch.7.

review of delays to children's heart surgery,¹⁹ *Gillick*,²⁰ the ability of a pregnant child to consent to abortion,²¹ refusal of consent by older children,²² and the House of Lords in *Re B (1988)* (above). Aside from *Gillick* and the judicial review cases, all of these cases were referred to court by a public authority, the local authority or health authority, asking the court to exercise its wardship jurisdiction. As a consequence, the focus of the judgments was upon the duties of the court and not upon the responsibilities of parents, professionals or the public services providing healthcare or responsible for child welfare.

There was much uncertainty as to the effect of the Children Act upon the ability of the court to exercise its protective jurisdiction over children. The first question for the courts, once the Children Act was in force, concerned the procedure by which cases involving disputes over the medical treatment of children could be referred to court. This, in turn, raised the further question of the approach to be adopted by the courts in resolving these cases.

A Responsibilities of the Court

1 Invoking the court's jurisdiction

The Law Commission Report which preceded the Children Act, *Review of Child Law*, did not propose substantial changes to wardship, rather it sought to 'incorporate the most valuable features' of wardship whilst reducing the need to use wardship except in the most 'unusual

¹⁹ Brought within a few months of each other, both concerned delays to heart surgery for a child due to a lack of intensive care nurses to staff beds in a paediatric intensive care ward at a Birmingham hospital, *R v Central Birmingham Health Authority, ex parte Walker*; *R v Secretary of State for Social Services and another, ex parte Walker*, CA, unreported 1987; *R v Central Birmingham Health Authority ex parte Collier*, 6 January 1988 unreported, official transcript on Westlaw.

²⁰ *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.

²¹ *Re P (A Minor)* [1986] 1 FLR 272; *Re B (Wardship: Abortion)* [1991] 2 FLR 426 (decided May 1991).

²² *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386 (decided September 1990), *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190 (decided July 1991).

and complex' cases.²³ The objective was to limit the use of wardship to those situations in which 'continuing parental responsibility of the court' was required²⁴ so that the use of wardship would not circumvent the statutory scheme established by the Children Act. Individuals, authorities or organisations with a genuine interest in a child's welfare would be able, with leave, to apply for a Specific Issue Order or Prohibited Steps Order both of which were 'modelled on the wardship jurisdiction'.²⁵ In making a Specific Issue Order the court determines a specific question in connection with parental responsibility, and a Prohibited Steps Order prohibits the taking of a step that could be taken by a parent in meeting his parental responsibility for a child, without the consent of the court, whilst the child's parents retain responsibility for the child's upbringing.²⁶ At the time the Children Bill was before Parliament Lord Mackay explained that

'Specific issue orders will allow the courts to decide any individual matter on which those responsible for the child, or indeed the child himself, are unable to agree amongst themselves. It will also allow parties to seek the court's agreement to matters which are so serious as to appear to require the authority of the court. The power to make specific issue orders is broad, covering everything from disagreements about which school the child should attend to major decisions such as whether a child should undergo major and irreversible treatment such as an abortion or sterilisation'.²⁷

Whilst abortion and sterilisation are major and irreversible procedures, they do not necessarily require the ongoing involvement of the court. Lord Mackay further noted that the inherent

²³ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 1.4. Responses to the Law Commission Working Paper on *Wards of Court* (Working Paper No.101, 1987) had supported reform but only after reform of the private and public law provisions, 1.4.

²⁴ *Ibid.*, Law Commission, 1988, 4.40.

²⁵ *Ibid.*, 4.20, 4.41.

²⁶ Children Act 1989, s.8(1), hence, along with the Child Arrangements Order, referred to as section 8 orders.

²⁷ Lord Mackay, 'Joseph Jackson Memorial Lecture – Perceptions of the Children Bill and beyond' (1989) 139 NLJ 505.

jurisdiction of the High Court would, subject to leave, still be available for a 'particularly difficult issue, such as an irreversible medical procedure'²⁸ and that, 'local authorities may still invoke wardship for [purposes other than care proceedings], provided that there is no alternative statutory procedure and there is an apparent likelihood of substantial harm to the child.'²⁹ Together it was anticipated that the reforms would 'substantially reduce the need to invoke the High Court's inherent jurisdiction'. In addition, the threshold requirements to be surpassed before the court can exercise its inherent jurisdiction or the local authority can intervene in families in public law proceedings, reflected the principle that it is 'important for the law in a free society expressly to protect the integrity and independence of families save where there is at least likelihood of significant harm to the child from within the family'.³⁰

The procedural basis by which cases of children's medical treatment could be brought before the court was directly addressed in two cases each involving an application for judicial authority to administer blood to a child whose parents, as Jehovah's Witnesses, were unable to agree to that aspect of the treatment.³¹ *Re O*³² concerned a premature baby who had respiratory distress syndrome. On the Friday afternoon when O was four days old, and in anticipation of an emergency arising over the weekend, the local authority were consulted and an Emergency Protection Order was made without notice to her parents. This conferred parental responsibility upon the local authority which gave consent to blood transfusions. The local authority then applied for a Care Order. In determining that application, Johnson J was asked to express a view as to the appropriate procedure for such decisions. The judge accepted the submission that it was 'wholly inappropriate for the court to make even an Interim

²⁸ *Ibid.*

²⁹ Hansard, *HL Debate*, vol.502, col.493 (6 December 1988).

³⁰ *Ibid.*

³¹ These cases were preceded by *Re S (A Minor) (Medical Treatment)* [1993] 1 FLR 376, in which the local authority applied under s.100 of the Children Act for the court to exercise its inherent jurisdiction and then to make an order authorising the administration of blood to 4 and a half year-old S who was receiving treatment for T-cell leukaemia. His parents, who were Jehovah's Witnesses, sought a Prohibited Steps Order. Thorpe J made the order sought by the local authority in the exercise of the court's inherent jurisdiction and without comment upon matters of procedure.

³² *Re O (A Minor) (Medical Treatment)* [1993] 2 FLR 149.

Care Order where the child's parents were caring, committed and capable' and there was only a single issue for determination.³³ Johnson J also thought that an Emergency Protection Order was inappropriate, and that medical treatment cases fell outside the scope of s.44(1) of the Children Act. Johnson J considered the exercise of the court's inherent jurisdiction following an application under s.100 of the Children Act to be the most appropriate procedure, whenever possible in an *inter partes* hearing before a judge of the Family Division so that 'justice is seen, and felt, to be done.'³⁴

In the case of *Re R*, which followed soon after, the local authority obtained leave to apply to the court for a s.8 Specific Issue Order to authorise the administration of blood to 10 month-old R, whose parents were unable to consent to that aspect of her treatment for B-cell lymphoblastic leukaemia. Booth J referred to the provisions of s.100(4) of the Children Act³⁵ and agreed with Counsel for the authority that an application for a Specific Issue Order was the most appropriate procedure for such cases. Applying the welfare principle and checklist, the judge authorised the administration of blood in a life-threatening emergency without consultation with the parents, requiring consultation if the situation was not imminently life-threatening.³⁶ The following year, the Court of Appeal expressed the view that there were 'ample procedures' to enable the involvement of the court where a child required a blood transfusion and the religious beliefs of his or her parents precluded consent and that the onus rested upon the hospital to involve the court.³⁷

³³ *Re O (A Minor) (Medical Treatment)* [1993] 2 FLR 149, 153.

³⁴ *Ibid.*, 155. Johnson J accepted Counsel's argument with respect to a Specific Issue Order that an 'issue' cannot be 'determined' on an ex parte application.

³⁵ Children Act 1989, s.100(4) 'The court may only grant leave if it is satisfied that—
(a) the result which the authority wish to achieve could not be achieved through the making of any order of a kind to which subsection (5) applies; and
(b) there is reasonable cause to believe that if the court's inherent jurisdiction is not exercised with respect to the child he is likely to suffer significant harm.'

³⁶ *Re R (minor) (Blood Transfusion)* [1993] 2 FLR 757, 761. Declarations in such terms are standard in cases of parental inability to consent to the administration of blood due to their religious beliefs, eg *Birmingham Children's NHS Trust v B and C* [2014] EWHC 531; *M Children's Hospital NHS Foundation Trust v Mr and Mrs Y* [2014] EWHC 2651.

³⁷ *Re S (A Minor) (Blood Transfusion: Adoption Order Condition)* [1994] 2 FLR 416.

In 2004, Stephen Gilmore reviewed cases in which the court had considered applications for Specific Issue Orders concluding that the case law revealed ‘some uncertainty concerning the nature and scope of the order’.³⁸ His review of the cases also demonstrates the limited use of Specific Issue Orders in cases concerned with children’s medical treatment.³⁹ Despite the enactment of the Children Act, where there is an issue to be determined concerning the medical treatment of a child the application most often takes the form of an application for the court to exercise its inherent jurisdiction. In *Re W*, Lord Donaldson MR emphasised that the court can exercise its inherent jurisdiction in relation to a child whether or not the child is a ward of court. The difference being that if a child is a ward of court ‘no “important” or “major” step in a ward’s life’ can be taken without the consent of the court.⁴⁰ the court can exercise its inherent jurisdiction without continued involvement. Whilst leave is required for non-entitled applicants such as an NHS Trust or local authority to apply for a Specific Issue Order⁴¹ and for the local authority to apply for the court to exercise its inherent jurisdiction,⁴² the circumstances in which leave will be granted differ, reflecting the aim that the exercise of the court’s inherent jurisdiction is limited to the most serious of cases. A section 8 order requires leave under s.10 in which the court must have regard to ‘(a) the nature of the proposed application for the section 8 order; (b) the applicant’s connection with the child; (c) any risk there might be of that proposed application disrupting the child’s life to such an extent that he would be harmed by it’.⁴³ Whereas, upon application by the local authority, the court can only grant leave to exercise its inherent jurisdiction if there is ‘reasonable cause to believe that if the court’s inherent jurisdiction is not exercised with respect to the child he is likely to suffer

³⁸ Stephen Gilmore, ‘The nature, scope and use of the specific issue order’ (2004) 16 CFLQ 367-385.

³⁹ *In re C (A Child) (H.I.V. Testing)* [2000] 2 WLR 270, considered further below. In *Re K, W and H (Minors) (Medical Treatment)* [1993] 1 FLR 854, on the question whether a consequential effect of the Children Act was to require a s.8 order when an older child was refusing consent despite written consent from his or her parents. Thorpe J described these applications as ‘misconceived and unnecessary’.

⁴⁰ *In Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1993] Fam 64, 73.

⁴¹ Children Act 1989, s.10(2)(b), which the court will grant if s.10(9) is fulfilled. The persons who are entitled to apply for a specific issue order or prohibited steps order are specified in s.10(4).

⁴² Children Act 1989, s.100(3).

⁴³ Children Act 1989, s.10(9).

significant harm'⁴⁴ and the authority cannot achieve the result they wish to achieve by any other order the local authority is entitled to apply for.⁴⁵ Which, of course, includes a s.8 order. Other applicants, such as the NHS Trust, do not require leave to ask the court to exercise its inherent jurisdiction.

