Court of Appeal
New South Wales

Case Title:	X v The Sydney Children's Hospitals Network
Medium Neutral Citation:	[2013] NSWCA 320
Hearing Date(s):	17 September 2013
Decision Date:	27 September 2013
Before:	Beazley P at [1]; Basten JA at [9]; Tobias AJA at [80]
Decision:	(1) Grant leave to the applicants to appeal from the orders of Gzell J made in the Equity Division on 28 March 2013. (2) Direct that the applicants file a notice of appeal in the form contained in the white folder within 14 days. (3) Vary order 1 made in the Equity Division by deleting the words "until further order" and replacing them with "until 18 January 2014 or earlier order". (4) Otherwise dismiss the appeal. (5) No order as to the costs of the proceedings in this Court. *[Note: The Uniform Civil Procedure Rules 2005 provide (Rule 36.11) that unless the Court otherwise orders, a judgment or order is taken to be entered when it is recorded in the Court's computerised court record system. Setting aside and variation of judgments or orders is dealt with by Rules 36.15, 36.16, 36.17 and 36.18. Parties should in particular note the time limit of fourteen days in Rule 36.16.]*
Catchwords:	COURTS - jurisdiction - parens patriae - power of court to consent to medical treatment - whether power extends to a mature minor capable of consenting to medical treatment - relevant considerations - consent to administration of blood

refused by minor on religious grounds - family subscribed to tenets of Jehovah's Witnesses

TORTS - trespass to person - medical treatment without consent - power of court to override refusal of consent by minor

STATUTORY INTERPRETATION - whether provision giving effect to consent by minor constituted 'code' - whether court retained power to override refusal of consent - Children and Young Persons (Care and Protection) Act 1998 (NSW), s 174

Legislation Cited:

Child and Family Services Act (Manitoba), s 25
Children and Young Persons (Care and Protection) Act 1998 (NSW), ss 3, 6, 174
Convention relating to the Status of Refugees (1951), Art 1A(2)
Crimes Act 1900 (NSW), ss 31A, 31C, 574B
Family Law Reform Act 1969 (UK), s 8
International Covenant on Civil and Political Rights, Art 18
Medical Consent of Minors Act 1976 (New Brunswick), ss 2, 3
Minors (Property and Contracts) Act 1970 (NSW), ss 8, 9, 14, 49
Uniform Civil Procedure Rules 2005 (NSW), r 42.1
Universal Declaration of Human Rights, Art 18

Cases Cited:

AC v Manitoba (Director of Child and Family Services) 2000 SCC 30; [2009] 2 SCR 181
Cruzan v Missouri Department of Health 497 US 261 (1989)
Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 AC 112
In re O'Hara [1900] 2 IR 232 at 239-240
In re T (Adult: Refusal of Treatment) [1993] Fam 95 at 115
J v C [1970] AC 668
Johnson v Director-General of Social Welfare (Vic) [1976] HCA 19; 135 CLR 92
JSC v Wren (1986) 76 AR 115 (CA)
K v Minister for Youth and Community Services [1982] 1 NSWLR 311
Malette v Shulman (1990) 72 OR (2d) 417
McKay v Bergstedt 801 P 2d 617 (1990)
Minister for Health v AS [2004] WASC 286; 29 WAR 517
Momcilovic v The Queen [2011] HCA 34; 245 CLR 1

	Re Alex (2004) Fam CA 297 Re AY (1993) 111 Nfld & PEIR 91 (Nfld SC) Re Bernadette (Special Medical Procedure) [2010] Fam CA 94 Re L [1998] 2 FLR 810 Re LDK (1985) 48 RFL (2d) 164 (Ont Prov Ct, Fam Div) Re W (a minor) (medical treatment) [1992] 4 All ER 627 Schloendorff v Society of New York Hospital 105 NE 92 (1914) Secretary, Department of Health and Community Services v JWB (Marion's Case) [1992] HCA 15; 175 CLR 218 Walker v Region 2 Hospital Corp (1994) 116 DLR (4th) 477
Texts Cited:	Young, Croft and Smith, On Equity (Law Book Co, 2009) at [4.170]-[4.240]
Category:	Principal judgment
Parties:	X (First Applicant) Y (Second Applicant) Z (Third Applicant) The Sydney Children's Hospitals Network (Randwick and Westmead) (incorporating The Royal Alexandra Hospital for Children (Respondent)
Representation	
- Counsel:	Counsel: D M Bennett QC/A L Tokley (Applicants) J K Kirk SC/J Downing (Respondent)
- Solicitors:	Solicitors: Vincent Toole Solicitors (Applicants) NSW Ministry of Health (Respondent)
File Number(s):	CA 2013/125272
Decision Under Appeal	
- Court / Tribunal:	Supreme Court
- Before:	Gzell J
- Date of Decision:	28 March 2013

- Citation: The Sydney Children's Hospital Network v X [2013] NSWSC 368

- Court File Number(s): SC 2013/88444

JUDGMENT

1 **BEAZLEY P**: I have had the opportunity of reading in draft the reasons of Basten JA. I agree with his Honour's proposed orders and with his reasons.

2 The jurisdiction invoked in this matter was the *parens patriae* jurisdiction of the Court. As Basten JA has stated, the origin of the jurisdiction is ancient. In its modern application, it is an "*essentially protective*" jurisdiction: *Secretary, Department of Health & Community Services v JWB & SMB (Marion's Case)* [1992] HCA 15; 175 CLR 218 at 280 per Brennan J. In circumstances where the Court's concern is with the welfare of a child, the authorities are clear that whilst the Court's jurisdiction is a broad one, it should act cautiously. This was explained by Fitzgibbon LJ in *In re O'Hara* [1900] 2 IR 232 at 239-240 in the following way:

> "In exercising the jurisdiction to control or to ignore the parental right the court must act cautiously, not as if it were a private person acting with regard to his own child, and acting in opposition to the parent only when judicially satisfied that the welfare of the child requires that the parental right should be suspended or superseded."

