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Confirmation of the High Court's Power to Override a Child's Treatment Decision: *A NHS Trust v X (In the matter of X (A Child) (No 2))* [2021] EWHC 65 (Fam)

Commentary

ABSTRACT

In *A NHS Trust v X* the High Court considered and upheld the principle established in *Re R* and *Re W* in the 1990s that a child's right to accept or refuse treatment is not absolute. An NHS Trust applied for a 2-year rolling order to authorise 'top up' blood transfusions for X that would last until her 18th birthday. For religious reasons, *Gillick*-competent X objected to blood transfusions that would in all likelihood be clinically necessary to treat her sickle cell syndrome. Indeed, on two previous occasions the court had authorised transfusions following urgent applications. Adults with capacity have the right to accept or refuse even life sustaining medical treatment. X argued that by virtue of her competence she should be extended the same right. Sir James Munby, however, upheld the 'conventional wisdom' that the court can overrule a child's competent or capacitous decision, but denied the rolling order as X's welfare in each crisis would be determined on the facts. The case preserves the status quo notwithstanding developments in children's rights. It also clarifies the justificatory rationale and raises new questions.

KEYWORDS: Best interest, Capacity, Children, Consent, Gillick competence, Jehovah's Witness

I. THE FACTS AND JUDGMENT

X, who was nearly 16 at the time of the application, was 'mature and wise beyond her years'.[1] She has a serious medical condition, sickle cell syndrome, which can cause crises where urgent administration of blood products that are contrary to her religious beliefs is clinically indicated. On two previous occasions urgent applications were made to the court and declarations permitted the administration of blood products.[2] On the second of those occasions, before Sir James Munby, the evidence suggested that X was making a *Gillick* competent refusal of treatment. Sir James described that case as a a 'scramble to justice' given the urgency of the application and the challenging nature of the arguments and opined that the best way forward was to consider the arguments at a hearing where sufficient time is available to reflect.[3] That opportunity was presented in *A NHS Trust v X*.

With thanks to Professor Deryck Beyleveld for the opportunity to talk this through.

[1] [2021] EWHC 65 (Fam), [4]. (Hereafter *X*)

[2] *Re X* [2020] EWHC 1630; *Re X* [2020] EWHC 3003 (Fam).

[3] [2020] EWHC 3003 (Fam), [21].

The Trust sought an order that 'top-up' blood transfusions would be lawful for a two-year rolling period that lasted until X's 18th birthday. Sir James considered the contemporary application of *In re R (A Minor) (Wardship: Consent to Treatment)* and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction*)[4] in light of social, cultural and legal developments, including the Mental Capacity Act 2005 (MCA 2005) and the Human Rights Act 1998. In *Re R* and *Re W* it was held in the early 1990s that competent refusals of treatment by children aged 15 and 16 respectively, could be overridden by parents or the court if the refusal would cause them grave harm and was not in their best interests. In *NHS Trust v X* the aspect of *Re R* and *Re W* under consideration was the ability of the *court* to overrule the child's decision.[5]

Counsel for X, Mr Brady, argued that the rolling order would violate her human rights at common law, under the MCA 2005 and under the European Convention on Human Rights (ECHR) articles 2, 3, 5, 8, 9, and 14. Sir James held that no child has an absolute right to accept or refuse treatment. Article 2 is engaged notwithstanding dicta from the ECtHR that a refusal of blood products by a Jehovah's Witness is not 'tantamount to suicide'.[6] Articles 3, 8, 9 and 14 are subject to the legitimate aim of preserving the lives of children, as, he held, is reflected in the UN Convention on the Rights of the Child articles 3, 6 and 24:

> There is … nothing in the jurisprudence of the Strasbourg court recognising, let alone mandating States to enforce, a principle that a child, even a child who, to use our terminology, is *Gillick* competent or who has reached the age of 16, is in all circumstances autonomous in the sense that a capacitous adult is autonomous; nor, specifically, that such a child is autonomous when it comes to deciding whether or not to accept life-saving medical treatment.[7]