Mostyn J observed in the recent case of *Re JM*⁴⁶ that it might seem that cases concerning the medical treatment of a child 'fall squarely' within the scope of s.8 as the determination of a specific question that has arisen concerning an aspect of parental responsibility. The Trust had applied for declarations of the court in the exercise its inherent jurisdiction. Following Booth J in *Re R* (above), Mostyn J had formed the view that the relief that should have been sought was a Specific Issue Order and gave leave to seek it. As the judge observed, the court's inherent jurisdiction may not be used to 'bypass' legislation but may be used to 'fill gaps in, or to supplement, a statutory scheme'.⁴⁷ But, upon further reflection the judge thought that the legislature might not have had in mind the situation in which an NHS Trust is seeking permission to carry out serious medical treatment upon a child contrary to the wishes of the child's parents, in this case removal of an aggressive cancerous tumour from J's jaw and reconstruction using bone from his leg. Mostyn J concluded that if the Trust is seeking final binding declarations, it should apply for leave for an application for a Specific Issue Order and combine that with an application for declaratory relief in the exercise of the court's inherent jurisdiction.⁴⁸ It should be noted that this conclusion was reached in the context of cuts to civil legal aid which was no longer available in applications for s.8 orders but continued to be available in cases concerning the exercise of the court's inherent jurisdiction. Such an approach may underscore a view of such issues as mere practicalities, tangential to the real

⁴⁴ Children Act 1989, s.100(4)(b).

⁴⁵ Children Act 1989, ss.100(4)(a) and 100(5)(b).

⁴⁶ *Re JM* [2015] EWHC 2832.

⁴⁷ *Ibid.*, [23].

⁴⁸ *Ibid.*, [24-27].

issue in such cases. As Lord Woolf MR stated in *Glass*, refusing an application to appeal against the judge's refusal to give relief in judicial review proceedings,

'I would emphasise that, particularly in regard to cases involving children, the last thing that the court should be concerned about is whether the right procedure has been used in the particular case. ... The important concern of the court is to ensure that what is in the best interests of the child is determined, so far as the court is able to do so, on the material which is before it.'⁴⁹

Yet, as is argued below, the procedure adopted has dictated the approach of the courts to cases of children's medical treatment focused upon the exercise of discretion in fulfilment of their own common law protective duties to the vulnerable. Proceedings under the Children Act could result in a very different approach.

2 *Exercise of the court's jurisdiction*

In response to media reports which questioned why the court was involved in the decision to separate conjoined twins, Jodie and Mary, Ward LJ explained that '[t]he Children Act 1989 now contains a statutory scheme for the resolution of disputes affecting the upbringing of children. If a person having a recognisable interest brings such a dispute to the court, the court must decide it.'⁵⁰ Once the jurisdiction of the court has been invoked, the responsibility for the decision about the child's medical treatment is removed from his or her parents and the duty rests with the court to reach an independent decision.⁵¹ As Lord Donaldson MR stated in *Re R*, the court does not 'step into the shoes of the parent'. The jurisdiction of the court is not 'derivative from the parents' rights and responsibilities' rather it 'derives from, or is, the

⁴⁹ *R v Portsmouth Hospitals NHS Trust, ex parte Glass* [1999] 2 FLR 905, 910. Judicial review proceedings were not appropriate as the issue was a difference of opinion between David Glass's mother and treating doctors about his prognosis and hence future treatment.

⁵⁰ *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 179.,

⁵¹ *Ibid.*, 179.

delegated performance of the duties of the Crown to protect its subjects and particularly children who are the generations of the future'.⁵² When issues of a child's medical treatment are brought before the court,

'in the exercise of its wardship jurisdiction the first and paramount consideration is the well being, welfare, or interests (each expression occasionally used, but each, for this purpose, synonymous) of the human being concerned, that is the ward herself or himself.'⁵³

Balcombe LJ suggested in *Re W* that, where the issue concerns the upbringing of the child, s.1(1) of the Children Act now gives statutory effect to the paramountcy of the welfare of the child.⁵⁴ Although, it is argued below that the approach to determining the welfare of the child under s.1(1) and s.1(3) of the Children Act is very different to that of the court in wardship proceedings.

The Court of Appeal in *Re W* was concerned, amongst other things, with the powers of the court in cases of children's medical treatment following the Children Act, in light of *Gillick* and the interpretation there given to s.8 of the Family Law Reform Act 1969.⁵⁵ Reflective of the Children Act principle that where a child is in local authority care, the local authority should make decisions about the upbringing of the child, the authority could not seek a Specific Issue Order⁵⁶ and s.100(2) of the Children Act meant that W could not be made a ward of court so the local authority applied under s.100(3) for leave to apply for the court to exercise its inherent jurisdiction. The local authority wanted to know whether it would be lawful to provide treatment to W against her wishes but did not, at that time, have any specific treatment in mind.⁵⁷ Nolan

⁵² *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190, 200.

⁵³ *Re B (a minor) (wardship: sterilisation)* [1988] AC 199, 202, per Lord Hailsham.

⁵⁴ *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 85.

⁵⁵ *Ibid.* Lord Donaldson MR was also responding to criticism of his earlier judgment in *Re R*.

⁵⁶ Children Act 1989, s.9(1).

⁵⁷ *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 73.

LJ emphasised that, whereas *Gillick* had been concerned with the extent of parental rights over the welfare of the child, *Re W* concerned the exercise of the court's jurisdiction,⁵⁸ in which the court had powers that were 'theoretically limitless'.⁵⁹ As Nolan LJ explained the court has the power and responsibility, where it considers it to be necessary in the best interests of the child, to override the views of both the child and the parent.⁶⁰ Furthermore, their Lordships emphasised, that the powers of the court exceed those of natural parents in that the court can override consent to medical treatment provided by a child aged 16 or older or *Gillick* competent whereas those with parental responsibility cannot.⁶¹ Whilst *Re W* concerned the powers of the court where it is asked to make decisions with respect to a child by the holder of parental responsibility, this approach to the powers of the court has been adopted in subsequent cases arising from a difference of opinion between a child's parents and treatment team about the medical treatment of a child.

First, the Court of Appeal, allowing the appeal in *Re T* on the first post-Children Act occasion that it considered the medical treatment of a young child, emphasised that the court does not merely review the reasonableness of the parental decision but reaches an independent determination of the best interests of the child.⁶² A few years later, in *Re A*, Ward LJ quoted from the pre-Children Act *Re B*⁶³ (above) emphasising that the decision of parents might be genuine, reasonable, responsible and caring but once referred to court the matter is for the court to decide.⁶⁴ The judge is not limited to choosing between the treatment regime preferred by either the treating professionals or the child's parents. Independent judicial assessment

⁵⁸ *Ibid.*, 93.

⁵⁹ *Ibid.*, 81, Lord Donaldson MR.

⁶⁰ *Ibid.*, 93.

⁶¹ A refusal of medical treatment by a child can be overridden by those with parental responsibility as well as the court, *Ibid.*, 83-84.

⁶² *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242.

⁶³ *Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1424.

⁶⁴ *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 179.

may, as in private law cases under the Children Act, mean that neither parties' preference is secured.⁶⁵

In determining applications concerning the medical treatment of a child the judiciary focus upon their own duty to protect, making their own assessment of the welfare of the child.⁶⁶ The standard, derived from the speech of Lord Upjohn in *J v C* is that of the 'judicial reasonable parent', 'reflecting and adopting the changing views as the years go by of reasonable men and women, the parents of children, on the proper treatment and methods of bringing up children.'⁶⁷ The Court must decide 'exercising the authority of the Crown as national', rather than natural, parent.⁶⁸ Whilst the court will not lightly override the natural parent the judge is required to act as a 'wise parent',⁶⁹ 'viewing the evidence more broadly from the standpoint of his own perception of the child's welfare when appraised in all its aspects'.⁷⁰ Ward J stated in *Re E* that the standard was that of the 'ordinary mother and father', an objective standard which was subjective to the extent that it was the welfare of the particular child under consideration, in that case, in light of his age and religious upbringing.⁷¹

How might the judicial, national, reasonable, parent differ in assessment of welfare from natural parents? As Butler-Sloss LJ explained in *Re T* the duty of the court is to undertake an independent assessment of the welfare of the child in the context of all the relevant facts including the view of the child's parents - depending upon the court's assessment of those views.⁷² Ward LJ said in *Re A*, 'Since the parents have the right in the exercise of their parental responsibility to make the decision, it should not be a surprise that their wishes should

⁶⁵ *An NHS Trust v MB* [2006] EWHC 507.

⁶⁶ *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 391.

⁶⁷ *Re D (a minor) (wardship: sterilisation)* [1976] Fam 185, 194, Heilbron J quoting Lord Upjohn in *J v C* [1970] AC 668, 722-723.

⁶⁸ *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190, 202, Staughton LJ.

⁶⁹ *Re D (a minor) (wardship: sterilisation)* [1976] Fam 185, 194.

⁷⁰ *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242, 254, Waite LJ.

⁷¹ *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 392-3.

⁷² *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242, 250.

command very great respect. Parental right is, however, subordinate to welfare.⁷³ This may lead the court to authorise treatment contrary to parental judgment or conscience. Conversely, judges have repeatedly stated that a court cannot require a doctor to treat contrary to their clinical judgment⁷⁴ or professional conscience.⁷⁵ If the court were to disagree with professional judgment, agreeing with parental assessment of the welfare of the child, the Trust would have a duty to assist the parents to find alternative means of securing the treatment. But there are no examples of this in the reported judgments.⁷⁶

Judges repeat that they approach the welfare of the child ‘in the widest sense and to include every kind of consideration capable of impacting on the decision. These include, non-exhaustively, medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations.’⁷⁷ Judgments are informed by the medical opinion of the child’s treating team, parental views and opinions – both perhaps gaining some clarity in formulation of a written statement or cross questioning – with the addition of views from independent experts. Judgments are reached through a balance sheet of benefits and burdens framed by abstract principles such as sanctity of life, quality of life, unique value of life, and dignity as a human being rather than the specific experiences of the individual child. In the majority of cases, with the notable exception of *Re T*,⁷⁸ it is the objectivity of prevailing

⁷³ *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 193.

⁷⁴ *In re J (A Minor)* [1992] 3 WLR 507, 516, Lord Donaldson MR. Although Lord Woolf MR qualified this as subject to the power of the court to decide according to the best interests of the child, this qualification has not been made in subsequent cases, *R v Portsmouth Hospitals NHS Trust, ex parte Glass* [1999] 2 FLR 905.

⁷⁵ *Re Wyatt* [2005] EWHC 2293, [32] Hedley J identifying a four-fold categorisation of disagreement.

⁷⁶ In *Simms v Simms* [2002] EWHC 2734, Butler-Sloss P invited the Department of Health to assist in the arrangements for the provision of experimental treatment to two patients, one a 16 year-old child, with v-CJD where the court had authorised the treatment as in the best interests of the patients but two committees of the hospital had not approved the treatment.

⁷⁷ *An NHS Trust v A* [2007] EWHC 1696, [40].