3 These remarks have been endorsed by the House of Lords in *J v C* [1970] AC 668 at 695, 706 and 722 and by Brennan J in *Marion's Case* at 280.

4 This case has presented the Court with a circumstance which is familiar to it but which has provided a particular challenge in its resolution. The familiar aspect is the belief held by those who belong to and follow the beliefs of the Jehovah's Witnesses, which forbids medical treatment in the

form of a blood transfusion. As the material in this case has revealed, that includes treatment by the transfusion of a patient's own blood products. The evidence also reveals that is a deeply held belief.

5 The evidence of X, being the young person in respect of whom Gzell J exercised the jurisdiction of the Court in this case, is that if he had treatment by way of a transfusion of blood or blood products, it would be a breach of his personal relationship with God. That is not, however, the challenging feature of the case. The challenging feature is that X is a young person who has nearly reached the age of eighteen years and has provided to the Court a cogent statement as to why he has and would continue to refuse to consent to treatment by way of transfusion. That refusal is strongly supported by his parents who have the same religious beliefs and who have brought X up in the faith community of the Jehovah's Witnesses.

6 As Basten JA has pointed out, the religious beliefs of a particular section or group within society are not to be discounted, even if not held by the broader community. However, the respect to be given to the particular religious beliefs of an individual is not the Court's only consideration. As the long history of the *parens patriae* jurisdiction reveals, the Court's ultimate determination must be based on what is best for the welfare of the person within its jurisdiction.

7 The orders made by the primary judge in this matter were made five months ago. The fact that X, at the time that the appeal was heard, was only some four months away from his eighteenth birthday, may lessen the Court's imperative in protecting his welfare by giving precedence to potentially saving his life over his personal wishes and those of his parents. However, a decision was made, undoubtedly for appropriate reasons, not to provide any up to date information to the Court as to X's present medical status or any treatment given in the meantime. Nor was there any challenge to the manner in which the primary judge had

exercised his discretion in making the orders sought by the Sydney Children's Hospital Network. The challenge was confined to alleging errors of law in his Honour's determination. That challenge has not succeeded.

8 Accordingly, notwithstanding the passage of time since those orders were made and the fact that X is now some four months from reaching his legal majority, no basis has been demonstrated for setting aside the orders made by the primary judge, save for the amendment to reflect that they operate only until the date that X reaches the age of 18, or earlier order of the Court.

9 **BASTEN JA**: The applicants, identified as X, Y and Z in keeping with a non-publication order made at trial and reiterated in this Court, are a young person and his parents. The young person, who will be referred to as "the applicant", is now 17 years and 8 months of age, suffers from an aggressive cancer known as Hodgkin's disease. A first period of chemo-radiotherapy resulted in complete remission, but only for three months. A further round of chemotherapy achieved only a limited reduction in the size of many tumours, but not remission. Medical advice from Professor Glenn Marshall, a paediatric haematologist and oncologist, was that he required higher doses of different cytotoxic chemotherapy agents, carrying an inevitable side effect of anaemia. By February 2013 severe anaemia had set in, requiring either a blood transfusion or cessation of the treatment. The applicant is a Jehovah's Witness and both he and his parents have refused consent to any treatment involving a blood or platelet transfusion.

10 On 20 March 2013 the respondent Hospital commenced proceedings by way of summons in the Equity Division seeking authority for "the administration of blood, blood products and platelet therapy and the reinfusion of [the applicant's] own blood" and "any treatment ancillary to" the principal treatment, believed to be "necessary to prevent serious damage to [the applicant's] health, including the alleviation of appreciable risk of serious damage to [his] health".

11 On 28 March 2013 Gzell J made the orders sought by the Hospital: *The Sydney Children's Hospital Network v X* [2013] NSWSC 368. The young person and his parents have sought leave to appeal from that decision. For the reasons explained below, there should be a grant of leave to appeal, but the appeal should be dismissed.

Capacity to refuse consent

12 The general principle of the common law is that non-consensual medical treatment involves an assault, thus constituting both a criminal offence and a tort. That "principle of personal inviolability", as noted in *Secretary, Department of Health and Community Services v JWB (Marion's Case)* [1992] HCA 15; 175 CLR 218 at 234, echoes the well-known words of Cardozo J in *Schloendorff v Society of New York Hospital* 105 NE 92 (1914) at 93:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."

13 Subject to an exception which will be addressed below, the submissions assumed that a young person under 18 years of age could not give a legally effective consent. Under the general law, such capacity was absent during "the disability of infancy", which ceased at the age of 21 years. Statute now provides that a person "is not under the disability of infancy in relation to a civil act in which the person participates when aged 18 years or upwards": *Minors (Property and Contracts) Act 1970* (NSW) ("*Property and Contracts Act*"), s 8. Section 9(1) further provides:

> **9 Full age generally**
>
> (1) After the commencement of this Act:
>
> (a) for the purposes of any rule of law ...
> ...

> a person ... who attains the age of eighteen years after the commencement of this Act:
>
> (c) is of full age and adult,
> (d) is sui juris, subject however to the law relating to mental illness, and
> (e) is not under any disability or incapacity of infancy.

14 More specifically, the Act provides that "[i]n matters of tort" the doctrine of "consent", applies "in the case of a person aged 18 years or upward": s 14(1).

