Neutral Citation Number: [2024] EWHC 2207 (Fam)

Case No: FD23P00426

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/08/2024

Before :

MR JUSTICE FRANCIS

- -

Between :

An NHS Trust	**Applicant**
- and -	
(1) Mother	
(2) Father	
(3) G (By her Children's Guardian)	**Respondents**

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Kyle Squire (instructed by **in-house legal team**) for **the Applicant**
Eva Holland (instructed by **Cafcass Legal**) for **the Third Respondent**
The First and Second Respondents not appearing and being unrepresented

Hearing dates: 29 September 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 22 August 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE FRANCIS

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

MR JUSTICE FRANCIS :

The issue before the court

1. On 29 September 2023, an NHS Trust ("the Trust") made an application to permit NG feeding and restraint in respect of G. The parties to the proceedings were respectively the Trust, G's mother, her father, and G through her Guardian Emma Huntingdon from the Cafcass High Court team.

2. Sensibly, shortly before the matter came into court, the parties were able to reach an agreement and I approved a consent order which declared that the Trust was entitled to rely upon the consent of G's parents in treating her. However, I was invited by counsel to produce a reserved Judgement in order to resolve what was referred to as:

   "an apparent tension between, on the one hand, the common law authorities around consent to treatment and restrictions for children and, on the other, the Code."

   This is that reserved Judgment.

3. The reference to "the Code" is the statutory guidance which is issued pursuant to section 118 of the Mental Health Act 1983 which provides as follows:

   "(1) the Secretary of State shall prepare, and from time to time revise, a code of practice-
   (a) for the guidance of registered medical practitioners, approved clinicians, managers and staff of hospitals, independent hospitals and care homes and approved mental health professionals in relation to the admission of patients to hospitals and registered establishments under this Act; and

   (b) for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder".

The facts of this case summarised

4. G is 12 years old, described as a bright, intelligent and articulate girl. She has a diagnosis of anorexia nervosa and depression. At the start of 2022, G started to restrict her oral intake of food, initially by cutting out snacks. She continued by restricting portion sizes, then cutting out food groups and ultimately ceasing all consumption of food and drink. This is plainly a life threatening situation and unimaginably traumatic for her family.

5. G was admitted to the general paediatric ward at a local hospital on 20 June 2023. Whilst the team at the local hospital was treating G to maintain her weight, she was not receiving further treatment to address her eating disorder. G continued to refuse oral intake but agreed to accept NG feeding without restraint.

6. In August 2023 G was admitted to a specialist Trust hospital and was transferred to an intensive intervention unit there. This is a seven bed unit for children aged 7 to 13 years old with a range of mental health problems, including eating disorders and emotional and behavioural disorders. The Trust which operates the Unit is not registered with the CQC to exercise powers available under The Mental Health Act 1983. Accordingly, use of "the section process" pursuant to that Act is not available.

7. Since her admission to the Trust hospital in August 2023, G has not been taking food or liquid orally, and has attempted to refuse food through her NG tube. There was a period of about a week in August 2023 when G had to be restrained to receive NG feeds, with up to four staff being required on some occasions. I have been shown a chronology of "unplanned clinical holds" which have been necessary in G's treatment and in order to prevent her from harming herself. It would be unnecessarily painful for anyone reading this Judgment for me to set out more detail about those restraints.

8. The Trust's application is supported by a statement from Dr H, a locum consultant Child and Adolescent Psychiatrist at the Trust. In August 2023, Dr H assessed G as not being "Gillick competent" in respect of NG feeding, and the restraint necessary on some occasions to ensure NG feeding. The treatment and restraint was consented to by G' mother and father, and they also agreed to the administration of medication and to G engaging with therapeutic support. Tragically, G has on occasions expressed that she does not want to live and it is thought that the resistance to the NG tube is a means of communicating this.