Sir James held that notwithstanding developments since *Re R* and *Re W* and the academic criticism they have sustained, they remain good authority for the proposition that the child's (under-18-year-old's) competent or capacitous refusal is not always determinative. Like Lord Donaldson in *Re W* before him,[8] Sir James asserted that any 'change … is a matter for Parliament, not the courts.'[9]

An appeal may follow if X applies directly to the Court of Appeal, but both an application for a leapfrog appeal to the Supreme Court and permission to appeal to the Court of Appeal were denied. As to whether a rolling order should be made, Sir James accepted that the court has the power to make such an anticipatory order, but refused the application in this case, in part to mitigate the risk of medical paternalism that would flow from clinicians having the power to override X's views and in part because the decisions should be fact specific.[10]

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[4] *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64. (Hereafter *Re R* and *Re W*).
[5] *X* (n 1) [32].
[6] *Jehovah's Witnesses of Moscow v Russia* [2019] ECJHR 192, [132].
[7] *X* (n 1) [120].
[8] *Re W* (n 4).
[9] *X* (n 1) [162].
[10] ibid [167]-[168].

The judgment lays bare the adoption of a future-orientated version of autonomy and a protectionist stance that will apply up to adulthood. Sir James stated that this is not to say that a child's view will never be determinative, but rather that the determinative nature is qualified, so that there will be some circumstances where it is not determinative.[11] The circumstances in which that will be the case have changed over time, because welfare is to be judged according to today's standards.[12] The judgment in *A NHS v X* is unlikely to be the final word on adolescent medical decision making. I shall set out considerations that were not raised on the facts and others that flow from the judicial reasoning.

II. THE 'CONVENTIONAL WISDOM'

Sir James recognised that the central point in this case is whether *Re R and Re W* (the 'conventional wisdom'[13]) remain good law in light of subsequent developments.[14] The courts are rightly reluctant to depart from established principle, but there are several examples of them having done so in order to limit medical paternalism and protect patient autonomy. In *Montgomery v Lanarkshire Health Board (Montgomery),* for example, the Supreme Court departed from *Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital*[15] to protect patient choice and limit medical paternalism.[16]

There have also been daring moves to develop the common law in order to recognise and protect children's rights. Andrew Bainham points to *Hewer v Bryant's* (1969) powerful legacy.[17] There, holding that the law 'can, and should, keep pace with the times'[18] Lord Denning found that it was no longer appropriate that the power to physically control a child did not end until the age of discretion at 21. Instead, the parental right to custody of a child dwindled as the child matured.

Gillick v West Norfolk and Wisbech Area Health Authority[19] is equally important. Mrs Gillick was successful in the Court of Appeal in her attempt to secure the right to veto contraceptive treatment being given to her daughter. Her right to do so was seen as an inalienable right of parents that (except in emergencies) could only be overridden by the court. The House of Lords diverged. It held that parental rights exist for the benefit of the child and dwindle as the child becomes more mature until they 'yield' to the child's right to decide 'when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision'.[20]

Both cases were referred to by Lady Hale and Lady Black recently in *Re D*. The Supreme Court by a majority of 3 to 2 allowed an appeal against Sir James Munby's Court of Appeal

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[11] ibid [30].
[12] ibid [159].
[13] ibid [2].
[14] ibid [173].
[15] [1985] AC 871.
[16] [2015] UKSC 12.
[17] A Bainham, 'Lord Denning as a Champion of Children's Rights: The Legacy of *Hewer v Bryant*' (1999) 14(1) *The Denning Law Journal* 81.
[18] *Hewer v Bryant* [1970] 1 QB 357, at p 269.
[19] [1986] AC 112, HL. See J Eekelaar, 'The Eclipse of Parental Rights' (1986) LQR 102, 4.
[20] ibid p 186D, per Lord Scarman.

judgment,[21] holding that it was not within the scope of parental responsibility to consent to arrangements for a young person of 16 or 17 which would otherwise constitute a deprivation of liberty. The case did not settle the matter of the scope of parental responsibility in relation to serious medical treatment.[22] Lady Black was clear that:

> Nothing that I have said is intended to cast any doubt on the powers of the courts … to make orders in the best interests of children up to the age of majority, with due regard to their wishes and those of their parents, but not dictated by them.[23]

But *Re D* does show the potential to develop the law to protect the human rights of children. Citing *Hewer* and *Gillick,* Lady Hale said: 'Two 20th century cases show how, whatever may have been the earlier position, the common law is capable of moving with the times.'[24] The majority in *Re D* amalgamate human rights, common law and statutory provisions to show that the human rights of 16 and 17-year-olds are now different to those of younger children.