15 In terms not entirely consistent with these provisions, s 49 of the *Property and Contracts Act* relevantly provides:

> **49 Medical and dental treatment**
>
> (1) Where medical treatment ... of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
>
> (2) Where medical treatment ... of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards.
>
> (3) This section does not affect:
>
> (a) such operation as a consent may have otherwise than as provided by this section, or
> (b) the circumstances in which medical treatment ... may be justified in the absence of consent.

16 Finally, it is necessary to note s 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) ("*Care and Protection Act*"), which, so far as relevant, provides:

> **174 Emergency medical treatment**

> (1) A medical practitioner may carry out medical treatment on a child or young person without the consent of:
>
> (a) the child or young person, or
>
> (b) a parent of the child or young person,
>
> if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health.
>
> ...
>
> (3) Medical ... treatment carried out on a child or young person under this section is taken, for all purposes, to have been carried out with the consent of:
>
> (a) in the case of a child - a parent of the child, or
> (b) in the case of a young person - the young person.
>
> (4) Nothing in this section relieves a medical practitioner ... from liability in respect of the carrying out of medical ... treatment on a child or young person, being a liability to which the medical practitioner ... would have been subject had the treatment been carried out with the consent of:
>
> (a) in the case of a child - a parent of the child, or
> (b) in the case of a young person - the young person.

17 The *Care and Protection Act* defines "child" to mean "a person who is under the age of 16 years" and "young person" to mean "a person who is aged 16 years or above but who is under the age of 18 years": s 3.

18 Taking these statutory provisions together, three propositions are apparent. First, there is no express statement of the "disability of infancy" or the "incapacity of infancy", reference to which may be found in the *Property and Contracts Act*. On the other hand, certain provisions in that Act refer to a "minor" which covers any person under the age of 18 years: s 6(1).

19 Secondly, the general effect of the *Property and Contracts Act* was to lower the age at which the disability or incapacity ceased from 21 years to 18 years. However, it was not the case either before or after the

commencement of the *Property and Contracts Act* that acts of persons during their minority were necessarily without legal effect.

20 Thirdly, although s 174 of the *Care and Protection Act* was limited to treatment that was "necessary, as a matter of urgency ... to save ... life or to prevent serious damage to ... health", there are issues raised by the provision which have potentially broader effects. Thus, the applicants argued that s 174(1) identified the limits within which medical treatment, absent consent, was permitted and, by inference, provided that consent was otherwise effective. Further, there appeared to be an inference implicit in sub-ss (3) and (4) that in the case of a child only a parent could give effective consent, but that in the case of a young person, that person could give effective consent. The last inference is one which requires elucidation and is addressed below.

21 Without relying on any inference drawn from s 174(3) or (4), the applicants contended that the capacity to consent to or refuse medical treatment arose before a person reached 18 years of age, where he or she demonstrated relevant decision-making competence. The argument derived from the judgment of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112. The critical question in that case was whether a girl under the age of 16 could give an effective consent to "advice and treatment including medical examination" for the purposes of contraception. The question arose in relation to girls who had not attained 16 years of age because, by statute, a minor who had attained the age of 16 years was able to give effective consent to medical treatment: *Family Law Reform Act 1969* (UK), s 8(1). The significance of the minor having capacity to give consent was that the practitioner did not need to obtain consent from her parents; nor did a refusal of parental consent constitute a veto on such medical treatment. Noting the references in *Blackstone's Commentaries* to the different ages at which a child might attain decision-making capacity under the general law, Lord Scarman stated at 186:

> "The underlying principle of the law was exposed by *Blackstone* and can be seen to have been acknowledged in the case law. It is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

22 More specifically, in a passage adopted by the majority in the High Court in *Marion's Case*, Lord Scarman stated at 188-189:

> "In the light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances."

23 In terms which will be identified below, the trial judge accepted in the present case that the applicant was competent, in this practical sense, to determine whether or not to consent to the proposed treatment. The question at the heart of this case is what flows, as a matter of law, from the principle adopted in *Gillick* and the factual finding with respect to the applicant.

***Parens patriae* jurisdiction**

24 The primary argument raised on behalf of the applicants was that the *parens patriae* jurisdiction of the Supreme Court only operated in a case of incompetence, because it permitted the Court to stand in the shoes of a person whose consent was required and decide whether his or her welfare required that consent be given or withheld. That being the case, the submission proceeded, if the applicant was competent to give or withhold consent, no consent was required from his parents and the Court had no power to override his decision.

25 *Gillick* itself was not a case dealing with the *parens patriae* jurisdiction: accordingly, in order to assess the strength of the applicants' submission, it is necessary to look elsewhere.

26 The historical origins of the *parens patriae* jurisdiction, arising from the feudal right of the English monarch as 'parent of the country' say little about the current exercise of that acknowledged inherent jurisdiction by the Supreme Court: see Young, Croft and Smith, *On Equity* (Law Book Co, 2009) at [4.170]-[4.240]. On the other hand, it is well-established that statutes enacted in all Australian jurisdictions for the welfare of children, absent some express language or necessary intendment, do not limit or exclude the operation of the inherent jurisdiction. Thus in *Johnson v Director-General of Social Welfare (Vic)* [1976] HCA 19; 135 CLR 92 at 97, Barwick CJ (with the agreement of Stephen and Mason JJ) stated:

> "This Court has been quite emphatic in expressing its view that, if the Parliament wishes to take away from the Court its power of supervising the guardians, and protecting the welfare, of children, it must do so in unambiguous language, in language which is either express or such as inescapably implies that expression of intention on the part of the Parliament ...."

27 In effect, the Court in *Johnson* asserted not merely a direct role to determine issues as to the best interests of children, but also a supervisory role with respect to the actions of parents, public servants and others to whose care children are committed, whether under the general law, by statute or by court order.