The application before the court

9. The Trust applied on 21 August 2023 for the following:

    i. *"a declaration that it is lawful to rely upon parental consent for G to be restrained in order to receive feeding via a nasogastric tube;*
    or, in the alternative
    ii. *a declaration that it is in G's best interests to be restrained in order to receive feeding via NG tube, as required, in order to restore her weight for height to at least 85%; it is currently 73%."*

10. At a hearing before Moor J on 23 August 2023, it was ordered that a children's Guardian be appointed to represent G. The Guardian is Emma Huntingdon from the Cafcass High Court team and I am grateful to her for her invaluable assistance in this case and, of course, to her representatives.

11. Dr H filed an updating statement dated 22 September 2023, where it was made clear that G's weight has increased, measured at 83.49% weight for height ratio. G continued to be fed twice a day and needs restraint by four or five members of staff on each occasion when being fed with an NG tube.

12. The Trust has contended that, whilst common law authorities demonstrate that it is lawfully permissible to rely on parental consent for treatment and restraint, the Code suggests that it is not lawfully permissible to rely on parental consent in the

circumstances pertaining.

13. There is an issue as to whether technically G comes within the scope of the Code. This is because she is not detained under section 2 or section 3 of the Mental Health Act 1983. I take the view that, although this technical issue is correctly raised, it would be incorrect to regard this case as being subject to different principles simply because it technically falls outside of the Code. In my judgement, the Trust is correct in contending that it is, in effect, bound by the Code, even though strictly speaking G is not detained pursuant to the Mental Health Act 1983. In my judgement, the Code is properly to be seen as guidance for registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.

The Guardian's analysis

14. The Guardian has of course spoken with the parents, with the consultant child and adolescent psychiatrist, Dr H, and with the care co-ordinator at the Unit, Dr I. The Guardian has also attended the weekly core team meeting in respect of G at the Unit on 19 September 2023. The Guardian met with G in the study room on the Unit on 20 September 2023. The Guardian has also spoken by telephone with the allocated social worker from the local children's services. I am satisfied that the Guardian has properly complied with her duties and has been able effectively to report G's ascertainable wishes and feelings to the court.

15. The Guardian informed the court that it was her impression that G was listening intently during their discussions and G indicated to the Guardian with the use of hand gestures that the Guardian's presence was "not bothering her". The Guardian explained her role to G and asked her what she would think if the Guardian was to put forward to the court the view that G's treatment was "right" and "the right thing to do". G did not respond to this but the Guardian considered it notable that G did not seek to reject or convey resistance to this. The Guardian reports that, unfortunately, there has been limited progress since G's admission to the Unit in terms of her ability to tolerate food or feed intake. However, G was described by Dr H as presenting as "less distressed" when receiving a feed than she was when she first arrived on the ward. The Guardian reports that G continues to present with low mood and there have been attempts at self-harm. Very sadly, G's relationship with her family has become strained and her verbal communication with them has been sporadic and, at times, hostile. It is clear that the parents welcomed the prospect of the court make a declaration in respect of G's treatment as this would potentially lessen the extent to which G holds her parents responsible.

16. The mother told the Guardian that the consent from her husband and herself remains open and that it is there until G starts eating. They cannot anticipate a scenario where they would feel unable to continue to consent.

17. G, her older sister (who also suffers from anorexia) and her younger brother have all been the subject of a Child and Family Assessment by the local Children's Services and have been assessed as meeting the threshold for support under a Child in Need Plan. I do not believe that it is necessary for me to go further into this aspect of this case for

the purposes of this Judgment, which is limited to the issue identified by me in paragraph 2 above.