⁷⁸ At first sight the case of *In the Matter of Ashya King (a Child)* [2014] EWHC 2964 may appear to be a further example. However, the preference of Ashya’s parents for Proton Beam Therapy was not opposed by his doctors; but they were not able to provide it as it was not at that time available in the UK and NHS England had refused to fund his treatment abroad. By the time his treatment was considered by Baker J in wardship proceedings, the judge was assured that the financial arrangements were in place for him to be provided with private treatment in Prague.

medical opinion which persuades the court of the welfare of the child, indicative of a distance between the views of national and natural parents.

Recently, the High Court has accepted the application of the propositions developed by the courts to guide their decision-making in cases of withdrawing or withholding treatment to the determination of the provision of treatment to children. Originating from the judgments of the Court of Appeal in the 1990 case of *Re J*,⁷⁹ set out as ‘intellectual milestones’ by the Court of Appeal in *Wyatt*,⁸⁰ and as ten propositions by Holman J in *Re MB*,⁸¹ these summarise the legal framework for judicial determination detailed above then note the weight to be given to prolongation of life, pain and suffering, and to the sanctity and quality of life. In *An NHS Trust v A*,⁸² Holman J explained that he considered the propositions to be a fair and accurate summary of the law and equally applicable as a guide for deciding cases whether it was the doctors or the parents who wished for treatment to be administered, withheld or withdrawn. More recently, Mostyn J in *Re JM* explained that he viewed these propositions as a ‘fuller explication’ of the principle of the paramountcy of the welfare of the child guiding the court in the exercise of its powers equally applicable as a guide to the court in judicial decisions on the provision of treatment as to decisions concerning the withholding or withdrawal of treatment.⁸³

Despite the obligations imposed upon individual healthcare practitioners, NHS Trusts, local authorities and the courts by the Human Rights Act 1998 (HRA),⁸⁴ the courts have declined the opportunity to ‘re-cast in a human rights framework’ the principles governing determination of children’s healthcare.⁸⁵ The Court of Appeal swiftly overturned the rights-based judgment

⁷⁹ *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33.

⁸⁰ *Wyatt & Another v Portsmouth Hospital NHS & Another* [2005] EWCA Civ 1181, [87] approving Hedley J in the court below *Portsmouth NHS Trust v Wyatt* [2004] EWHC 2247.

⁸¹ *An NHS Trust v MB* [2006] EWHC 507, [16].

⁸² *An NHS Trust v A* [2007] EWHC 1696, [40].

⁸³ *Re JM* [2015] EWHC 2832, Mostyn J, [14].

⁸⁴ Human Rights Act 1998, s.6(3).

⁸⁵ Jane Fortin, ‘The HRA’s impact on litigation involving children and their families’ (1999) 11 CFLQ 237, 239.

of Laws J in the judicial review of the refusal of Cambridge Health Authority to fund further treatment against leukaemia for Jaymee Bowen.⁸⁶ In *Re T*, Waite LJ said that ‘It is not an occasion – even in an age preoccupied with “rights” – to talk of the rights of a child, or the rights of a parent, or the rights of the court’ as the paramountcy of the welfare of the child was the ‘sole yard-stick’.⁸⁷ Whilst, in *Re C (HIV)*, Wilson J countered the father’s submission that they ‘had ...stood up for our rights’ with the retort that ‘This baby has rights of her own’.⁸⁸ Wilson J noted that both baby and parents had a right to respect for family life under Article 8 but left for consideration once the HRA was in force what effect that would have upon welfare determinations. Dismissing the parental application to appeal three days before the court-authorized HIV test was due and when the whereabouts of parents and child were unknown, Butler-Sloss LJ likewise stressed that the case was about the rights of the child, not parental rights. Her Ladyship did not think it necessary to consider the United Nations Convention on the Rights of the Child (UNCRC) believing it to be ‘encapsulated in s1 of the Children Act’ although the UNCRC supported the conclusion that the parental views were outweighed by the rights of the child to ‘be properly cared for in every sense’.⁸⁹ Whilst Baker J in *King*, stated that his duty was to determine Ashya’s future medical treatment with paramount consideration given to his welfare, and with regard to his rights under Articles 2 and 8 of the European Convention of Human Rights (ECHR),⁹⁰ the judge gave no analysis of either.⁹¹ A common approach is that although several articles of the ECHR are engaged in relation to issues of children’s healthcare, they confirm rather than ‘alter or add to established principles of English domestic law’ so that ‘specific consideration’ of the ECHR is not necessary.⁹² Whilst in *Re A* the HRA, which would be in force by the time the operation was performed, was briefly

⁸⁶ *R v Cambridge District Health Authority, ex parte B* [1995] 1 FLR 1055.

⁸⁷ *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242, 253. For critical comment see Andrew Bainham, ‘Do Babies Have Rights?’ (1997) 56 CLJ 48.

⁸⁸ *In re C (A Child) (H.I.V. Testing)* [2000] 2 WLR 270, 282H.

⁸⁹ *Re C (HIV Test)* [1999] 2 FLR 1004, 1021

⁹⁰ *In the Matter of Ashya King (a Child)* [2014] EWHC 2964, [30].

⁹¹ *Ibid.*, [30].

⁹² *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, Robert Walker LJ, 257; *An NHS Trust v A* [2007] EWHC 1696, [44]; *Portsmouth NHS Trust v Wyatt* [2004] EWHC 2247 [25].

mentioned, as Andrew Bainham has observed, '[t]he influence of rights based arguments was negligible if not non-existent.'⁹³ The Article 2 rights of the twins were acknowledged but not analysed. Brooke LJ expressed the view that the application of the welfare principle balancing the conflicting interests of the babies provided justification for interference with Mary's Article 8(1) right to respect for private and family life.⁹⁴ But his Lordship did not consider whether Article 8 required the court to adopt a different approach to determination of welfare. Nor did the court examine the parents' Article 8 rights to respect for private life nor the right to respect for the family life of them all. Whilst the ECHR, in *Glass v UK*, held that David's Article 8 right had been interfered with and, although his doctors had acted with a legitimate aim (in accordance with their clinical judgment of David's best interests), administration of diamorphine against his mother's wishes without seeking consent from the court was not necessary in a democratic society.⁹⁵ Still, the court concluded that English Law was compatible with Convention Rights. The effect, as the barrister representing David and Carol Glass, Barbara Hewson QC, has commented, is that the question must be referred to court before 'maternal opinion' can be overridden.⁹⁶

As Jonathan Montgomery has observed, the courts in healthcare decisions have not sought to 'codify principles, preferring to use the concept of best interests as a way to resolve individual disputes without articulating precise legal rules.'⁹⁷ Whilst judges approach these cases with the utmost care, they cannot avoid becoming adversarial battles between the claims of adults with different experiences and perspectives to know what is best for a child, one of which prevails. Court proceedings are stressful for parents and professionals alike, can have a detrimental effect upon the relationships of care and distract attention from the needs

⁹³ Andrew Bainham 'Can We Protect Children and Protect their Rights?' (2002) Fam Law 279.

⁹⁴ *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, Brooke LJ, 238.

⁹⁵ *Glass v United Kingdom* (2004) 39 EHRR 15, [77-83].

⁹⁶ Barbara Hewson, 'When maternal instinct outweighs medical opinion' (2004) 154 NLJ 522.

⁹⁷ Jonathan Montgomery, 'Law and the demoralisation of Medicine' (2006) 26 Legal Studies 185-210, 202.

of the child.⁹⁸ Despite being particularistic assessments of welfare, they can appear distanced from the child whose medical treatment, wellbeing and future is at issue. In such circumstances the expropriation of the parental right to decide can leave parents unpersuaded that the objective assessment of the court better demonstrates appreciation of their child's best interests. The parents of Baby C took her to Australia in order to avoid the court ordered blood test; Neon Roberts' mother both ignored orders of the court and appealed against them; JM's parents informed the court they would not be attending the hearing of the application of the Trust for authority for the surgery his doctors considered he urgently required and were believed at that time to be in Poland. Furthermore, as Peter Cane has argued, the law is, or should be, 'at least as concerned with telling us what our responsibilities are, and with encouraging us to act responsibly'⁹⁹ as it is with accountability for past actions or the resolution of disputes. With this in mind, I now turn to consider the principles and concepts of the Children Act. I argue that these provide a guide to parents in fulfilment of their responsibilities to their children, working in partnership with healthcare professionals in the provision of healthcare and placing duties upon public authorities to work together in the welfare of children and upon the courts in the resolution of disagreements which arise, putting the child at the centre of relationships of care. However, the utility of these principles and concepts to understandings of respective responsibilities, encouraging fulfilment of them and in the resolution of disputes have not been fully realised in the context of children's healthcare.

III THE PRINCIPLES, CONCEPTS AND UTILITY OF THE CHILDREN ACT WITH RESPECT TO CHILDREN'S HEALTHCARE

⁹⁸ Liz Forbat, Bea Teuten and Sarah Barclay, 'Conflict escalation in paediatric services: findings from a qualitative study' (2015) *Arch Dis Child*, doi:10.1136/archdischild-2014-307780.

⁹⁹ Peter Cane, *Responsibility in Law and Morality* (Hart 2002) 30.

The Law Commission's 1988 Report, *Review of Child Law: Guardianship and Custody*, proposed a single code, a coherent framework for the 'care, protection and upbringing of children and the provision of services to them and their families'¹⁰⁰ and set of remedies for child law consistent across both public and private law.¹⁰¹ The philosophy of the Children Act is given effect through concepts which should inform understandings of the duties of those with responsibility for the welfare of children, including the provision of healthcare to children.

Baroness Hale, who was the Law Commissioner responsible for the review of child law which resulted in the Children Act, has described parental responsibility as 'the fundamental *concept* of the Children Act 1989 and one of its most important underlying *principles*'.¹⁰² Equally applicable to public and private law, it encapsulates both that parents have responsibilities to their children rather than rights over them and that children are primarily the responsibility of their parents, not the state.¹⁰³ As Baker J stated in his judgment in the high-profile case of Ashya King, it is thus a 'fundamental principle of family law in this jurisdiction that responsibility for making decisions about a child rest with his parents. In most cases, the parents are the best people to make decisions about a child'¹⁰⁴ and parents are given considerable freedom to take responsibility for their child's upbringing and welfare. However, 'the concept of partnership' whilst, as Baroness Hale has explained, 'not expressed in the Act; ... is certainly an underlying principle; and that principle is 'one of working together in the interests of the child.'¹⁰⁵ The responsibility of public institutions is to work in partnership with parents

¹⁰⁰ Hansard, HL Debates, vol.502, col.488 (6 December 1988).

¹⁰¹ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 1.5; following four Consultation Papers on *Guardianship*, No.91, 1985; *Custody*, No.96, 1986; *Care, Supervision and Interim Orders in Custody Proceedings*, No.100, 1987, *Wards of Court*, No.101, 1987.

¹⁰² Writing after time as Law Commissioner and before her appointment to the judiciary, Brenda Hoggett, *Parents and Children: The Law of Parental Responsibility*, 1993, 9, emphasis in the original.

¹⁰³ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 2.1. Reflecting both a lack of confidence in the state and an emphasis upon individual responsibility and choice, John Eekelaar, *Family Law and Personal Life*, 2006, 16.

¹⁰⁴ *In the Matter of Ashya King (A Child)* [2014] EWHC 2964, [31].