28 In *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311, Helsham CJ in Eq was asked to order that a ward of the Minister, who was then about 12 weeks pregnant, be permitted to undergo an abortion, which was not illegal in the circumstances but for which consent had been refused by the Minister. The Chief Judge held at 327:

> "If a fifteen and a half year old girl comes within this situation, makes a well informed decision that her pregnancy be terminated,

> and shows that this is necessary for her welfare, then the Court will not back off from ensuring so far as it can that her welfare is safeguarded.
>
> ... It may only be necessary for the Court to declare that the Minister is not entitled to refuse his consent to an abortion."

29 Importantly, the Chief Judge also considered the operation of s 49 of the *Property and Contracts Act*, set out above at [15]. After noting the content of the provision he continued:

> "Whether this has something to do with the general provisions of the Act making a minor's actions in which his participation is for his benefit presumptively binding on him, I need not pause to consider. It is a protective section at least in one respect, that is in the case of a 14 to 16 year old, because it takes away a right to sue which he otherwise would have, notwithstanding his consent, if the treatment were performed without consent of his parent or guardian. It does not take away any power of a guardian to withhold consent or to refuse. Whether the section of itself would have the effect of requiring the Court to refuse relief to a guardian who sought to restrain an unwarranted operation (take, for example, an unnecessary sterilisation) about to be performed with the consent of a 14-year-old, it is unnecessary to decide. I rather think it would not take away the right of the guardian to relief. But in the present case the most that could be said about the operation of the section is that if an abortion were to be performed by a medical practitioner in the course of his or her practice of medicine or surgery then the consent of this girl would free the practitioner from liability under any claim by her for assault or battery because of its performance."

30 The orders made in *K*, in the exercise of the *parens patriae* jurisdiction, are inconsistent with the proposition that whenever a child has legal capacity to give an effective consent to medical treatment, that jurisdiction cannot be invoked. (It is not necessary for present purposes to consider whether any other jurisdiction was available, nor the effect of statutory provisions governing the powers of the Minister.)

31 As the applicants conceded, there is authority in the Supreme Court of Western Australia which is inconsistent with the limited role for which they contended. *Minister for Health v AS* [2004] WASC 286; 29 WAR 517 involved a proposed blood transfusion to a 15 year old Jehovah's Witness,

identified as "L". L refused consent to a blood transfusion. The trial judge, Pullin J, was "satisfied that L is of sufficient maturity and intelligence to understand the nature and implications of his decision which he has made after discussions with his treating doctors and his parents": at [2]. In the face of that refusal, the Minister sought an order that a transfusion could be given in certain clinical situations identified in the order. Pullin J expressed no doubt "that this Court has jurisdiction to make orders of the kind sought and to give directions in all matters relating to the welfare of infants whether they be a child of the marriage or otherwise, including where parents have the power to consent or otherwise": at [16]. The case was apparently conducted on the basis that both the parents and L had refused consent. Pullin J identified the Court's "independent and objective judgment" as to the best interests of a child as imposing a limit on the power of the parents and of the child to give or withhold consent at will. He concluded at [23]:

> "Obviously the court's power in the inherent jurisdiction to countermand the wishes of a child patient or a parent is to be exercised sparingly and with great caution. However, there are cases where it is necessary to do so. I have carefully considered the wishes of L as well as the wishes of his parents, but I have reached the view that this is clearly such a case. L's wishes are governed by his religious belief which is leading him to the conclusion that he has reached, a conclusion which is supported by his parents. This conclusion has led him to reject the expert medical advice which is available to him. The justification for overriding his wishes and that of his parents is that on the evidence his health and even his survival are seriously at risk unless steps are taken to give him a transfusion if the need arises."

32 There is express authority at appellate level in the United Kingdom contrary to the applicants' submissions. Thus, in *Re W (a minor) (medical treatment)* [1992] 4 All ER 627, the Court of Appeal considered an application to treat a girl aged 16 years suffering from anorexia nervosa. Lord Donaldson MR held "that it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice": at 637e. However, while that did not mean that the wishes of the minor should be

disregarded entirely, it meant that they should be given less weight than if she were "*Gillick* competent". The Master of the Rolls continued:

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

33 Balcombe LJ, considering the provision in the *Family Law Reform Act 1969* providing that consent of a minor who has attained the age of 16 years shall be effective as if he or she were of full age, held at 641g:

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

34 Referring to the discussion in the speech of the Lord Scarman in *Gillick*, Balcombe LJ continued at 642-643:

> "I accept that the words 'or not' in this passage suggests that Lord Scarman considered that the right to refuse treatment was coexistent with the right to consent to treatment. I also accept that if a '*Gillick* competent' child under 16 has a right to refuse treatment, so too has a child over the age of 16. Nevertheless I share the doubts of Lord Donaldson MR whether Lord Scarman was intending to mean that the parents of a '*Gillick* competent' child had no right at all to consent to medical treatment of the child as opposed to no exclusive right to such consent. ... It is also clear that Lord Scarman was only considering the position of the child vis-à-vis its parents: he was not considering the position of the child vis-à-vis the court, whose powers, as I have already said, are wider than the parents'."

35 In *Re W*, Nolan LJ also affirmed "the unlimited nature of the court's inherent jurisdiction over minors, a jurisdiction which empowers and may require the court to override the wishes of a minor, even if he or she has sufficient understanding to make an informed decision": at 646c. He too, referring to the approach adopted in *Gillick,* noted that it was "essential to bear in mind that their Lordships were concerned with the extent of parental rights over the welfare of the child ... [and] were not concerned with the jurisdiction of the court": at 647g.