Submissions and my analysis

18. The Trust refers to paragraph 19.40 and 19.41 of the Code in relation to the matter of parental consent which states:

"In some circumstances, it will be possible for children lacking competence and young people lacking capacity to be admitted to hospital and/or treated on the basis of parental consent (see paragraphs 19.53 – 19.70). However, practitioners must be satisfied that it is appropriate to rely on parental consent. This is important because court decisions relating to parental consent have emphasised that there are limits to both the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made. For example, when making decisions on behalf of their child, parents must act in their child's best interests. The limits to what a parent can consent to on behalf of their child is relevant to whether a deprivation of liberty has arisen (see paragraphs 19.44 – 19.48). This guidance uses the term 'scope of parental responsibility' to highlight the need to establish whether the particular decision can be authorised by parental consent or not. Those cases in which parental consent is sufficient are described as falling within the scope of parental responsibility.

19.41 Whether the particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case. Practitioners will need to consider a range of factors. These are set out below, under the two key questions that must be addressed (the term 'parent' is used to cover all people with parental responsibility)

• First, is this a decision that a parent should reasonably be expected to make? If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required. When considering this question, any relevant human rights decisions made by the courts should be taken into account. Significant factors in determining this question are likely to include:

• the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. Relying on parental consent to authorise an intrusive form of treatment might be justified because it is necessary to prevent a serious deterioration of the child or young person's health, but this would need to be balanced against other factors such as whether the child or young person is resisting the treatment; whether the specific form of treatment is particularly invasive and/or controversial (eg careful consideration should be given to the appropriateness of relying on parental consent to authorise electro-convulsive therapy)

• the age, maturity and understanding of the child or young person: the role of parents in decision making should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person

• the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision, and
• whether the child or young person had expressed any views about the proposed intervention when they had the competence or capacity to make such decisions; for example, if they had expressed a willingness to receive one form of treatment but not another, it might not be appropriate to rely on parental consent to give the treatment that they had previously refused.

Secondly, are there any factors that might undermine the validity of parental consent? Irrespective of the nature of the decision being proposed, there may be reasons why relying on the consent of a person with parental responsibility may be inappropriate; for example:

• where the parent is not able to make the relevant decision; for example, this may arise, if the parent lacks capacity as defined in the MCA, because of their own mental health problems or learning disabilities. In cases of doubt, the parent's capacity will need to be assessed in accordance with the MCA

• where the parent is not able to focus on what course of action is in the best interests of their child; for example, where the parents have gone through a particularly acrimonious divorce, they may find it difficult to separate the decision whether to consent to their child's admission to hospital from their own hostilities

• where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so that they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken, and

• where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility, it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court.

A 14 year old girl is assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. She is severely anorexic and the proposed treatment is that she is fed by naso-gastric tube. The naso-gastric tube may need to be in place for several weeks in order to restore the child to a safe BMI (body mass index). The care team conclude that as this is a particularly invasive form of treatment and the girl is likely to resist the insertion of the tube, it would not be appropriate to rely on parental consent to authorise this intervention. Accordingly, even though a person with parental responsibility consents, the child is not admitted and treated informally under section 131(1) of the Act. If the child meets the relevant criteria, she could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken."

19. Eva Holland's very helpful skeleton argument on behalf of the Guardian correctly identifies that the Code refers to a number of cases in a footnote to section 19.40 and these are also referred to in the Position Statement on behalf of the Trust. The Code came into force in 2015. Ms Holland submits to the court that practitioners must be guided by the developing case law in this area. I agree; it is, it seems to me, clear that the Code must follow case law. Case law will be developed with the basis of legal analysis following expert evidence. Parliament produces statutes. Judges interpret statutes where that is necessary. The Common Law is derived from judicial precedents, to which the long established and understood doctrine of precedent applies. These are basic truisms. It is a fundamental principle of our doctrine of precedent that the Common Law in England and Wales is developed by Judgments of the High Court and above. Of course when delivering a Judgment, judges will always take into account the expert evidence that is placed before them. I am not in any doubt that it is judges, and not those writing the Code, that state the law. Indeed, I cannot see how any student of jurisprudence could suggest that a Code of Practice could be superior to judicial precedent. From time to time the Code will be developed and updated, based upon judicial precedent. I agree with the submission that there should be no tension between the Code and the common law authorities. However, if there is, the matter must be referred to the court for the judge to decide.