Counsel for X invited Sir James to review the law and recognise a competent or capacitous decision as authoritative. This case, like *Montgomery, Gillick, Hewer* and *Re D* presented an opportunity to develop the common law to reflect a revised understanding of human rights. But Sir James took a narrow view of the question of whether *Re R* and *Re W* remain good law. His focus was on whether they are justifiable rather than whether they are justified. Mr Brady for X and Ms Butler-Cole and Mr Ruck Keene for the CAFCASS[25] argued that the pertinent parts of *Re R* and *Re W* were *obiter* because the children at the heart of those decisions probably lacked competence, but Sir James responded:

> How sensibly can this be treated as mere *obiter*? I do not criticise counsel for taking the point, but I have to say that it is the kind of point which probably has more traction amongst the dreaming spires of the Academy than in the robust and ultimately pragmatic world of the court room.[26]

Re R and *Re W* have been consistently followed, most recently in *Bell & Anor v The Tavistock and Portman NHS FT.*[27] Sir James did not consider that the court was free to consider the possible impact of changes in the balance between medical paternalism and patient autonomy. He acknowledged that 'a family court cannot be blind to the changes in society's views and values which are such a striking feature of modern life',[28] but nor, he argued, can it 'reject the learning – the law – as set out'[29] in *Re R* and *Re W*. He said he cannot

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[21] [2017] EWCA Civ 1695.
[22] *In the matter of D (A Child)* [2019] UKSC 42, [50] (Lady Hale), Lady Arden [117]. (Hereafter *Re D*).
[23] ibid [90].
[24] ibid [22].
[25] The Children and Family Court Advisory Support Service which represents children in the family court in England, giving independent advice as to what is in their best interests.
[26] *X* (n 1) [60].
[27] [2020] EWHC 3274 (Admin), [109]-[113]. (Hereafter *Bell*). A judicial review of the practice of prescribing puberty blockers to children experiencing gender dysphoria based on their informed consent. A *Medical Law Review* Commentary by another author is forthcoming.
[28] *X* (n 1) [159].
[29] ibid [160].

overthrow those cases 'merely because society's views have changed, even assuming that they have'.[30] But whilst Sir James opined that only Parliament can make the change, based on the examples given above it is questionable that a challenge to *Re R* and *Re W* to assert a child's decision-making authority would have offended the rule of law.

III. OVERRULING COMPETENT AND CAPACITOUS CHILDREN

If, as I argue, there was scope to adopt a different position, should the opportunity have been grasped? Sir James makes a strong case for the continued justifiability of the power of veto notwithstanding legislative developments including the MCA 2005 (which addresses incapacity and not capacity) and the Human Rights Act. But this does not exclude the possibility that an alternative view would also be justifiable and potentially preferable.

We should not duck the issue at the heart of this case. A child seeks the right to refuse treatment without which she will suffer grave harm and probably death. The equivalent situation in relation to adults was set out in *Re T* in 1992,[31] and clarified in *B v An NHS Hospital Trust* ten years later.[32] Ms B had become quadriplegic as a result of a burst blood vessel in her spinal cord. She took the NHS Trust to court when they refused to switch off her ventilator because they believed all treatment options had not been exhausted. Dame Butler-Sloss P said the 'immensely impressive' Ms B showed 'a very high standard of mental competence, intelligence and ability'[33] and thus was entitled to refuse treatment that would result in her death. Her competence (pre MCA 2005) was commensurate with the gravity of the decision to be made. Butler-Sloss P recognised that: 'There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient.'[34] More recently, as we have seen, efforts to effect a transition away from paternalism and toward the protection of adult patient choice are clear from *Montgomery,* where it was recognised that 'a conscious adult patient of sound mind is entitled to decide for herself whether or not she will submit to a particular course of treatment proposed by the doctor'.[35]

Like Ms B, X was fighting for the right to make a decision that could result in her death. Like Ms B, X was competent to make the decision. But X's status as a child brings to bear welfare considerations that are not relevant to adults with mental capacity. For X 'benevolent paternalism' was accepted by the court: competence or capacity to make the decision is a necessary but not always sufficient ground for the child's right to make a definitive treatment decision that will result in grave injury.