36 Senior counsel for the applicants sought to distinguish the reasoning in this case as reflecting the particular condition of the minor, which caused them to doubt that she was competent to give or withhold consent. While that correctly reflects the context, the language set out above is more general and reflects principle rather than application of principle in the circumstances of the case.

37 It is necessary to refer to a decision of the New Brunswick Court of Appeal, upon which the applicants sought to place significant weight, namely *Walker v Region 2 Hospital Corp* (1994) 116 DLR (4th) 477. Joshua Walker, at the age of 15 years and 9 months, was diagnosed with acute myeloid leukaemia. The treatment was likely to require blood transfusions but he refused consent to any transfusion of blood or blood products, "even if physicians deem such necessary to preserve my life or health": at 481b. Under the Province's *Medical Consent of Minors Act 1976*, two provisions were significant:

> 2 The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of 16 years in the same manner as if they had attained the age of majority.
>
> 3 (1) The consent to medical treatment of a minor who has not attained the age of 16 years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner ...,
>
> (a) the minor is capable of understanding the nature and consequences of a medical treatment, and

> (b) the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well being."

38 The judgment of the Court of Appeal (delivered by Hoyt CJNB) turned on the facts of the case and the operation of the provisions set out above. As to the facts, two doctors expressed the view that the proposed treatment, which did not call for blood transfusions, was in the patient's best interests: at 480f-g. Accordingly, the circumstances in s 3(1)(b) were satisfied. In passing, however, the Chief Justice noted at 488:

> "When a minor is found to be mature, I see no room for the operation of the Court's *parens patriae* jurisdiction. If the *parens patriae* jurisdiction were to apply, children between 16 and 19 would be placed in an anomalous situation. The Act sets 16 as the age after which consent may be given without the intervention of two medical practitioners. If however, the *parens patriae* jurisdiction exists with respect to consent to medical treatment by minors, it would apply to anyone under the age of 19, which ... is the age of majority in New Brunswick."

39 Apart from this conclusion being obiter, there was little discussion in the reasons of the proposition, which had been accepted by the trial judge, that a statute giving effect to the consent of a minor did not necessarily indicate the consequences of a refusal to give consent to treatment deemed medically necessary. Further, the language of the two provisions set out above is significantly different from that of the statutes in this State. *Walker* provides no persuasive authority with respect to the operation of the *parens patriae* jurisdiction in the present case.

40 Finally, it is helpful to refer to the judgment of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)* 2000 SCC 30; [2009] 2 SCR 181. The principal judgment was delivered by Abella J (for Le Bel, Deschamps, Charron JJ and herself). The applicant, AC, was 14 years and 10 months when she was admitted to hospital suffering lower gastro-intestinal bleeding as a result of Crohn's disease. As a Jehovah's Witness, she refused blood transfusions under any

circumstances. A court order was requested under the Manitoba *Child and Family Services Act*, s 25, which relevantly stated:

> 25 (8) Subject to subsection (9), upon completion of a hearing, the court may authorise ... any medical ... treatment that the court considers to be in the best interests of the child.
>
> (9) The court shall not make an order under subsection (8) with respect to a child who is 16 years of age or older without the child's consent unless the court is satisfied that the child is unable
>
> (a) to understand the information that is relevant to making a decision to consent or not consent to the medical ... treatment;
> (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical ... treatment.

41 A transfusion was ordered and AC recovered: [13]. However, AC and her parents complained that the order should not have been made because s 25(8) only applied to minors under 16 without capacity and, alternatively, that those provisions were unconstitutional as unjustifiably infringing AC's rights under the Charter of Rights and Freedoms.

42 The applicant was unsuccessful on both issues, but for reasons which are not presently significant. However, in construing the legislation and considering the justification for such provisions under the Charter, Abella J discussed a number of matters concerning common law principles.

43 After referring to *Gillick* and *Re W*, Abella J noted that the English Court of Appeal had "definitively established that even 'mature minors' were subject to the court's inherent *parens patriae* jurisdiction": at [54]. She also stated, in a passage not challenged in this Court, that "[t]o date, no court in the United Kingdom has allowed a child under 16 to refuse medical treatment that was likely to preserve the child's prospects of a normal and healthy future, either on the ground that the competence threshold had not been met ... or because the court concluded that it had the power to override the wishes of even a '*Gillick*-competent' child": at [57]. Further, the reasons, at [58], adopted a passage from the judgment of Kerans JA in *JSC v Wren*

(1986) 76 AR 115 (CA) in respect of a 16 year old girl who had received medical approval for a therapeutic abortion, but whose parents sought to assert their rights of veto until she reached majority at the age of 18:

> "Parental rights (and obligations) clearly do exist and they do not wholly disappear until the age of majority. The modern law, however, is that the courts will exercise increasing restraint in that regard as a child grows to and through adolescence."

44 After reviewing the law in other jurisdictions (including reference to *Marion's case*) Abella J concluded:

> "[66] Individual states have approached the issue of adolescent decision-making in various ways, some enacting statutory exceptions to the default presumption of incapacity, and some embracing the common law 'mature minor' doctrine to varying degrees. As in the UK and Canada, no state court has gone so far as to suggest that the 'mature minor' doctrine effectively 'reclassifies' mature adolescents as adults for medical treatment purposes. ...
>
> ...
>
> [69] What is clear from the above survey of Canadian and international jurisprudence is that while courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the 'mature minor' doctrine as dictating guaranteed outcomes, particularly where the consequences for the young person are catastrophic."