¹⁰⁵ Brenda Hale, 'In Defence of the Children Act' (2000) *Archives of Diseases of Childhood* 463, <http://adc.bmj.com/content/83/6/463.full.pdf+html> (last accessed 9/1/17).

supporting them to fulfil their responsibility to their children and to work together to prevent the need for compulsory action or court orders. The principle of partnership thus applies both between parents and authorities and to inter-agency co-operation to secure the welfare of children. The 'prior claim' of parents to responsibility can be interfered within the interests of the child's welfare,¹⁰⁶ although compulsory intervention is limited to circumstances where parental care places the child at unacceptable risk of harm. Where the state becomes involved, in either private disputes or public proceedings, decisions are made according to the welfare of the child. This may lead the court to the conclusion that it should not intervene, applying the principle of no unnecessary order. Where the court does intervene, the welfare of the child is the paramount consideration and the state can place limits upon the exercise of parental responsibility in the interests of the child's welfare.

The Children Act places the child at the centre of relationships of care and, reflecting *Gillick*, emphasises both respect for the individual child and protection of his or her welfare. Applying the principles of the Children Act whilst also respecting the human rights of the child would support the Children Act's emphasis upon recognition of the child as an individual, not just a 'clinical problem[] with a collection of symptoms'.¹⁰⁷ All children have independent interests under the Article 8 right to respect for private and family life, to respect for physical, bodily and personal integrity, which may need to be balanced with the parental right to respect for private and family life. Interference with either will require justification. Decisions about the medical treatment of a child may engage the child's Article 2 right to life which places upon public authorities a negative obligation and a positive obligation to do 'all that can be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge'.¹⁰⁸ Consideration of the rights of the child alongside his or her welfare, therefore,

¹⁰⁶ Law Commission, *Review of Child Law: Guardianship and Custody*, No 172, 1988, 1.5.

¹⁰⁷ *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, CM5207(1), July 2001, ch.23, paras.1-2.

¹⁰⁸ *Osman v United Kingdom* [1999] 1 FLR 193, [116], *An NHS Foundation Hospital v P* [2014] EWHC 1650, [15], Andrew Bainham, 'Can we Protect Children and Protect their Rights? (2002) 32 Family Law 279.

would ensure that the individual interests of all involved are identified, evaluated and any interference justified in the discharge of professional duties whether healthcare professional, Trust manager or judge.¹⁰⁹ The conclusion of the ECHR in *Glass v UK* (noted above),¹¹⁰ may have afforded sufficient protection to the rights of the child on the facts of that case in which the mother refused her consent to palliative care in preference for active treatment for her child, rejecting the medical view that he was dying. But what of the rights of the child in the situation where a parent is refusing to allow doctors to provide recommended treatment to their child, delaying treatment, or threatening to remove the child from hospital to avoid treatment? Although the application of the HRA to children's healthcare is not the purpose and is beyond the scope of this article, it is acknowledged that to read the provisions of the Children Act in light of the obligations imposed by the HRA would support a child-centred approach which protects the welfare and interests of the individual child whilst recognising relationships of care.

A Parental Responsibility for Children's Healthcare

The law imposes a duty upon anyone caring for children, and not just those with parental responsibility, to seek medical advice. Failure to do so, deliberately, recklessly or due to a lack of care whether assistance is required¹¹¹ can amount to the criminal offence of child neglect¹¹² and, if the child dies, to murder or manslaughter.¹¹³ This reflects the particular vulnerability of children and the state's interest in ensuring the wellbeing of children by putting those caring for children under a duty to act, in this context to secure medical assistance, as

¹⁰⁹ Jane Fortin, *Children's Rights and the Developing Law*, (CUP, Cambridge, 2009) 363-371.

¹¹⁰ *Glass v United Kingdom* (2004) 39 EHRR 15.

¹¹¹ *R v Sheppard* [1981] AC 394, 418.

¹¹² Children and Young Persons Act 1933, s.1(2), failure by the child's parent, legal guardian or other person 'legally liable to maintain a child' to provide, or to take steps to procure medical aid, amounts to the offence of child neglect in s.1(1). This section also makes it an offence for a person over the age of 16 with responsibility for the child to wilfully assault, ill-treat, neglect, abandon or expose in a manner likely to cause unnecessary suffering or injury to health. *R v Hayles* [1969] 1 QB 364; *R v Wills* [1990] Crim L R 714.

¹¹³ *R v Harris and another* 23 BMLR 122, 1994.

well as a duty to take care when acting. The vast majority of parents or carers of children will seek medical assistance for the child in their care not to avoid criminal sanctions but because they are concerned for the life, health and wellbeing of their child. The offence will become relevant in those cases where parents fail to seek, or avoid, medical care, not where those with responsibility to provide care disagree about which treatment is best for the child. Consistent with the criminal law provision, s.3(5) permits anyone in whose care a child is to 'do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare', enabling them to make necessary decisions where they have to be made before the person with parental responsibility can be contacted. The Law Commission gave the example that this would permit someone caring for a child whilst his or her parents were on holiday to ensure the child received treatment following an accident, but it would not permit them to arrange major elective surgery.¹¹⁴

The Law Commission considered that framing the legal relationship between parent and child in terms of responsibility would 'reflect the everyday reality of being a parent',¹¹⁵ focused upon the practicalities of caring for children and 'taking responsibility for the safety, nurture and upbringing of the child'.¹¹⁶ The change in the discourse from parental rights was to reflect the 'practical reality' that caring for children is a 'serious responsibility' rather than a theoretical exercise of rights.¹¹⁷ The Law Commission expressed this in strident terms: 'Parental responsibility should mean what it says. The power to control a child's upbringing should go hand in hand with the responsibility to look after him or to at least see that he is properly looked after.'¹¹⁸

¹¹⁴ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 2.16.

¹¹⁵ *Ibid.*, 2.4.

¹¹⁶ Baroness Brenda Hale of Richmond, 'Family Responsibility: Where are We Now?' in Jo Bridgeman, Heather Keating and Craig Lind (eds), *Taking Responsibility, Law and the Changing Family*, Ashgate, 2011, 25-35, 26.

¹¹⁷ Brenda Hoggett, 'The Children Bill: The Aim' [1989] *Family Law* 217-221, 217.

¹¹⁸ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 2.23.

Parental responsibility is defined in s.3(1) of the Children Act as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property.'¹¹⁹ The concept thus encapsulates the entire 'bundle of duties towards the child with their concomitant powers and authority over him together with some procedural rights to protection from interference'¹²⁰ variously expressed in different legislative provisions. Parental responsibilities change according to needs and circumstances and, as in *Gillick*, with the age and maturity of the child.¹²¹ It is parental responsibility which gives the holder the duty, powers and authority to provide day-to-day care and to make major decisions concerning a child's health and wellbeing from a visit to the GP for treatment for a persistent cough, to making decisions about a child's treatment for cancer, to agreeing to the cessation of active treatment and the provision of palliative care to a child with a life-limiting condition. The Children Act left it to the courts to consider what the concept of parental responsibility means in the variety of instances in which it might apply. Yet, with respect to a child's medical treatment, the courts have retained the legal discourse of parental responsibility as a right and duty¹²² and have not examined what differences, to parental duties, result from the introduction of the concept of parental responsibility. What can we say of parental responsibility for children's health from other cases concerning parental responsibility?

For many children there will be two holders of parental responsibility, their biological parents.¹²³ Amendments to the Children Act in the intervening years enable step-parents and civil partners to acquire parental responsibility¹²⁴ and enact specific rules for children born following assisted reproduction.¹²⁵ Reflecting the principle that the key purpose of parental

¹¹⁹ It was accepted in *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 78, that decisions about a child's medical treatment come within parental responsibility.

¹²⁰ Brenda Hoggett, 'The Children Bill: The Aim' [1989] Family Law 217, 217.

¹²¹ Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 2.3-2.6.

¹²² *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 178.

¹²³ Automatically vested in the child's mother and husband, Children Act 1989 ss.2(1); 2(2); Acquired by the unmarried father, Children Act 1989, s.4.

¹²⁴ Children Act 1989, ss.4(A).

¹²⁵ Children Act 1989, ss.2(1A); 4ZA.

responsibility is to enable the holder to care for the child, the Children Act provides for others to acquire parental responsibility, for example, where a Child Arrangements Order has been made naming a child's grandparents as the persons with whom she shall live they will also have parental responsibility for her, whilst the order is in force, to enable them to care for her including full authority with respect to decisions about her medical treatment. When the court makes an order which confers parental responsibility upon an adult it may place limits upon its scope. In *Re D (Contact and Parental Responsibility: Lesbian Mothers and Known Father)*, Black J made a Parental Responsibility Order in favour of D's biological father; D's biological mother and her partner already had parental responsibility. The judge also placed conditions, which the father had proposed, upon the order including that he would not contact any health professional involved in 5 year-old D's care for juvenile idiopathic arthritis without the prior written consent of her mothers. In return, her mothers were expected to keep him informed about the medical issues concerning D.¹²⁶ Similarly, limits were placed upon the mother's exercise of her parental responsibility when the judge made private law orders determining a number of issues about the post-separation parental care of four year-old, N. The judge ordered that should a blood transfusion or any other medical treatment be recommended for N when he was in his mother's care, the mother, who was a Jehovah's Witness, should provide the contact details of the father and inform the medical professionals and authorities of his ability to consent.¹²⁷ In both cases, limits were placed upon the exercise of parental responsibility in the interests of the welfare of the child.

Section 2(5) of the Children Act provides that there can be more than one holder of parental responsibility with respect to a child at any time, enabling, for example, the child's father to agree to the x-ray of a suspected broken limb in the absence of the child's mother. Parental responsibility is therefore often shared and a parent does not lose parental responsibility

¹²⁶ *Re D (Contact and Parental Responsibility: Lesbian Mothers and Known Father)* [2006] EWHC 2.

¹²⁷ *Re N (A Child: Religion: Jehovah's Witness)* [2011] EWHC 3737.

where another acquires it through agreement or court order.¹²⁸ The discharge of some or all of their responsibilities may be delegated to another holder, other individuals or agencies such as schools, holiday clubs or the local authority.¹²⁹ This permits someone without parental responsibility, say a child's grandmother, who looks after the child whilst her parents are at work, for example, to take the child to the GP and to administer antibiotics prescribed for an ear infection. But parental responsibility cannot be surrendered or transferred to another, it ends only with an adoption or parental order (following a surrogacy agreement), when the child reaches the age of 18, or upon the death of child or holder of parental responsibility.¹³⁰

To enable the care of children, s.2(7) provides that each holder of parental responsibility can, unless legislation provides otherwise, exercise it independently. Through case law, the courts have added to these exceptions ritual male circumcision and immunisation against infectious diseases. The law gives parents 'a large measure of autonomy in the way in which they discharge their parental responsibilities'¹³¹ so that, where holders of parental responsibility are agreed, the former is not prohibited and the latter is not compulsory. But, in the event of a disagreement amongst holders of parental responsibility, the matter must be referred to court for either a Specific Issue Order or Prohibited Steps Order.