As long as welfare is a paramount or even a primary consideration, then even if we accept that maximally autonomous decisions should be upheld, it is not clear that the current tests for decision-making ability are sufficiently robust to accurately identify such decisions.[36] Mr

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[30] ibid [161].
[31] R*e T (Adult: Refusal of Medical Treatment)* [1992] EWCA Civ 18
[32] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).
[33] ibid [53].
[34] ibid [94].
[35] *Montgomery* (n 16) [50] (Lords Kerr and Reed).
[36] E Cave, 'Goodbye Gillick? Identifying and resolving problems with the concept of child competence' (2014) 34(1) LS 103.

Brady for X and Ms Butler-Cole and Mr Ruck Keene for the CAFCASS argued it was possible to refine the tests for competence and capacity: for children under 16 the authority of their decision should turn on whether or not they are *Gillick* competent, taking into consideration both the child's development and any temporary factors impacting on their decision-making ability; for young people of 16 and 17, a finding that they are both *Gillick* competent and have not had their presumption of capacity rebutted under the MCA 2005, should give them authority to decide.[37] But Sir James referred to this argument as a 'conceptually problematic' 'will-o'-the-wisp' that focussed too heavily on academic opinion:

> I have to say, however, that some of the thinking in the Academy savours too much of the Thomist schoolmen. In the law, as in other areas of human endeavour, Ockham's Razor surely has an important part to play.[38]

I shall make two brief retorts in support of academic endeavours to bolster tests for decision making, so they might reflect maximally autonomous decisions which could then be recognised as authoritative. Firstly, one might employ Ockham's razor to uphold the idea that the hypothesis with the fewest assumptions is that recognition in *Gillick* of the power of competent children to consent incorporates a power of competent children to refuse consent. Secondly, Ockham's razor is all very well when complex and simpler explanation are of equal value. The more 'Thomist' solutions flow from the belief that they are not. It is simpler and more pragmatic to disengage decision-making ability and decision-making authority, but the result is arbitrary: The right to authoritative medical treatment decision-making at 18 will result in injustices on both sides of the line.[39] It also limits the meaningfulness of the child's expression of their view: whilst the balancing exercise in court will take into consideration the view of the child, it is uncertain that this would always be translated accurately into practice. From a rights-based facilitative account of welfarism, if the decision is maximally autonomous it ought to be upheld. John Coggon has argued that we should be reluctant to distinguish competence and authority:

> We see that generally to exercise autonomy is good. Further, we see that a limit to that exercise inflicted by society needs justification. Thirdly, we see that where we can respect it, we do so by allowing people to make lawful decisions.[40]

If it were accepted that the current tests for competence and incapacity are too blunt to identify autonomous decision-making in children, then the options would be to amend them or to divorce competence / capacity and authority. Sir James chose the latter and his view that a version of the former would be 'conceptually problematic' suggests that his reluctance does not flow purely from a position that reform would be contrary to the rule of law. Rather, he seems to accept that however autonomous a child's decision, there might

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[37] *X* (n 1) [70].
[38] ibid [71].
[39] Consider *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, for example. A blood transfusion of a 15-year-old Jehovah's Witness was authorised by Ward J. At aged 18 the boy refused treatment and died. See C Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment (1999) 62(4) MLR 585, 588.
[40] J Coggon, 'Varied and principles understandings of autonomy in English law: Justifiable inconsistency or blinkered moralism? (2007) 15 *Health Care Analysis*, 235-255.

still be occasions when the court would overrule it in order to prevent grave harm to the child.

