Neutral Citation Number: [2019] EWHC 1670 (Fam)

Case No: TBA

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/06/2019

Before:

THE HONOURABLE MR JUSTICE MACDONALD

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Between:

University Hospitals Plymouth NHS Trust	**Applicant**
- and -	
B (A Minor)	**Respondent**

- -
- -

Mr Ranald Davidson (instructed by **the Hospital Trust**) for the **Applicant**
The Respondent did not appear and was not represented

Hearing dates: 21 June 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE MACDONALD

This judgment was delivered in private. The Judge has given permission for this anonymised version of the judgment (and any of the facts and matters contained in it) to be published on condition always that the names and the addresses of the parties and the children must not be published. For the avoidance of doubt, the strict prohibition on publishing the names and addresses of the parties and the children will continue to apply where that information has been obtained by using the contents of this judgment to discover information already in the public domain. All persons, including representatives of the media, must ensure that these conditions are strictly complied with. Failure to do so will be a contempt of court.

Mr Justice MacDonald:

INTRODUCTION

1. This is an urgent without notice application being dealt with at 2.00pm on the afternoon of Friday 21 June 2019 in the urgent applications list with respect to the current refusal of a sixteen year old child to accept treatment, namely insulin, for a life threatening condition, namely diabetic ketoacidosis (DKA). The application is brought by the University Hospitals Plymouth NHS Trust, the NHS Trust responsible for the medical care and treatment of B.

2. The application concerns the welfare of B who was born on 6 May 2003 and is now 16 years old. There is no evidence that B lacks capacity. B was reviewed on 20 June 2019 by the local Community Mental Health Services and has been regularly reviewed by the paediatric diabetic clinicians responsible for her care. Her treating team are satisfied that she has good knowledge of her condition, and of the implications of not receiving insulin for the same, namely a risk of death. B has stated a wish to die. B is aware that this application is being made.

3. B lives with her grandfather. He supports the decision to provide the treatment necessary to reverse her current DKA. B is understood by the Applicant to have a difficult relationship with her mother and has refused to allow the hospital services to contact her mother. As the Applicant understands it, there is no ongoing relationship between B and her father.

4. With respect to evidence in support of this urgent application, I have received a report dated 21 June 2019 prepared by Dr Y (Consultant Paediatrician) and Dr O (Consultant Paediatrician) who are responsible for B's care.

BACKGROUND

5. B suffers from insulin dependent diabetes mellitus (IDDM). In the days prior to her current admission to hospital B had been refusing to administer her insulin therapy despite requests that she do so. For a number of days she also refused to be admitted to hospital. However, within this context, it is important to note that the following steps were ultimately achieved by agreement:

    i) B agreed to be admitted to the Applicant's Hospital yesterday evening after discussions with her treating paediatric diabetic consultant Dr S.

    ii) At approximately 0100hours B agreed to undergo testing to determine the level of her blood sugars and ketones.

    iii) At between 0900 to 0930 hours B agreed to have an intravenous cannula inserted.

6. The testing undertaken at 0100hrs found her blood sugars and ketones to be markedly elevated with a sugar level of over 38 (versus normal of up to 10) and a ketone level of 2.5. At this point B was refusing any insulin at all. Later blood testing demonstrated a blood sugar level of 27.8 and ketone level of 5.5 and a blood pH of 7.19 (acidosis). The staff continued to have no success in persuading B to have

insulin administered. As the cannular was being inserted, allowing rehydration to be commenced, B appeared confused and vomited, the result of her failure to administer her insulin being that she had by now developed DKA. As a result, B was admitted to the High Dependency Unit.

7. I pause to note that DKA is a severe decompensation of diabetes and a condition that is life-threatening without appropriate treatment. It is a condition whereby the uncontrolled rise in blood sugars and ketones due to a lack of insulin causes an electrolyte imbalance. That condition can lead to brain swelling and, ultimately, death if left untreated. The immediate management of DKA involves inpatient care, intravenous fluids and intravenous insulin. Subcutaneous insulin therapy may also be needed to maintain blood sugar levels. Within this context, it is apparent that B's treating team state that:

    i) More aggressive treatment is required in the form of intravenous fluid infusion (to reverse the current electrolyte imbalance) and intravenous insulin. Frequent blood monitoring, including two to four hourly blood test will be required;

    ii) Subcutaneous insulin treatment may be required after some control of the DKA has been achieved;

    iii) The treatment needed to reverse the DKA is likely to last 24- 48 hours;

    iv) In the event that B develops cerebral oedema she will need a hypertonic saline bolus and, possibly, infusion, an urgent CT scan, admission to the PICU and intubation and ventilation may be required;

    v) Other complications of DKA and its treatment include hypoglycaemia, cardia arrhythmias secondary to abnormal potassium levels and, in severe cases of dehydration, renal failure.

    vi) Treatment for DKA is "meticulously standardised" in the United Kingdom and there is "universal consensus" in the paediatric community about the interventions that are required.