20. I have helpfully been reminded of the decision of Lieven J in AB v CD [2021] EDWHC Civ 741 (fam) at [116] where the judge stated:

"The analysis of the case law shows that the cases supporting a special category of treatment of children which require Court approval are very limited. In fact, the only case where the Court has found a legal requirement to come to Court in respect of treatment of a child, where both parents consent, is Heilbron J in Re D, the case of a "non-therapeutic" sterilisation of an 11 year old. In all other contexts, including where the parental decision will lead to the child's life ending, the Court has imposed no such requirement. There are a range of cases where there does have to be Court approval, but this is where there is a clinical disagreement; possible alternative treatment of the medical condition in issue; or the decision is, in the opinion of clinicians, finely balanced. These are fact specific instances rather than examples of any special category of treatment where the Court's role is required simply because of the nature of the treatment".

21. I agree with the submissions made on behalf of the Trust that the authorities establish the following proposition: where a child lacks Gillick competence to make their own decision, and there is agreement between the clinical team and parents as to the best interests of the child, a parent can consent to both medical treatment and any consequent deprivation of liberty. This enables clinicians lawfully to carry out the treatment plan. In those circumstances, no court authorisation is required. NG Tube feeding, even if contrary to the non-Gillick competent child's wishes, does not fall within a special category that requires court authorisation. The primary purpose of the tube feeding is to preserve life. Rather than being a case where it will have long-term physiological consequences, I agree with the submission made on behalf of the Trust that the opposite is in fact true, to the extent that without tube feeding the child might (probably would) die. I agree with the submission made by the Trust that the guidance in the Code that there are limits on the decisions which can be taken by parents in relation to treatment of their children under the age of 16 is erroneous. Where there is consensus of the

clinical team and parents, the parents are able to provide their consent.

22. The Trust, supported by the Guardian, invites the court to conclude that for those in G's situation, a parent can consent to treatment on their behalf, even that which is repeatedly invasive and amounts to a deprivation of liberty, and a court application is not required. It seems to me that the Code has not been updated since 2015 and that updating is now required. It is not, of course, the judicial function to become immersed in the drafting of such guidance; however, of course, the Code will from time to time be amended to reflect judicial decisions.

23. I have also heard detailed and careful submissions on the issue of restraint that can lead to a deprivation of liberty. In respect of the matter of the restraint, the question arises whether G's parents can consent to a deprivation of her liberty. As summarised in the Trust's position statement, the Judgment of Lieven J in Lincolnshire County Council v TGA [2022] EWHC 2323 (fam) provides a survey of the authorities. Lieven J considers the Judgment of Keehan J in Re D (Deprivation of Liberty) [2015] EWHC (fam) where a parent was acting within the "zone of parental responsibility" and could consent to the deprivation of liberty of their 15 year old son who suffered from Aspergers syndrome and Attention Deficit Hyperactivity Disorder in a psychiatric unit, and whether this decision has been overtaken by the Supreme Court decision in Re D (A Child) [2019] UKSC 42.

24. Lieven J stated at [47]- [51] and [58]:
47. *"The conclusion I have reached is that a parent can consent to a deprivation of liberty within Storck component (b) for a child under 16, who lacks Gillick competence, where there is no dispute that such a deprivation is in the child's best interests. As I have explained above, none of the previous domestic cases are binding upon me in respect of the role of parental consent for under 16 year olds. On the other hand, Nielsen expressly dealt with the point and the ECtHR found the deprivation of liberty in that case did fall within the parental power to deprive a child of his/her liberty*.