A glimmer of hope for young people who seek to make authoritative decisions flows from the refusal of a rolling order. There is tacit acknowledgement that X's situation might change with time. As X gets ever closer to her 18th birthday, if her opinions remain steadfast, her best interests might one day be served by acceding to her wishes. Sir James does not state that a child's views will never be determinative where grave injury would result, but that the determinative nature is qualified.[41] The question of what is appropriate in a particular case therefore lies beyond the scope of this judgment and this commentary, in the balancing exercise on the facts of each case, between the protectionism required by article 3 of the UN Convention of the Rights of the Child and the requirement in article 12 to consider the child's opinions and take them seriously.

IV. CLARIFICATIONS AND CONUNDRUMS

So far, I have focussed on the controversial retention of the disconnect between competence or capacity and authority: the decision in *X* makes clear that children's decisions are subject to veto by the court. It also raises a number of additional issues.

First, Sir James states that the power of veto is not peculiar to treatment refusals. It applies in relation to treatment decisions that risk the child's life or health, whether they be decisions to consent or objections to treatment, and this is so in relation both to under 16-year-olds and those of 16 and 17.[42] There is support for the veto's application in relation to decisions to consent as well as to refuse in *Re R* in relation to children under 16.[43] For children of 16-17, however, section 8 of the Family Law Reform Act 1969 allows the child to give consent that is 'as effective as it would be if he were of full age'. Whilst, according to *Re W*, others can provide an effective consent if the child will not provide it (so supporting a power to override a refusal),[44] it is not as clear that, as Sir James contends, this interpretation of section 8 would support overriding an effective consent.

Second, Sir James held that the relevant test for children under 16 is *Gillick*-competence, and once a child reaches 16 there is an assumption of legal capacity according to section 8 of the Family Law Reform Act 1969 unless the presumption of mental capacity in the MCA 2005 is rebutted.[45] This might usefully be taken into consideration when the next version of the MCA Code of Practice is published, as the current version intimates that a 16 or 17-year-old may be unable to make a decision for some reason other than a lack of mental capacity in which case common law principles will apply.[46]

Third, it leaves open the question of whether, like the High Court, those with parental responsibility might veto their child's competent refusal. Lady Hale considered this

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[41] ibid [30].
[42] ibid [2].
[43] *Re R* (n 4) p 28 per Staughton LJ.
[44] *Re W* (n 4) p 77.
[45] *X* (n 1) [57], [77].
[46] *MCA 2005 Code of Practice* (Department for Constitutional Affairs, 2013), para 12.13.

proposition 'controversial' in *Re D*[47] but that does not settle the matter. If Ockham's Razor supports the view that the powers of the court to overrule the child is part of the *ratio* of *Re R* and *Re W* then it seems likely that the same can be said of the power of parents.

It also leaves open the question of whether treatment of a child would be justifiable if physical force were required. Breach of article 5(1) may be lawful in relation to 'persons of unsound mind' but a child making a competent or capacitous decision is unlikely to be characterised as such. X was compliant with previous orders, so the matter did not arise. Emergency treatment requiring a deprivation of liberty is also justifiable.[48] Longer term deprivations of liberty, such as was required in Connecticut when 15-year-old Cassandra C was required to undergo a course of chemotherapy for non-Hodgkin's lymphoma against her will,[49] would be difficult to justify.

Additionally, the decision in *X* has impact beyond the refusal of life sustaining treatment. It confirms different purposes to the provision of consent to treatment depending on the age of the person with capacity or competence. For adults, valid consent protects bodily integrity and patient autonomy and is bolstered by the law of negligence which requires informed consent to protect patient choice for which the patient takes responsibility.[50] For adults the law has moved away from the idea that consent is to protect the clinician from liability and embraced the idea of a patient-centred, autonomy-enhancing process through which the patient takes responsibility for their decision. The reasoning in *X* affirms the departure from this rationale in relation to children. For them, the primary purpose of valid consent is to provide the clinician with a 'flak jacket' to protect her from a claim in trespass to the person.[51] The court's power of veto reduces the potential for consent to protect current autonomy and bodily integrity. *Montgomery's* patient-centred test for materiality of risk was seemingly accepted as being applicable to child consent in *Bell.*[52]A distinction was drawn between valid and informed consent: children do not need to understand all the information given by a *Montgomery*-compliant clinician in order to be considered *Gillick* competent, for to do otherwise would be to set the threshold for competence too high.[53] This creates a conundrum for the clinician who would seek to avoid a claim in negligence by disclosing material risks even if she believes the competent child is not capable of understanding them. *X* and *Bell* both raise questions as to the purpose and limitations of child consent.