45 Principle as well as authority is against acceptance of the applicants' proposed limitation on the scope of the Court's jurisdiction. The very concept of a "mature minor" envisages a fact-finding exercise with respect to a specific young person. That exercise is itself, presumably, undertaken in the *parens patriae* jurisdiction. Accordingly, the applicants' submissions are best understood as imposing a limit on the power to grant relief if a particular finding is made, rather than the imposition of a limitation on the jurisdiction of the court.

46 Even a limitation on the power to grant relief, is inconsistent with the exercise undertaken in determining that a particular young person is a

mature minor. Once it is accepted that the approach adopted in *Gillick* does not diminish the scope of the *parens patriae* jurisdiction, it is consistent with the flexibility inherent in that approach that it should provide a basis for a court to mould orders to the specific circumstances of the case, rather than impose a categorical restriction on the availability of relief.

47 For these reasons, and accepting that the trial judge was satisfied that, in a general sense, the applicant was capable of understanding and consenting to or withholding consent from a particular form of treatment, the orders made were nevertheless within power, absent statutory preclusion under s 174 of the *Care and Protection Act*.

Statutory preclusion

48 A second argument put forward by the applicants was that s 174 of the *Care and Protection Act* provided some kind of "code" as to the circumstances in which a practitioner could or could not lawfully provide medical treatment. Thus, by providing statutory authority for such treatment without consent in cases where the medical practitioner believed it to be necessary, as a matter of urgency, to save the life or prevent serious damage to the health of the young person, no question of court authority was required. The statutory presumption was that such treatment was carried out as if the young person had consented. It would be inconsistent with that regime, the submission proceeded, to permit the Court to deny authority to the young person to consent in circumstances where consent was available and had been given or withheld.

49 By reasoning analogous to that of Helsham CJ in Eq in *K* (set out at [29] above with respect to s 49 of the *Property and Contracts Act*) and that of Balcombe LJ in *Re* W (set out at [33] above with respect to the UK provision) that argument cannot be accepted. First, it is no doubt implicit in equating the circumstances of treatment provided in an emergency without consent to circumstances with respect to a young person who has

consented, that the consent of a young person is effective. That is, the section is protective of the medical practitioner who, operating in an emergency without consent, might otherwise be sued for assault. The implicit assumption is that a practitioner operating with the consent of the young person would equally be protected from liability for a battery.

50 However, the section is silent as to the right of a young person to refuse consent to treatment which is necessary to save his or her life or prevent serious damage to his or her health. The section is also silent as to the orders which may be made by a court in respect of a young person, in the exercise of the *parens patriae* jurisdiction. Accordingly, applying the principle that the jurisdiction of the court to make orders for the welfare of children and young persons is not to be taken to have been abrogated except by clear words or necessary intendment, the submission must be rejected. Indeed, the restriction proposed by the applicants, far from being a clear or necessary inference from the statutory language, is not available on a purposive construction.

Exercise of discretionary power

51 The factors relied on by the applicants as imposing a legal limit on the scope of the court's jurisdiction or its powers were also invoked as matters to be taken into account by the trial judge in exercising such powers as he in fact had. Thus it was contended in various ways that the judge "failed to take into account":

(a) the right of a mature minor to self-determination and autonomy with respect to medical treatment;
(b) the fact that such autonomy would be unqualified and beyond the interference of the Court once the young person turned 18, which would be in January 2014;
(c) the absence of evidence that the proposed treatment was necessary to avoid death or serious injury to health prior to the applicant's 18th birthday, and

(d) the ability of the applicant (as opposed to the court) to determine what was in his own "best interests".

52 At one level, the response to these complaints (not all of which were articulated in oral argument) is that each matter was in fact "taken into account" by the trial judge in his reasons. That the judge was directly concerned with the medical evidence as to the current state of health of the applicant and the expert opinion as to appropriate treatment is apparent from the detailed analysis contained within the judgment.

53 It is also beyond doubt that the trial judge gave anxious consideration to the ability of the applicant to assess his own condition and the medical treatment proposed. He accepted that he was a "mature minor": at [39]. He then considered the significance of his Jehovah's Witness faith, finding that "there is no doubting [the applicant's] devotion to his faith, but his life has been cocooned in that faith": at [41]. The judge referred to part of the reasoning of Sir Stephen Brown P in *Re L* [1998] 2 FLR 810 at 812, including a comment on the evidence of a "well-respected consultant child psychiatrist":

> "He makes the point that the girl's view as to having no blood transfusion is based on a very sincerely, strongly held religious belief which does not in fact lend itself in her mind to discussion. It is one that has been formed by her in the context of her own family experience and the Jehovah's Witnesses' meetings where they all support this view. He makes the point that there is a distinction between a view of this kind and the constructive formulation of an opinion which occurs with adult experience."

54 The trial judge concluded:

> "[48] Notwithstanding the strong and genuine views taken by [the applicant] and his parents in opposition to blood transfusions and notwithstanding that the effect of the orders may only extend [the applicant's] life for 10 months when he becomes an adult and may stop the treatment, I am of the view that the orders sought should be made.
>
> [49] The sanctity of life in the end is a more powerful reason for me to make the orders than is respect for the dignity of the individual."

55 It is one thing to disagree with the outcome of the assessment made by the trial judge (which the applicants clearly do); it is quite another to contend that the various factors set out above, with the possible exception of the operation of s 174 of the *Care and Protection Act*, were not taken into account. They clearly were, and not in a cursory or dismissive manner.

56 It is true that the trial judge gave no particular weight to the operation of s 174, but there are two answers to that complaint. The first is, as counsel for the respondent stated in this Court without contradiction, it had not been raised in those terms before the trial judge. Secondly, for the reasons explained above, the section had no relevance, direct or indirect, to the exercise being undertaken.