8. In their report Dr Y and Dr O make clear that without treatment for her DKA, B's condition will worsen to the point of cerebral oedema and death. Whilst they have had some success in persuading B to be admitted to hospital and to receive a cannula, she has refused insulin and the treating clinicians are concerned that, even if she were to agree, she may again refuse of the 48 hour period of that the treatment is required to be administered.

9. B herself has stated that she is aware of the risks attendant on her DKA not being treated. Her treating clinicians have reiterated to her the gravity of her current condition and the risk of serious injury and death which may arise by further refusal of treatment. B has acknowledged these risks and, as I have noted, reported to her clinicians that she wishes to die. Whilst she has a history of refusing to administer her insulin, resulting in in-patient care, this is the most prolonged period of refusal and is coupled with the most severe episode of DKA she has suffered to date.

10. Within the foregoing context, the Applicant NHS Trust seeks permission to administer intravenous fluids and insulin (intravenous and subcutaneous) to the B in the absence of her consent.

LAW

11. With respect to the question of competence, a child will be considered *Gillick* competent in respect of a decision concerning medical treatment if he or she has achieved sufficient understanding and intelligence to understand fully what is proposed (*Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] 1 FLR 224).

12. As noted in Mr Davidson's comprehensive and helpful Skelton Argument, unlike the position with competent adults a refusal by a minor recognized by law as having the capacity to authorise treatment (whether given by a child over the age of 16 or a younger *Gillick* competent child) is not binding on the doctors if another person with capacity to consent to treatment does so. In effect, this means that any person with parental responsibility can authorize the imposition of medical treatment on an unwilling child, as can the court (*Re K, W and H (Minors) (Consent to Treatment)* [1993] 1FLR 854).

13. In *Re W (A minor: Consent to medical Treatment)* [1993] 1 FLR 1 Balcombe LJ observed as follows:

> "One must start from the general premise that the protection of the child's welfare implies at least the protection of the child's life. I state this as a general and not as an invariable premise because of the possibility of cases in which a court would not authorise treatment of a distressing nature which offered only a small hope of preserving life. In general terms however, the present state of law is that an individual who has reached the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age…To take it a stage further, if the child's welfare is threatened by a serious and imminent risk that the child will suffer grave and irreversible mental or physical harm, then once again the court when called upon has a duty to intervene."

14. Within this context, law that the court must apply when determining whether to grant the relief sought by the NHS Trust is well settled and can be summarised as follows (drawn from in particular *In Re J (A Minor)(Wardship: Medical Treatment)* [1991] Fam 33, *An NHS Trust v MB* [2006] EWHC 507 (Fam), *Wyatt v Portsmouth NHS Trust* [2006] 1 FLR 554 and *Kirklees Council v RE and others* [2015] 1 FLR 1316:

    i) The paramount consideration of the court is the best interests of the child. The role of the court when exercising its jurisdiction is to give or withhold consent to medical treatment in the best interests of the child. It is the role and duty of the court to do so and to exercise its own independent and objective judgment;

    ii) The starting point is to consider the matter from the assumed point of view of the patient. The court must ask itself what the patient's attitude to treatment is or would be likely to be;

iii) The question for the court is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken;

iv) The term 'best interests' is used in its widest sense, to include every kind of consideration capable of bearing on the decision, this will include, but is not limited to, medical, emotional, sensory and instinctive considerations. The test is not a mathematical one; the court must do the best it can to balance all of the conflicting considerations in a particular case with a view to determining where the final balance lies. In reaching its decision the court is not bound to follow the clinical assessment of the doctors but must form its own view as to the child's best interests;

v) There is a strong presumption in favour of taking all steps to preserve life because the individual human instinct to survive is strong and must be presumed to be strong in the patient. The presumption however is not irrebuttable. It may be outweighed if the pleasures and the quality of life are sufficiently small and the pain and suffering and other burdens are sufficiently great;