48. *I agree with Munby P that, using the language of the subsequent case of Storck, the ECtHR in Nielsen at [73] was finding that the mother could consent to the child being deprived of his liberty in the hospital. It is possible to analyse the case as finding that the mother was able to "authorise" the State, through the hospital, to deprive the child of his liberty. However, in my view, that introduces an extra and unnecessary level of complication into the analysis. It is simpler, and more in keeping with the domestic caselaw, to see Nielsen as being about the child's deprivation of liberty falling within the scope of parental responsibility.*

49. *The power of parents to exercise custody over their children, or in modern parlance, to deprive children of their liberty, has long been accepted by the common law, see Hewer v Bryant. That power in respect of under 16 year olds has not been removed by statute. There can be no doubt that in respect of very young children, as Lord Kerr phrased it, they can be restrained to a point where Storck (a) is met, whether in the family setting or in school or any other setting.*
50. *The contrast with the statutory position of children aged 16 and over is set out by Lady Hale in Re D at [26]. There are a host of statutory provisions which mark the legal importance of attaining the age of 16, and the legal separation that gives between a child's rights and those of his/her parents.*

> 51. *However, the position is different for a child under 16 years old, both in common law and under the ECHR. It follows that the very nature of "family life" and therefore the protections under Article 8 for the parents' rights, will be different for a younger child. It is however critical to have in mind that the exercise of any parental rights in respect of a child must be for the benefit of the child. If the parent was exercising parental rights, including consenting to the deprivation of liberty, in a way which was said to be contrary to the child's best interests then such a decision would no longer fall within the zone of parental responsibility.*
>
> 58. *"if a child under 16, such as K, plainly does not have Gillick competence to make the decision as to his liberty, and his parents (or in this case his testamentary guardians) decide to deprive him of his liberty, and no third party (such as the local authority or an NHS body) consider such deprivation to be contrary to his best interest, then the parents can lawfully deprive him of his liberty".*

25. I agree with that Judgment of Lieven J. but would add this, perhaps by way of qualification: in [51] above, Lieven J said, "*If the parent was exercising parental rights, including consenting to the deprivation of liberty, in a way which was said to be contrary to the child's best interests then such a decision would no longer fall within the zone of parental responsibility".* It seems to me that even a decision which was made contrary to the child's best interests could still be a decision made in the exercise of parental responsibility. Every day parents will exercise parental responsibility and will sometimes make decisions that are contrary to their child's best interests. This is still exercising parental responsibility. It is the duty of the State to intervene where a decision is contrary to the best interests of the child, and might cause the child to suffer significant harm. However, where, as in the instant case, the treating medical team and the parents agree, the state's intervention is unnecessary; indeed, in my judgement, it would be inappropriate unless, for example (in what I believe would be a very rare case) a local authority or the Children's Guardian took the view that both the hospital and the parents had "got it seriously wrong". Such cases, as I have said, will be extremely rare.

26. Accordingly, I conclude that in G's sad and difficult situation, where the parents and the treating medical team are "at one", it is lawful to rely on parental consent, that an application is not only unnecessary, but would make an already almost unbearable situation in respect of G (from her family's perspective) even more difficult, and would also cause huge expense and delay. Accordingly, a declaration that it is in G's best interests to receive the treatment and, if needed, to be restrained in order to receive the NG treatment, is unnecessary.

27. However, because:
    a. this matter has been so carefully argued before me;
    b. I have concluded that it clearly in G's best interests to receive the treatment and, if necessary, to be restrained;
    c. It is possible that an appeal may follow this Judgment on a point of legal principle

    I regard it as appropriate to make the declaration with which all parties agree. Accordingly, I invite the advocates to draw up an order which declares (1) that a

declaration is unnecessary and (2) that, in any event, and without prejudice to the foregoing declaration, the court makes the declaration, as invited, regarding treatment and any necessary restraint.

28. I conclude by expressing:
    a. my hope that, since this matter was last in court, G has responded well and is now showing some signs of improvement; and
    b. my thanks to the advocates and their legal teams for the expertise that they have demonstrated in putting this matter before the court in the way that they have.