57 Apart from stating that the matters in issue were addressed, there is a further response to this composite ground of appeal, namely that it is unhelpful to extract particular issues which are said to be relevant considerations (in the sense of being material, whether or not mandatory) and analyse the reasons of the trial judge in respect of those matters. Rather, what is required is an analysis of the reasons by reference to the broader interests at stake. Nor is it apposite to seek to compare the broader or "public" interests with the interests of the applicant as an individual. In reference to [49] (set out above at [54]), the "dignity of the individual" is as much an aspect of the broader interests to be protected by the court as is the "sanctity of life". The court is not balancing the interests of the individual against broader public or governmental interests, but is balancing fundamental principles which are in tension in their application to an individual.

58 In this context, the Charter cases in Canada and the constitutional cases in the USA and other countries with constitutional provisions similar to the US Bill of Rights, are instructive. For example, in *Malette v Shulman* (1990) 72 OR (2d) 417, the Ontario Court of Appeal considered the case of an adult

Jehovah's Witness who arrived at hospital unconscious, but with a signed medical alert card stating that no blood should be administered under any circumstances. The emergency doctor gave blood, and was sued for battery. In addressing the conflicting values, the Court stated at 429f:

> "The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life .... Recognition of the right to reject medical treatment cannot, in my opinion, be said to depreciate the interest of the state in life or in the sanctity of life. Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life."

59 These questions involve a nice balance, although properly understood preservation of life and individual autonomy are both fundamental principles demanding state protection, which must be reconciled in their application to the particular person. It may also be noted that preservation of life directly conflicts with individual autonomy with respect to suicide. Yet the state's response may be nuanced. In this State, it is not a crime to attempt or commit suicide (*Crimes Act 1900* (NSW), s 31A), but it is a crime to incite, counsel, aid or abet suicide: s 31C. It is also lawful to use reasonably necessary force to prevent suicide: s 574B. The legal concept of suicide, being the intentional taking of one's own life, is not engaged in a case where medical assistance is refused, even in the knowledge of certain death: *McKay v Bergstedt* 801 P 2d 617 (1990) at 626, Steffen J of the Nevada Supreme Court disagreeing with statements of Scalia J in *Cruzan v Missouri Department of Health* 497 US 261 (1989) at 296-297.

60 The interest of the state in preserving life is at its highest with respect to children and young persons who are inherently vulnerable, in varying degrees. Physical vulnerability diminishes (usually) with age and is at its height with respect to babies. Intellectual and emotional vulnerability also diminish with age but, as the facts of this case illustrate, may be a function of experience (including but by no means limited to education) as well as

age. Vulnerability lies at the heart of the disability identified by legal incapacity.

61 Children and young people may be vulnerable in a different sense: they are dependent on others, in varying degrees, to satisfy their needs, whether physical, emotional or experiential. In most cases and most of the time, society relies upon natural or adoptive parents to achieve those ends. In other cases, they may be achieved through foster care or institutional care. In any case, a child or young person may be vulnerable if his or her interests conflict with those of otherwise appropriate carers. Such concerns were noted in *Marion's case*. They are also reflected in the power of the court to provide an independent view as to the "best interests" or welfare of the child in cases where the risk of such vulnerability has materialised: *AC* at [80]-[82].

62 Many of these ideas are succinctly captured by the concepts of "sanctity of life" and "best interests" of a young person, used by the trial judge in this case and forming part of the standard lexicon. In assessing the course taken by the trial judge in making orders in the exercise of a judicial discretion, it may be necessary to spell out in more detail these broader fundamental rights and interests which underlie the *parens patriae* jurisdiction.

63 In considering the exercise of the power, the motivation underlying the decision of the applicants is by no means irrelevant and does not become so because it is not based on an assessment of the medical treatment in isolation. Nor is the appropriateness of an order to be judged solely according to the view the court forms as to the best medical treatment. On the one hand, where a refusal of treatment results from an assessment of the advantages and disadvantages of the treatment and the likelihood of an improved quality of life, and where the choice is one as to which reasonable minds might differ, the court may be reluctant to intervene. On the other hand, where the decision is thought to be affected by the very

condition which requires treatment, less weight may be accorded the choice: see, eg, *Re W* where the psychiatric evidence indicated that the young person's decision was affected by her anorexia nervosa.

64 Nor is the balance necessarily achieved by characterising the young person's choice as either rational or irrational. Factors, including minority religious beliefs, may be deemed irrational by broader community standards. They are not, for that reason, to be disregarded - indeed with respect to an adult it has been said that "it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent": *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 115 (Lord Donaldson of Lymington MR). Indeed, religious beliefs are internationally accepted as an aspect of an individual's fundamental autonomy with which the state cannot interfere and should not disregard: Universal Declaration of Human Rights (1948), Art 18; International Covenant on Civil and Political Rights (1966), Art 18; Convention relating to the Status of Refugees (1951), Art 1A(2). Such a motivation is likely to be one to which the Court will accord respect and weight, other things being equal.

65 To accord a religious belief weight is not to treat it as determinative. There may be cases in which the strength with which a belief is held, and the distress which would be caused by treatment which overrode that belief, might diminish the effectiveness of the treatment: *Re LDK* (1985) 48 RFL (2d) 164 (Ont Prov Ct, Fam Div), discussed in *AC* at [62]; and see *Re AY* (1993) 111 Nfld & PEIR 91 (Nfld SC) discussed in *AC* at [63].