The approach adopted by the courts to the resolution of parental disagreements over the 'preventative healthcare' issue of immunisation against infectious diseases originates in the judgment of Sumner J in *Re C*, approved on appeal.¹³² Applying the welfare checklist, Sumner J first considered the medical evidence in relation to each vaccination, the wishes of 10 year-

¹²⁸ Children Act 1989, s.2(6).

¹²⁹ Children Act 1989, s.2(9), Although such an arrangement does not affect the liability of the holder of parental responsibility for failure to meet any aspect of responsibility for the child, s.2(11); Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 2.13.

¹³⁰ *JS v M & F* [2016] EWHC 2859.

¹³¹ *Regina v Secretary of State for Education and Employment and Others* [2005] UKHL 15, [72].

¹³² *Re C (A Child) (Immunisation: Parental Rights)* [2003] EWHC 1376 upheld on appeal *B (Child)* [2003] EWCA Civ 1148. Other cases concern disputes between parents and the local authority which shares parental responsibility of children in care, *LCC v A and others* [2011] EWHC 4033; *London Borough of Brent v AL and others* [2017] EWHC 125.

old F, whilst ‘largely discounting’ those wishes because she would accept the decision of the court, and the harm each child was at risk of suffering if they remained unvaccinated. Further, Sumner J considered the children’s emotional needs, recognising the risk of a damaging effect upon the bond between primary carer and the child of immunisation against the committed values of the primary carer. Whilst recognising that the application was an ‘affront to the beliefs’ of the mother of 4 year-old C, who adopted natural parenting and holistic health, Sumner J determined that a programme of vaccinations was in the best interests of both children. In *F v F*,¹³³ Thesis J emphasised that parents are encouraged to agree on the issue of immunisation, an exercise of parental responsibility usually ‘negotiated’ between the parents and then put into effect. The judge stressed that it would have been best for the children had the parents reached an agreement but, as they had been unable to, it had fallen to the court to decide in the welfare interests of each child. As the court had now exercised judgment on that issue of parental responsibility, it was incumbent upon the parents to ‘exercise their parental responsibility in the light of the court’s decision’ to ‘ensure that the consequences of the court’s decision will be managed in a responsible way.’¹³⁴ The application of the welfare principle has been criticised in these cases. Richard Huxtable has argued that immunisation is a public health issue which may be considered to be of greater benefit to society more generally rather than in the interests of the individual child. Whilst Emma Cave has argued that insufficient respect was given to the views of the older children.¹³⁵ However, as one of the few examples of s.8 orders with respect to children’s health, these cases do show the potential, as yet unrealised, for placing decisions within the context of the realities of parenting and for the development of a principled approach to the limits of freedom in the exercise of parental responsibility through a wider view of the welfare of the individual child.

¹³³ *F v F* [2013] EWHC 2683.

¹³⁴ *Ibid.*, [22].

¹³⁵ Richard Huxtable, ‘*Re C (A Child) (Immunisation: Parental Rights)*’ [2003] EWCA Civ 1148’ (2004) 26 *Journal of Social Welfare and Family Law* 69-77; Emma Cave, ‘Adolescent Refusal of MMR Inoculation: *F (Mother) v F (Father)*’ (2014) 77 *MLR* 630–640.

Where clinically indicated the courts have been prepared to authorise male circumcision, whilst requiring the procedure to be performed in hospital and any 'religious ceremonies' observed to be 'consistent with the practice at the hospital.'¹³⁶ As a consequence of the freedom parents have to raise their children according to their values and beliefs, as Sir James Munby observed in *Re B and G (Children)*, non-therapeutic male circumcision performed for 'social, societal, cultural, customary or conventional' reasons is tolerated as within the sphere of 'reasonable' parenting.¹³⁷ But where an irreversible operation is not medically necessary it should only be carried out with the agreement of both parents or upon the authority of the court.¹³⁸ Where parents disagree and the child is experiencing two religious upbringings which adopt different stances on the issue, the principles of the Children Act require the court to adopt a child-centred approach which does not assume that the child will share the views of either parent. The court will give weight to the welfare and the developing capacity of the child respecting the child as an individual who will develop his or her own values and beliefs and decisions made now should respect their freedom to do so. That may lead to the conclusion there should be no order, leaving the decision to the child once they have the maturity to make their own choice according to their own values.¹³⁹

Subsequent to the Children Act but following *Re B (1988)* (above), Peter Singer QC said in *Re HG* that, 'one of the responsibilities incorporated into the definition of parental responsibility is a responsibility to bring before a High Court judge the question whether your child should be sterilised'.¹⁴⁰ Confined to non-therapeutic sterilisation¹⁴¹ parents freedom to exercise their

¹³⁶ *T v S (Wardship)* [2011] EWHC 1608.

¹³⁷ *Re B and G (Children)(No 2)* [2015] EWFC 3, [61], [72].

¹³⁸ *Re J (A Minor) (Prohibited Steps Order: Circumcision)* [2000] 1 FLR 571, dismissing appeal from *Re J (Specific Issue Orders: Muslim Upbringing and Circumcision)* [1999] 2 FLR 678, *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282, *Re S (Change of Names: Cultural Factors)* [2001] 2 FLR 1005.

¹³⁹ *Re L and B (Children)* [2016] EWHC 849, [143]; *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282, [83].

¹⁴⁰ *Re HG (Specific Issue Order: Sterilisation)* [1993] 1 FLR 587, 595.

¹⁴¹ *Re E (A Minor) (Medical Treatment)* [1991] 2 FLR. 585.

parental responsibility is thus limited in the interests of child welfare. The willingness of the courts to give authority, justified in terms of protection and care, has been subjected to much criticism.¹⁴² Although the more cautious approach subsequently established by the Court of Appeal in two cases concerning adults, *Re A* and *Re SL*,¹⁴³ must be equally applicable to children. The guidelines or safeguards which the case of *Re D* had demonstrated a need for did not materialise. Had these cases come before the courts in applications for s.8 orders, a careful application of the principles and concepts of the Children Act may have ensured a child-centred approach which may have recognised the need for the state to work together to support parents of children with learning difficulties rather than sterilise them in their efforts to care.

Unlike preventative healthcare and non-essential, non-therapeutic, procedures the provision of medical treatment recommended by responsible physicians does not require the agreement of all holders of parental responsibility. Disagreement *between* parents about a child's medical treatment may present the doctor with a professional, or ethical, dilemma but no legal issue, as long as consent is provided by one person with authority to do so, treatment will not amount to a civil or criminal battery.¹⁴⁴ In *An NHS Trust v SR*, Bodey J observed that the Trust need not have applied to court for authority to administer conventional radiotherapy and chemotherapy in the post-operative treatment of medulloblastoma, given the consent of Neon's father. Although the judge recognised that, where parents are not agreed on treatment for a serious medical condition, an application by the Trust to court is understandable.¹⁴⁵ The mother was vehemently opposed to the conventional treatment, which carried risks of serious and life-altering side effects, preferring alternative and complementary therapy. To ensure

¹⁴² See for example, Kirsty Keywood, 'Hobson's Choice: Reproductive Choices for Women with Learning Difficulties' (1998) 17 *Medicine and Law* 149-165.

¹⁴³ *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549; *Re SL (adult patient: medical treatment)* [2000] 2 FLR 452. The question should first be asked whether contraception is necessary because the individual is engaging in consensual sexual activity and then whether less invasive methods have been attempted or are suitable.

¹⁴⁴ *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190, 196.

¹⁴⁵ *An NHS Trust v SR* [2012] EWHC 3842, [2].

that those treating Neon had confidence in their ability to administer the treatment he required, Bodey J included in the orders authority for treating clinicians to act on the consent of the father alone, provided that the issue had been discussed with the mother where reasonable and practicable.¹⁴⁶ Appreciating the stress for the mother of the court proceedings and that she had previously ‘panicked’ and disappeared with Neon, the court placed limits on the mother’s exercise of her parental responsibility through the use of orders aimed at clarifying the father’s authority in the interests of the welfare of the child.

As *Gillick* established, and as Ward LJ emphasised in the post-Children Act case of the conjoined twins,¹⁴⁷ parental rights are enjoyed to enable parents to fulfil their duties to their children,¹⁴⁸ and must be exercised for the welfare of the child.¹⁴⁹ As Lord Scarman explained in *Gillick*, the welfare, or best interests, principle acts as a guide for the actions and decisions of parents and court alike:

[W]hen a court has before it a question as to the care and upbringing of a child it must treat the welfare of the child as the paramount consideration in determining the order to be made. There is here a principle which limits and governs the exercise of parental rights of custody, care and control. It is a principle perfectly consistent with the law’s recognition of the parent as the natural guardian of the child: but it is also a warning that parental right must be exercised in accordance with the welfare principle and can be challenged, even overridden, if it be not.¹⁵⁰

As the Law Commission stated, parents cannot ‘insist upon action which is contrary to or resist action which will promote’ the welfare of the child,¹⁵¹ they are required to ‘adopt a child centred approach to their responsibilities in meeting the child’s welfare’.¹⁵² Parental responsibility is

¹⁴⁶ *Ibid.*, [28].

¹⁴⁷ *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 178.

¹⁴⁸ *Gillick v West Norfolk and Wisbech Area Health Authority and another* [1986] AC 112, 170, Lord Fraser.

¹⁴⁹ *Ibid.*, 184, Lord Scarman.

¹⁵⁰ *Gillick v West Norfolk and Wisbech AHA and another* [1985] 3 WLR 830, 845.

¹⁵¹ Law Commission, Consultation Paper No.91, *Guardianship*, 1985, 1.11.

¹⁵² *Re C (Children)* [2016] EWCA Civ 374, King LJ, [43], quoting Sharpe J in the Family Court.

thus primarily responsibility *to* the child.¹⁵³ Of course, day-to-day decisions will not all be made always to optimise a child's welfare, or alternatively, in relation to day-to-day matters the optimisation of the interests of the child includes balancing the interests of relevant others.¹⁵⁴ Most parenting and care of a child's health and wellbeing takes place in the home where parents are at liberty to make decisions about matters such as diet, exercise, care of a child's emotional wellbeing, use of natural, alternative or complementary medicines. But beyond everyday illnesses and cuts and bruises, a parent who has concerns about a child's health will seek advice from primary healthcare services and where the child's condition is serious be referred for specialist care. In such circumstances, the welfare of the seriously ill child will be the focus of parental concern. Parental responsibility with respect to their child's health is fulfilled by seeking the assistance of experts and by making decisions about the treatment the child will receive considering the information and advice provided by those with medical expertise; professionals who also have legal duties to the child. The provision of healthcare to young children is thus dependent upon a partnership between parents who have unique knowledge and expertise in the individual child¹⁵⁵ and professionals with medical expertise.

In the article quoted above, McFarlane LJ observed that inherent within the responsibility of the parent to do their best to meet the needs of the child is, where parental responsibility is shared, the responsibility to respect the rights of the other.¹⁵⁶ It is not uncommon in private law proceedings under the Children Act for the judge to urge parents to try, in the interests of the welfare of the child, to reach an agreement. In the context of medical treatment, fulfilment of parental responsibilities to their child requires parents to work together making decisions

¹⁵³ Law Commission, Working Paper No.96, *Custody*, 1986, 7.16.