vi) Within this context, the court must consider the nature of the medical treatment in question, what it involves and its prospects of success, including the likely outcome for the patient of that treatment;

vii) There will be cases where it is not in the best interests of the child to subject him or her to treatment that will cause increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's and mankind's desire to survive;

viii) Each case is fact specific and will turn entirely on the facts of the particular case;

ix) The views and opinions of both the doctors and the parents must be considered. The views of the parents may have particular value in circumstances where they know well their own child. However, the court must also be mindful that the views of the parents may, understandably, be coloured by their own emotion or sentiment;

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

DISCUSSION

15. As I indicated at the conclusion of the hearing, I am entirely satisfied that it is in B's best interests to make the orders sought by the NHS Trust. My reasons for so deciding are as follows.

16. In light of the evident and extreme urgency of the required decision on whether to administered treatment, I decided that it was necessary take the decision on the basis of submissions advanced by counsel. I was of course conscious that it was not possible, in the very short timescale available, to arrange representation for B. I was however satisfied that, in the circumstances of this case, an urgent decision was

required in light of the grave consequences that pertain were B's DKA left untreated any longer than absolutely necessary. I also bore in mind in this regard that at points leading up to the hearing B had agreed to certain aspects of her treatment.

17. In deciding that the treatment of B in the manner proposed by her treating clinicians is in her best interests, I have borne in mind in particular the following factors:

    i) The court has before it cogent evidence that B has developed DKA. She has already showed signs of confusion and vomiting. Testing at 0100hrs found her blood sugars and ketones to be markedly elevated with a sugar level of over 38 (versus normal of up to 10) and a ketone level of 2.5. At this point B was refusing any insulin at all. Later blood testing demonstrated a blood sugar level of 27.8 and ketone level of 5.5 and a blood pH of 7.19 (acidosis). There is no indication that those readings have improved and the medical evidence before the court is clear that her situation is now parlous. She has been admitted to the HDU.

    ii) If left untreated B's DKA will be fatal to her. Her condition will worsen to the point of cerebral oedema and, ultimately death. In addition, she is at risk of hypoglycaemia, cardiac arrhythmias secondary to abnormal potassium levels and, in severe cases of dehydration, renal failure.

    iii) Within this context, the window for administering treatment to B is a narrow one. As I have already noted, she has already showed signs of confusion and vomiting and her blood sugars and ketones have been markedly disordered for a significant period.

    iv) There is a strong presumption in favour of taking all steps to preserve life because life has unique value and the individual human instinct to survive is strong and must be presumed to be strong in the patient. Within this context, the court must have regard to the fact that there is a strong presumption in favour of preserving B's life. In the circumstances of this case, that presumption is a *very* compelling factor.

    v) The treatment proposed by the NHS Trust represents that favoured by a consensus of reasonable medical opinion and is, on the evidence before the court, "meticulously standardised" in the United Kingdom and there is "universal consensus" in the paediatric community about the interventions that are required. The treatment proposed will be effective in ameliorating B's DKA and thus carries with it manifest benefits.

    vi) Whilst not determinative, I also bear in mind also that B's grandfather, who cares for her, is in favour of treatment being administered to address B's DKA.

18. I have also borne in mind B's stated wishes and feelings. However, the law is clear that the court is not mandated to accept the wishes and feelings of a competent child where to honour those wishes and feelings would result in manifest, and even fatal, harm to that child.

19. In this context, I have borne in mind that this is not the first time that B has refused, for a period, to take her insulin. Whilst I have not had the benefit if psychiatric

evidence in this case (an examination being pending) this court is aware that children who have to live with the unenviable burden of chronic medical conditions sometimes seek, particularly during their teenage years, to deal with the unremitting pressure of such a situation by seeking to exercise control of the seemingly uncontrollable in the only way available to them, namely by refusing to co-operate with their treatment. Within this context, I consider it significant that B has already consented to admission to hospital, to a series of blood tests and to insertion of cannula. This suggest that her position in respect of treatment is not completely concrete and, further, suggests degree of co-operation.

CONCLUSION

20. In all the circumstances, I am satisfied that it is in B's best interests, objectively assessed, to receive the treatment proposed by her treating team and I will make orders accordingly.

21. That is my judgment.