66 As noted by Balcombe LJ in *Re W* at 643e, "[i]n logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment". While that may be so, the consequences are not necessarily identical. For example, a statute which confers immunity from suit in circumstances where a young person has consented, may not confer immunity from suit with respect to a failure to treat, where the young person has withheld consent. The *parens patriae* jurisdiction is not limited

to cases of refusal of medically recommended treatment; questions also arise where the child or young person wishes to have treatment about which there is doubt as to whether it is in his or her best interests: see, eg, *Re Alex* (2004) Fam CA 297 (Nicholson CJ), involving hormonal treatment for gender identity dysphoria; *Re Bernadette (Special Medical Procedure)* [2010] Fam CA 94 (Collier J), involving hormonal treatment for transsexualism.

67 These broader considerations are significant for two reasons. First, it is important to have regard to the potential breadth of the court's jurisdiction in considering whether a particular principle (such as that of the mature minor) or a statutory provision having a cognizable and limited purpose, should be seen as limiting that jurisdiction. Secondly, the jurisdiction requires the reconciliation of fundamental, but potentially conflicting, principles of constitutional significance inherent in the common law, absent any written bill of rights: cf *Momcilovic v The Queen* [2011] HCA 34; 245 CLR 1 at [42] (French CJ). Acknowledging that the jurisdiction may be varied by statute, there is nevertheless sound reason to doubt that any parliament in a liberal democratic state would intend such a result without pellucid language: *Momcilovic* at [43] and authorities cited at fn (215).

68 There is no basis for concluding that the trial judge in the present case failed properly to take into account any of the considerations set out above, relevant to the circumstances before him. The reasons of the trial judge demonstrate no appellable error in the exercise of the broad discretionary power vested in the court.

Conclusions

69 These reasons lead to the conclusion that, whilst important issues are raised which undoubtedly warrant a grant of leave to appeal (and indeed one wonders why an appeal should not be available as of right in such circumstances), nevertheless the appeal should be dismissed. There is, however, one further factor which needs to be taken into account.

70 The appeal was run on the evidence as it was before the trial judge in March. That is, neither party sought to put on evidence as to any change in the applicant's medical condition, nor as to any treatment which may have been carried out in the past five months. The only qualification to that proposition is that the applicant said that this Court should take into account the fact that he will attain his 18th birthday in about four months time. How this factor was to be taken into account was not entirely clear. If error were found in the reasoning of the trial judge, no doubt it would be a relevant factor if this Court were required to re-exercise the Court's discretion. However, that point has not been reached.

71 A second possibility was that some adjustment should be made to the form of the order as it presently stands. In one respect, it was common ground that the order made below should be amended. The authority granted to the Hospital was stated to be "until further order". The parties accepted that the temporal limit should properly be expressed as "until 18 January 2014 or earlier order". That amendment should be made.

72 Once the analysis set out above is accepted, there is no reason why a different result should be achieved because the applicant is now five months closer to his 18th birthday. The interest of the state is in keeping him alive until that time, after which he will be free to make his own decisions as to medical treatment.

73 In that context, the applicant contended that the evidence did not suggest an imminent likelihood of death. It followed, the submission continued, that the interest of the state in keeping him alive until he turned 18 was not jeopardised. Assuming the correctness of the factual premise, the state interest is not limited to saving life. However, the medical evidence, as at March 2013, was that the tumours had returned and required treatment by chemotherapy at a level which would lead to anaemia and hence an 80% chance of death unless blood products were given. The state interest is

not satisfied merely by keeping the applicant alive until his 18th birthday if the appropriate treatment to allow the continuation of his life thereafter should be given now.

74 In these circumstances, other things being as they were in March 2013, the mere fact that the applicant is closer to his 18th birthday than he was then does not provide a sufficient basis for revoking the order. Accordingly, the appeal should be dismissed.

Costs

75 No order was made as to the costs of the proceedings below, nor did the respondent seek costs of the trial. The respondent did, however, seek its costs in this Court in the event that the applicants were unsuccessful. It did so on the basis that the *parens patriae* jurisdiction had been duly exercised in the Court below and that appeals from such orders should not be encouraged by departure from the usual rule that costs follow the event. Further, the principles having been correctly identified by the trial judge, the applicants were acting in their own self-interest and not in any broader interest.

76 It must be accepted that costs in the proceedings should follow the event, in accordance with the terms of Uniform Civil Procedure Rules 2005 (NSW), r 42.1, unless it appears to the court that some other order should be made. Although it is true that the applicants bring these proceedings to further their own interests, underlying those interests are important principles as to the allocation of responsibility for life and individual autonomy, as between the state and its citizens. Those principles, in the circumstances of the present case, have not previously been articulated at appellate level in this country. The extent to which religious beliefs can provide a sufficient basis for rejecting potentially life saving medical treatment in the case of a person under 18 years of age raises an important issue as to the scope and operation of fundamental human rights and freedoms. Although each case will be fact-specific, the

statement of principle is likely to be significant in other matters, particularly with respect to those who adhere to the tenets of a Jehovah's Witness.

77 The issue is also likely to be of broader concern to the respondent. It commenced the proceedings to clarify the legal limits of its powers and responsibilities with respect to this patient, in circumstances which will have relevance, no doubt, in other cases.

78 Given those factors, it is appropriate that the Court depart from the general rule and decline to award costs to the successful respondent.

Orders

79 The Court orders are:

(1) Grant leave to the applicants to appeal from the orders of Gzell J made in the Equity Division on 28 March 2013.

(2) Direct that the applicants file a notice of appeal in the form contained in the white folder within 14 days.

(3) Vary order 1 made in the Equity Division by deleting the words "until further order" and replacing them with "until 18 January 2014 or earlier order".

(4) Otherwise dismiss the appeal.

(5) No order as to the costs of the proceedings in this Court.

80 **TOBIAS AJA**: I agree with the orders proposed by Basten JA for the reasons he has expressed. I also agree with the additional remarks of the President.

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