¹⁵⁴ More along the lines of the relationship-based welfare advocated by Jonathan Herring, Jonathan Herring, 'Farewell Welfare?' (2005) 27 JSWFL 159-171; Jonathan Herring, 'The Human Rights Act and the welfare principle in family law – conflicting or complementary?' (1999) 11 CFLQ 223; Jonathan Herring and Charles Foster, 'Welfare means relationality, virtue and altruism' (2012) 32 Legal Studies 480-498.

¹⁵⁵ Priscilla Alderson, 'Consent to Children's Surgery and Intensive Medical Treatment' (1990) 17 Jo of Law and Society 52-65, 61.

¹⁵⁶ The Right Honourable Lord Justice McFarlane, 'Making Parental Responsibility Work' [2014] Fam Law 1264-1276.

about the best interests of the child. But further, parental responsibility *to* their child requires parents to respect the co-existing duties of healthcare professionals and public authorities and places them under a duty to work together in the welfare of the child. In the vast majority of cases parents will work together in partnership with healthcare professionals appreciating their dependency upon them to ensure that their child receives the medical care they require. But where parents disagree with professionals about the best interests of their child they may need to be reminded of the importance of working together with professionals in the partnership of care. Bodey J in *An NHS Trust v SR* expressed the hope that Neon's mother would accept the decision of the court and 'support him through the very difficult times ahead. N clearly needs both his parents to be pulling together alongside the treating team and nothing could be worse than for him to pick up on any sense of maternal opposition to the treatment.'¹⁵⁷ This is reflected also in the comments of Butler-Sloss LJ in *Re C (HIV)* (above), the emphasis upon the clinical purpose of consent ensuring the confidence and commitment of the patient or their carer to the proposed treatment emphasised in *Re T*¹⁵⁸ and behind the words of Hedley J when he urged Charlotte Wyatt's parents to 'seize this opportunity constructively to build upon their trust and confidence in Dr 'K' and the staff who have committed themselves in such exemplary fashion to her case'.¹⁵⁹ As McFarlane LJ said, "the courts are entitled to look to each parent to use their best endeavours to deliver what that child needs, hard or burdensome or downright tough though that may be'.¹⁶⁰ Parents have a responsibility *to* their child to respect the legal duties of healthcare professionals and to work together with professionals in a partnership of care for the child.

B Parent/Professional Partnership in the Provision of Healthcare to Children

¹⁵⁷ *An NHS Trust v SR* [2012] EWHC 3842, [22].

¹⁵⁸ *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242, 252, Butler-Sloss LJ quoting *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 76.

¹⁵⁹ *Portsmouth NHS Trust v Wyatt* [2005] EWHC 2293, [42].

¹⁶⁰ The Right Honourable Lord Justice McFarlane, 'Making Parental Responsibility Work' [2014] Fam Law 1264-1276, 1270.

Stephen Gilmore has argued that *Gillick* established that the limits of parental discretion are set by both the welfare of the child and when their protective role can be abandoned because the child has the capacity to exercise independent judgment to consult with healthcare professionals.¹⁶¹ In the same way, with respect to young and dependent children, the limits of parental discretion are, I argue, set by the duty to work together in the best interests of the child with professionals in the fulfilment of their legal duties to children in their care framed at the boundaries by the ordinary principles of criminal and civil law supplemented by standards of professional conduct.¹⁶²

The House of Lords in *Gillick* recognised that there would be circumstances in which doctors would be justified in treating a child without the consent of someone with authority. Notably, Lord Scarman referred to 'exceptional situations' such as 'emergency, parental neglect, abandonment of the child, or inability to find the parent' when the doctor would be justified in providing treatment without the knowledge or consent of the child's parents.¹⁶³ Lord Templeman recognised that it may not be possible to obtain a court order prior to the provision of emergency treatment necessary for the survival or health of a child without parental consent. In such circumstances, his Lordship said, the doctor should have the 'courage of his convictions' that the treatment is 'necessary and urgent'. Professional legal duties to the child take precedence. If need be, the court *will* 'approve after the event treatment which the court would have authorised in advance'.¹⁶⁴

Gillick precedes the Children Act and it is possible that s.3(5) could be relied upon to justify the provision of treatment without parental consent, although with few cases of a child's medical treatment directly informed by the Children Act there is no direct authority that it

¹⁶¹ Stephen Gilmore, 'The Limits of Parental Responsibility' in in Rebecca Probert, Stephen Gilmore and Jonathan Herring (eds), *Responsible Parents & Parental Responsibility*, (Hart, Oxford, 2009), 63-83, 63.

¹⁶² *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 76, 78.

¹⁶³ *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, 189, Lord Scarman.

¹⁶⁴ *Ibid.*, 200, Lord Templeman.

extends to such circumstances. In *R (on the application of G) v Nottingham City Council*,¹⁶⁵ Munby J said, obiter, that s.3(5) may justify medical treatment of a child without parental consent or a court order in an emergency to prevent irreversible harm and ‘if parents are acting unreasonably or contrary to the child’s best interests, even despite a parental refusal of consent’.¹⁶⁶ In other circumstances, healthcare professionals require the consent of someone with parental responsibility or the authority of the court before administering medical treatment to a child in their care. Legally consent is the ‘flak jacket’ which protects the doctor from claims by the litigious’.¹⁶⁷ Consent provides the doctor with the authority to provide the proposed treatment without requiring them to if, in their professional judgment, it is no longer in the child’s best interests. Consent does not impose an obligation to treat.¹⁶⁸ Professional judgement still needs to be exercised.

Healthcare practitioners have legal duties of care to act in ‘accordance with good medical practice recognised as appropriate by a competent body of professional opinion’¹⁶⁹ in diagnosis, identification of treatment options and treatment. They have a duty to provide information about the ‘material risks’ of significance to the reasonable parent in the position of the parent or of which the doctor is, or should reasonably be, aware that the particular parent is likely to attach significance.¹⁷⁰ In his October 2005 judgment concerning the medical treatment of Charlotte Wyatt, Hedley J considered an application by her parents, given evidence of improvement in her condition, for a discharge of the declaration which authorised withholding of ventilation and an application by the Trust for a declaration that in the event of an irreconcilable difference her doctors should decide about her treatment. Discharging the declaration, Hedley J was concerned to explain the nature and limits of the duties of doctors. The judge emphasised that the doctor’s duty is to the patient. Doctors have a ‘professional

¹⁶⁵ *R (on the application of G) v Nottingham City Council* [2008] EWHC 152.

¹⁶⁶ *Ibid.*, [25-26].

¹⁶⁷ *In Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1993] Fam 64, 78.

¹⁶⁸ *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190, Lord Donaldson MR, 196.

¹⁶⁹ *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33, 40.

¹⁷⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [87].

duty' to act in the best interests of the child¹⁷¹ and advise parents accordingly about the medical facts and the decision to be made.¹⁷² Fulfilment of the doctor's duty, in turn, enables parents to fulfil their duty to consent to the medical treatment from the range of clinically indicated alternatives which, in their evaluation, is in the best interests of their child.

Further, Hedley J stressed that it is the responsibility of doctors to work in partnership with the child's parents.¹⁷³ Reflective of the principles and concepts of the Children Act, this view was informed by the 1990 case of *Re J* in which the Court of Appeal considered an appeal by the Official Solicitor against the decision of Scott Baker J authorising the hospital to withhold mechanical ventilation from Baby J in the event that he stopped breathing. Ordinarily, Lord Donaldson MR observed, the care and treatment of a child would be 'discussed and decided by the doctors in consultation with the parents.'¹⁷⁴ An effective partnership, he considered, would mean that parents would have confidence in the doctors, that doctors would recognise the agonising dilemma of the parents and take the time required to explain the limited options available leading to agreement on the appropriate course of action. Doctors are under a 'responsibility to work in partnership with parents'¹⁷⁵ through a process of discussion and negotiation, to agree a treatment plan reflecting their parental and professional judgment of the best interests of the child accommodating parental wishes as far as 'professional judgment and conscience' allows.¹⁷⁶ In other words, the partnership between parents and professionals is framed by the responsibility of parents to their child and the legal duties of professionals to the child in their care requiring them to work together to determine what is best for the child. Together, the child's parents and treating team have the knowledge, expertise and skills with respect to the specific needs of the particular child arising from their respective roles, responsibilities and relationships with the child. Working in partnership requires a professional

¹⁷¹ *Portsmouth NHS Trust v Wyatt* [2005] EWHC 2293, [29].

¹⁷² *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 78.

¹⁷³ *Re Wyatt (a child) (medical treatment: continuation of order)* [2005] EWHC 2293, [29].

¹⁷⁴ *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33, 39.

¹⁷⁵ *Portsmouth NHS Trust v Wyatt* [2005] EWHC 2293, [29].

¹⁷⁶ *Ibid.*, [41].

response to a deteriorating relationship, breakdown in trust or parental disengagement. Communication is essential. A principle of the Children Act is that court orders should be avoided if at all possible. When professionals disagree with parental decisions about what is best for the child, they should first seek to ensure that the parents understand the facts and that they understand the reasons for the parental view. Where there is disagreement, fulfilment of professional duties may require doctors to engage in further discussion, secure second opinions, involve support and advocacy services, or ethical and religious advisors in the attempt to reach agreement on the best interests of the child. Parents cannot insist on treatment, and doctors can refuse treatment which they consider to be medically contra-indicated or which they cannot conscientiously administer.¹⁷⁷ A doctor cannot be required to act contrary to his or her professional conscience.¹⁷⁸ Hedley J explained that this requires the doctor to consider all the circumstances, professional guidance, second opinions and arrive at an intellectual conclusion 'honed by experience of patients, exposure to the practice of colleagues, and the ethos of his work.'¹⁷⁹ Whilst there is no concept of professional responsibility comparable to parental responsibility, healthcare professionals have legal duties to the child, derived from common law, to be exercised in accordance with their clinical judgment and professional conscience. The Children Act principle of working together to support parents to fulfil their parental responsibilities and the principle of adopting the least interventionist approach places Trusts under an obligation to support professionals to attempt to resolve disagreements with parents over what is best for the child.

C *Working Together in the Provision of Healthcare to Children*

The emphasis given in the case law to the parental right to decide about their children's medical treatment and, where a difference of opinion develops into an intractable conflict, the

¹⁷⁷ *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33, 40, Lord Donaldson MR.

¹⁷⁸ *Portsmouth NHS Trust v Wyatt* [2005] EWHC 2293, [32].

¹⁷⁹ *Ibid.*, [34-5].

duty of the public authority to seek an independent assessment of the child's best interests by the court¹⁸⁰ fails to reflect foundational principles of the Children Act. That is, the responsibility upon the state 'to help rather than to interfere'¹⁸¹ with the fulfilment of parental responsibility, and upon public bodies to work together to try to prevent the need for compulsory action, adopting the least interventionist approach consistent with protection of child welfare, seeking court orders only where necessary. Whilst parental responsibility is primary, it co-exists with the responsibilities of the state to children through public protection of their welfare.

Where parental refusal to consent to proposed treatment cannot be resolved by the treating team, the focus of the Trust must be upon their obligation to, as the ECtHR said in *Glass*, 'take the initiative and to defuse the situation'.¹⁸² And, although in the context of the present legal framework for decision-making, the ECtHR held that the Trust could have brought the matter to court, the ECtHR also observed that the Trust had involved the police in their attempts to persuade the mother, which is hardly an effective prescription for reaching an agreement between diametrically opposed views. Research has demonstrated that a developing conflict between parents and professionals not only risks damaging the relationship between them upon which the care of the child depends but escalation can result in the conflict becoming the centre of attention rather than the child.¹⁸³ The principles of the Children Act place the Trust under a duty to support the partnership of care, seek to defuse the situation, and to attempt to resolve the disagreement in the interests of the child whose treatment is at issue. This could be by facilitating further communication between parents and professionals, directing parents to reliable sources of independent advice, or to counselling services, or ensuring they get support from PALS, ethical or religious advisors. It may secure a second

¹⁸⁰ *Glass v United Kingdom* (2004) 39 EHRR 15, [79], the hospital notes referred to in the judgment of the ECtHR make numerous references to seeking legal advice and referring the dispute to court.

¹⁸¹ Brenda Hoggett, 'The Children Bill: The Aim' [1989] Family Law 217, 217.

¹⁸² *Glass v United Kingdom* (2004) 39 EHRR 15, [79].

¹⁸³ Liz Forbat, Bea Teuten and Sarah Barclay, 'Conflict escalation in paediatric services: findings from a qualitative study' (2015) Arch Dis Child, doi:10.1136/archdischild-2014-307780.

opinion, and explore whether consideration by the Clinical Ethics Committee, mediation or other alternative dispute resolution may resolve the disagreement. Working together in the interests of the welfare of the child, parents, professionals and the Trust have an interest in agreeing the way forward seeking to avoid the need to refer the question of the best treatment for a child to the court in potentially divisive, stressful, legal proceedings.

In *King*, echoing the language of the Children Act provisions concerning compulsory state intervention, Baker J said,

‘the State – whether it be the court, or any other public authority – has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child not being what it would be reasonable to expect a parent to give.’¹⁸⁴

Whilst Baker J rightly observed that there is a threshold to be crossed before the state can intervene, he was here referring to the terms of the threshold for considering Care or Supervision Orders set out in s.31(2) rather than requirements for leave to apply for a Specific Issue or Prohibited Steps Order or even the restrictions upon applications from the local authority for leave for the court to exercise its inherent jurisdiction.¹⁸⁵ In the vast majority of cases, the specific issues of unresolved disagreement between ‘caring, committed and capable’¹⁸⁶ parents and professionals concerning the child’s medical treatment, particularly where the child’s condition requires hospitalisation and the disagreement relates to aspects of

¹⁸⁴ *In the Matter of Ashya King* [2014] EWHC 2964, [31].

¹⁸⁵ The threshold to be satisfied before the court can consider making a Care Order, Supervision Order or Interim Orders which is set out in s.31(2) and provides, ‘A court may only make a care order or supervision order if it is satisfied - (a) that the child concerned is suffering, or is likely to suffer, significant harm; and (b) that the harm, or likelihood of harm, is attributable to - (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or (ii) the child’s being beyond parental control.’ The threshold for an Emergency Protection Order is set out in s.44(1). If the threshold is met, the court must consider the welfare principle, welfare checklist and no unnecessary order principle.

¹⁸⁶ *Re O (A Minor) (Medical Treatment)* [1993] 2 FLR 149.

that treatment, or disagreement over alternatives, or whether it is time to move to a more aggressive form of treatment, can be resolved by an application by the Trust for a Specific Issue or Prohibited Steps Order. The potential benefits of applications for section 8 orders over the exercise of the court's inherent jurisdiction are considered below.

Securing the medical treatment a child requires may be more complex where treatment for the child's medical condition does not require permanent hospitalisation, although this can still be achieved through the Children Act. This can be illustrated with the examples of the disagreement over the post-operative treatment following surgery to remove a medullablastoma for seven year-old Neon Roberts and five year-old Ashya King. In both cases, an application to resolve the disagreement could have been made by the Trust for a Specific Issue Order. However, in both cases the hospital responded to the removal of the child from care at a time when post-operative treatment had become urgently necessary, by his mother in Neon's case and parents in Ashya's case. As they were missing the order for Neon's mother to attend court for the hearing on his post-operative treatment could not be served. The court made an Interim Care Order. When located, Neon was briefly placed in foster care until he could be returned to the care of his father and the order was discharged. Ashya King's parents removed him from Southampton General, taking him to Spain with the intention of raising the money to pay for Proton Beam Therapy in Prague. They explained that the relationship with his treating doctors had broken down and they believed that if they continued to question the treatment being offered to him the Trust would seek an Emergency Protection Order.¹⁸⁷ These cases thus raise the question of the use of the compulsory public law powers for child protection in cases in which parents are seeking the best medical treatment for their child but acting in a way which, objectively, appears misguided and putting

¹⁸⁷ Naveed King, 'Real Story of Ashya King', www.youtube.com/watch?v=14ETQn9ZPwk, posted 30 August 2014, [last accessed 9/1/17]. Baker J was unable to find on this disputed fact, *In the Matter of Ashya King* [2014] EWHC 2964, [12]. Although as Johnson J observed in *Re O*, above, it is difficult to see how the threshold requirements would be satisfied.

the child at risk of harm. The interests of the child lie in receiving the required medical treatment best secured through the co-operation of the child's parents.

Where the welfare of the child requires state intervention in family life, the principles of the Children Act require the adoption of the least interventionist means necessary. An Interim Care Order is, along with an Emergency Protection Order, a Supervision Order and a Care Order, an order made in the exercise of the public law provisions under the Children Act permitting compulsory intervention of the state, through the local authority child protection powers. Care Orders confer parental responsibility upon the local authority and, although the parents retain parental responsibility, the local authority has both the power to make decisions about the child's upbringing and to determine the extent to which the parents may meet their parental responsibility.¹⁸⁸ Consideration of care proceedings is appropriate where there are 'broader welfare considerations', which may involve issues of medical treatment as part of a care plan, but care proceedings are not the appropriate mechanism through which to secure medical treatment which the local authority considers is in the best interests of the child in circumstances where the Trust declines to intervene or issue a summons.¹⁸⁹ Neither are care proceedings the mechanism through which to secure the medical treatment proposed by professionals to which parents are in disagreement.¹⁹⁰ As the court recognised in *Re C*,¹⁹¹ the threat of care proceedings may undermine trust and the 'co-operative relationship' between the healthcare professionals and parents working together to care for the child.¹⁹² Threats of child protection proceedings will not defuse the situation. Such threats are more likely, as they did in the *King* case, to close down communication, further erode trust and

¹⁸⁸ Children Act, 1989, s.2(6), s.33(3), (4).

¹⁸⁹ *Local Authority v SB & AB & MB* [2010] EWHC 1744, [15], [28], in which the local authority wanted surgery to be performed, the child's parents were not giving consent and the hospital were, at that point, prepared to explore alternatives.

¹⁹⁰ *Re O (A Minor) (Medical Treatment)* [1993] 2 FLR 149.

¹⁹¹ *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180.

¹⁹² *Re S (A Minor) (Medical Treatment)* [1993] 1 FLR 376.

precipitate the removal of a seriously ill child from hospital by his parents without the knowledge of his treating doctors.

Although Neon Roberts' mother continued to object to the administration of conventional treatment, it may be that a s.8 Residence Order (now a Child Arrangements Order) with directions as to how it was to be put into effect could have secured his return to his father's care. Where parents are seeking to do their best for the child, Care Orders, associated with neglect and harm are best avoided when, consistent with the aims of the Children Act there are less intrusive approaches by which parents can be supported to work with professionals to protect the welfare of the child. Circumstances such as developed in the *King* case, where the parents were united in their opposition and had removed him from the medical care he required may have developed into a serious situation where continued involvement of the court through wardship is appropriate, if only briefly to secure the return of the child to hospital for medical treatment. The wardship court can then make section 8 orders to secure the medical treatment the child needs.

In cases where the child's condition is chronic rather than acute and parental decisions or beliefs raise broader welfare concerns it may be appropriate, because of the obligation upon authorities to work together and to try to avoid the need for compulsory action, for the local authority to be involved. Where court orders are necessary to secure the co-operation of parents, subject to the limitations upon applications by the local authority, they may apply for leave but there needs to be a live issue which either the Trust or parents invite the court to decide.¹⁹³ The child may have ongoing medical needs making him or her a child in need, under s.17, to whom local authority has a duty to provide support. Where parents are failing to seek medical advice or not co-operating, it may be necessary for the Trust to work with the local authority and for public law orders to be employed in order to secure the co-operation of the

¹⁹³ *Local Authority v SB & AB & MB* [2010] EWHC 1744, [15].

parents such as in *Re JA* when the parents missed appointments with professionals who wished to test 14 year-old JA to determine whether he was HIV positive. Having tested HIV positive, following an order of the court made at the request of the Trust, and in the context of the need for outpatients treatment, ongoing monitoring, blood tests and chest x-rays, psychotherapy and peer support, the court concluded that the threshold criteria under s.31 were satisfied and made a Supervision Order for 12 months.¹⁹⁴ The principles of the Children Act support the use of the least interventionist approach to secure the welfare of the child with public authorities working with parents in a partnership of care.

D. A Child-Centred Approach to Children Act Orders on issues concerning Children's Healthcare

The court can make a s.8 order in any family proceedings in which a question arises concerning the welfare of the child including proceedings under the court's inherent jurisdiction,¹⁹⁵ upon application,¹⁹⁶ on the court's own volition,¹⁹⁷ or in a freestanding application by an entitled applicant or with leave.¹⁹⁸ Both Specific Issue Orders and Prohibited Steps Orders provide a 'practical answer to a practical problem', they are not concerned with the allocation of rights.¹⁹⁹ In contrast to the vague 'no important step'²⁰⁰ limitation imposed by wardship, these orders have the advantage of making the limitations on the exercise of parental responsibility clear and specific. To ensure orders are effective, the court can include directions as to how the order is to be put into effect or impose conditions to be complied with by any person with parental responsibility or anyone in whose favour the order is made, specify

¹⁹⁴ *In the Matter of JA (a minor)* [2014] EWHC 1135.

¹⁹⁵ Children Act 1989, s.8(3).

¹⁹⁶ Children Act 1989, s.10(1)(a).

¹⁹⁷ Children Act 1989, s.10(1)(b).

¹⁹⁸ Children Act 1989, s.10(2).

¹⁹⁹ Law Commission, *Review of Child Law: Guardianship and Custody*, No 172, 1988, 4.23.

²⁰⁰ *Ibid.*, 4.20.

the period of time for which the order or any provisions in it is to have effect and make such incidental, supplemental or consequential provisions as the court thinks fit.²⁰¹

In complex cases, such as that of Neon Roberts discussed above, it may be necessary for the court to make a range of orders under the Children Act to secure the medical treatment the child needs. Upon application by the Trust, Bodey J made a declaration that the treatment package proposed was lawful, authorised ancillary treatment, and treatment upon the consent of his father alone, in both cases following discussion with his mother as far as reasonable and practicable.²⁰² With reference to the “no order” principle’, the welfare of the child as the paramount consideration and the welfare checklist, Bodey J also made a Residence Order in the father’s favour and a Prohibited Steps Order preventing the mother from removing Neon from his father’s care whilst he was undergoing treatment, giving the mother reasonable contact. The proposed order that the mother hand Neon’s passport to his father was dealt with by an assurance from his mother that he did not currently have a passport and an undertaking not to apply for one without the father’s consent.²⁰³ Centred around ensuring that Neon was provided with the medical treatment he required, orders thus extended to the practical arrangements for Neon’s care, limiting the mother’s exercise of her parental responsibility and enabling his father to work in partnership with the healthcare professionals.

For disagreements between parents and healthcare professionals about a child’s medical treatment to be referred to court in an application for a Specific Issue or Prohibited Steps Order would direct the court to the fact that it is determining an issue of the exercise of parental responsibility, focusing attention upon concrete issues arising from the practical reality of caring for the child rather than legal status or theoretical rights and duties.²⁰⁴ Discharge of

²⁰¹ S.11(7).

²⁰² *An NHS Trust v SR* [2012] EWHC 3842, [23-28].

²⁰³ *Ibid.*, [29].

²⁰⁴ Lord Mackay, ‘Joseph Jackson Memorial Lecture – Perceptions of the Children Bill and beyond’ (1989) 139 NLJ 505.

parental responsibilities to the child depends upon the specific needs of the child focusing attention on the child and offering the potential for a child-centred resolution.

Court orders have the effect of modifying parental responsibility, placing limits upon its exercise in those aspects covered by the order. For example, in cases where parents are unable to agree to the administration of blood due to their religious beliefs and the court authorises the administration of blood products, the 'responsibility for consent' for that aspect of the treatment is replaced by the judicial decision.²⁰⁵ The standard order made by the courts in such cases authorises the administration of blood in an imminently life-threatening situation, otherwise requiring doctors to consult with the parents and authorising the administration of blood products if there is no 'reasonable alternative'. Further, the courts appreciate that it is not in the best interests of the child for his or her condition to deteriorate until blood can be administered in an emergency and that doctors will need to treat the child without repeated recourse to the courts. Whilst responsibility for the child's upbringing, including other aspects of his or her medical treatment, remain with his or her parents according to their sincerely held beliefs, decisions about the administration of blood are made according to clinical judgement. Section 2(8) provides that holders of parental responsibility are prevented from acting in a way which is incompatible with the order. So if the court made a Specific Issue Order, upon application from a Trust, authorising a surgical procedure in the welfare of the child, parents are prevented from removing the child from the hospital to prevent that surgery from going ahead, to do so would be incompatible with the order.²⁰⁶

When determining s.8 applications the court must apply the welfare checklist, although the court is not confined to considering these factors. The point has been made that there are

²⁰⁵ *Re S (A Minor)* [1993] 1 FLR 376, 380.

²⁰⁶ Holman J in *Re TM* [2013] EWHC 4103, expressed the view that, in an extreme situation a parent may have the right to seek to have her child removed to a different hospital for treatment, but not without very good reason, stipulate by whom within the hospital the treatment should be carried, [23].

currently limited examples of applications for Specific Issue Orders in the context of decisions concerning children's healthcare, examples which have inevitably been subjected to criticism. However, greater use of Specific Issue Orders would build up expertise in the context of children's health where application of the checklist offers the potential to widen welfare determinations beyond the current focus upon medical best interests. The aim of the welfare checklist is to focus attention upon the needs of the child.²⁰⁷ Application of the checklist thus has the potential to ensure a child-centred approach, even more so were the courts to also undertake a detailed examination of the rights of the child under the ECHR in this context. The court is required to consider, for example, the ascertainable wishes and feelings of the child in light of his or her age and understanding in order to reflect the 'increasing recognition' of the 'child's status as a human being in his own right.'²⁰⁸ Supporting children to develop independence and decision-making skills whilst protecting them from disproportionate or irreversible harm is, as Lord Donaldson put it in *Re W*, 'wholly consistent with the philosophy of section 1 of the Children Act 1989'.²⁰⁹ This must surely require the court to consider how the wishes and feelings of the child could be heard in an age appropriate way, from meeting with the child, receiving written statements, a letter or visiting the child and in the case of very young children seeking views about the child's characteristics and experiences not only from parents but also the nursing staff and other healthcare professionals involved in their day to day care.

Determining the welfare of the child in relation to their medical treatment with consideration of their current and future physical and emotional needs, their age, sex, background and relevant characteristics, and any harm the child has suffered or is at risk of suffering likewise directs the attention of the court to the individual child.²¹⁰ Importantly, in approaching questions of

²⁰⁷ Brenda Hoggett, 'The Children Bill: The Aim' [1989] Family Law 217-221, 220.

²⁰⁸ Law Commission, *Review of Child Law: Guardianship and Custody*, No 172, 1988, 3.24, quoting *Gillick*.

²⁰⁹ *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 82.

²¹⁰ Children Act 1989, s.1(3).

harm the court must be informed by the child's perspective on the nature of the harm they have experienced or are at risk of experiencing supplemented by, or in the case of younger children informed by, accounts from those who know the child best. The experiences of other children of the medical condition, its treatment and side-effects could inform the questions to be asked in order to gain understanding of the nature of the harm. .

Following *Re T* and *Re C*, the court will also consider the views of the child's parents and the effect of these views upon the treatment and care provided, including the effect upon their ability to care for the child of any emotional distress if their wishes are overridden.²¹¹ This reflects the reality of medical treatment being one moment in a past, present and future relationship of care. The attempts by the Court of Appeal in *Re T*²¹² to recognise the importance of parental care to a very young child before, during, and after, a liver transplant were rightly recognised by Marie Fox and Jean McHale as a welcome development which was not fully worked through in that case.²¹³ Addressing the reservations of parents who disagree with the treatment proposed by their child's doctors must be an important function of any resolution to secure their commitment to the treatment, confidence in, and co-operation with, professionals, and to addressing any emotional harm to the child from overriding their sincerely held views about what is best for their child.

Section 1(5) requires the court to be satisfied that making the order would better serve the welfare of the child than making no order.²¹⁴ Andrew Bainham has described this as a provision of 'common sense'; there is no point in the court making an order unless to do so

²¹¹ *In re C (A Child) (H.I.V. Testing)* [2000] 2 WLR 270, 280. Although the judge did not predict that the effect would be that the parents would leave the jurisdiction with the child.

²¹² *Re T (a minor) (wardship: medical treatment)* [1997] 1 WLR 242, 252.

²¹³ Marie Fox and Jean McHale, 'In Whose Best Interest?' (1997) 60 MLR 700-709, 708.

²¹⁴ *In the matter of E (A Child) (Medical Treatment)* [2016] EWHC 2267. On the facts of that case Sir James Munby P declined to make an order; at the time there was no clear answer whether E should undergo a cranioplasty operation, ordinarily it is a matter for those caring for the child, and as the decision did not have to be made, it could be left to those to whom E's long term care were to be entrusted, [33].

would enhance the welfare of the child.²¹⁵ However, it also reflects the principle that court orders are not necessarily the best way of securing the welfare of the child and that the court does not necessarily know better than the child's parents so should only intervene where it is satisfied that it is necessary to do so. It underscores the focus upon the welfare of the child and not the dispute between the parents and professionals. And whilst, by the time the matter has been referred to court it may seem that the question about a child's medical treatment needs to be determined as a matter of urgency, it should also be practice for the court to require the Trust to detail the steps which have been taken to attempt to resolve the issue prior to application to court. Greater use of s.8 orders in the consideration of the specific issue of a child's medical treatment, not confined to the factors listed in the welfare checklist, has the potential to direct the judiciary to the wider welfare context of the individual child, the exercise of parental responsibilities and caring relationships in the provision of care to children. It offers the potential for court determination of disagreements over a child's medical treatment through a particularistic and relational analysis considering the immediate and the long term welfare of the child judged by the ordinary standards of the day.²¹⁶ Parental responsibility must be limited where necessary in the interests of child welfare but being faithful to the principles of the Children Act would lead the courts to adopt a child-centred approach to welfare focused upon the needs of the individual child.

IV THE CHILDREN ACT: A FRAMEWORK FOR WORKING TOGETHER TO CARE

From its inception the Children Act, its philosophy and its concepts have been subjected to critique.²¹⁷ It has been argued that commitment to the welfare principle has meant a

²¹⁵ Andrew Bainham, 'Changing Families and Changing Concepts: reforming the language of family law' (1998) CFLQ 1-15.

²¹⁶ *Re G (Children)* [2012] EWCA Civ 1233.

²¹⁷ Andrew Bainham argued that it amounted to the 'The Privatisation of the Public Interest in Children' (1990) 53 MLR 206-221 and Gillian Douglas to the 'de-regulation of child law', 'Family Law under the Thatcher Government' (1990) 17 Journal of Law and Society 411-426, 418. Criticisms I do not think are equally valid in the specific context of children's healthcare.

reluctance to engage with, or resistance to, children's Convention rights.²¹⁸ Michael Freeman has argued for its replacement with a Children's Act which assimilates the UNCRC.²¹⁹ None of this literature has engaged with its application to children's healthcare law and some of the criticisms may be equally valid in that context. It is also necessary to recognise that with very few cases having been brought under the Children Act the application of its provisions remains underdeveloped in that context.

The current law emphasises the right of parents to make decisions about their child's medical treatment requiring professionals who are unable to accept their decisions to refer the disagreement to court. This article has argued that determination of disputes about children's healthcare in the exercise of the courts' inherent jurisdiction has resulted in judicial adjudication between the competing claims of parents and professionals to know what is best for the child which can distract attention from the child to the dispute itself.²²⁰ Decisions can seem distanced from the child whose welfare and future is at issue and may leave parents unpersuaded. The principles and concepts of the Children Act provide a guide to parents in fulfilment of their responsibilities to their children, working in partnership with healthcare professionals in the provision of healthcare and placing duties upon public authorities to work together in the welfare of children and upon the courts in the resolution of disagreements which arise, putting the child at the centre of relationships of care. The 'importance and the utility'²²¹ of these concepts and principles have not yet been fully realised in the context of children's healthcare.

²¹⁸ Andrew Bainham 'Can We Protect Children and Protect their Rights?' (2002) Fam Law 279; Shazhia Choudhry and Helen Fenwick, 'Taking the Rights of Parents and Children Seriously: Confronting the Welfare Principle under the Human Rights Act' (2005) 25 Oxford Journal of Legal Studies 453-492.

²¹⁹ Michael Freeman, 'The next Children's Act?' [1998] Fam Law 341-348.

²²⁰ Liz Forbat, Bea Teuten and Sarah Barclay, 'Conflict escalation in paediatric services: findings from a qualitative study' (2015) Arch Dis Child, doi:10.1136/archdischild-2014-307780.

²²¹ The Right Honourable Lord Justice McFarlane, 'Making Parental Responsibility Work' [2014] Fam Law 1264-1276, 1270.