Finally, *X* raises a question as to what must be understood to be *Gillick* competent. In *Bell*, Dame Victoria Sharp P, Lewis LJ and Lieven J approved of the approach set out in *Re S.*[54]

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[47] *Re D* (n 25) [26i]. And see Department of Health, *Reference Guide to Consent for Examination or Treatment*, 2nd ed, (Department of Health, London 2009) p 34.
[48] *X* (n 1) [127]; *R (Ferreira) v Inner South London Senior Coroner (Intensive Care Society and others intervening)* [2017] EWCA Civ 31; *In re D Birmingham City Council v D (Equality and Human Rights Commission and others intervening)* [2019] UKSC 42, [119]-[120] (Lady Arden).
[49] *In re Cassandra C*, 112 A 3d 158 (Conn. 2015).
[50] *Montgomery* (n 16) [81] (Lords Kerr and Reed).
[51] *Re W* (n 4) p 76H and 78D-F (Lord Donaldson).
[52] *Bell* (n 19).
[53] ibid [130]. On the application of *Montgomery* to children see E Cave & C Purshouse, 'Think of the Children: Liability for Non-disclosure of Information Post-Montgomery' (2020) 29(2) *Medical Law Review* 270.
[54] [2020] EWHC 3274 (Admin), [116]-[118]. *Re S (A Child) (Child Parent: Adoption Consent)* [2019] 2 Fam 177.

There, in the context of an adoption case, Cobb J determined that, absent the assumption of capacity and diagnostic criteria, the MCA 2005 incapacity test was relevant to the determination of competence in an under 16-year-old. This accords with the view of the current President of the Family Division, Sir Andrew McFarlane, writing extra-judicially in 2011.[55] Sir James takes a quite different approach. Respectfully disagreeing with the argument set out in *Bell*, he argues that mental capacity and competence should be recognised as distinct concepts, assigning mental capacity's relevance to psychiatry, and *Gillick* competence to psychology.[56]

V. CONCLUSION

Gillick set out a libertarian stance to autonomous decision making that is difficult to reconcile with a veto on a refusal to consent. For Gillian Douglas, *Re R* and *Re W* retreat from *Gillick*.[57] For Margaret Brazier and Emma Cave they 'make a nonsense of Gillick'.[58] And for Ian Kennedy they drive 'a coach and horses' through it.[59] Many of the academic arguments focus not on the outcome of paternalistic decisions to keep children alive into adulthood, but on the judicial rationalisation of that position. They ask questions such as: Is there a better way to balance the child's interests and their view?[60] Is there a way to bolster the tests for competence and capacity so that they more accurately capture autonomous decision making?[61] Can a distinction between the competence required to consent and the competence required to refuse all treatment?[62] It is with great appreciation that I note that the barristers in this case gave consideration to the considerable academic literature on this topic and that Sir James took the time to read and absorb it. But there is a perceptible sense of frustration in his interpretation of the discourse from the 'dreaming spires of the Academy'.[63] Sir James notes that the 'substantial volume of academic legal literature, medical literature, social sciences literature and comparative jurisprudence' is 'of absorbing interest but most of it is of only limited use';[64] that criticism of *Re R* and *Re W* is divided and not all suited to the 'pragmatic world of the court room';[65] and (as we have seen) that 'some of the thinking in the Academy favours too much of the Thomist schoolmen.'[66]

The search for a view that reconciles protectionism and the libertarian values expressed in *Gillick* is not over. The Academy's interest is not confined to the test case but no doubt it will add much of value on the important questions raised in this commentary and elsewhere, that this case does not resolve. With regard to the power of the court to

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[55] A McFarlane, 'Mental Capacity: One Standard for All Ages' [2011] 41 Fam L 479.
[56] *X* (n 1) [73] - [75]. See also N Pearce, S Jackson, 'Mental Capacity Act 2005: Not the Children Act for Grown-ups' [2011] 41 Fam L 697.
[57] G Douglas, 'The Retreat from Gillick' (1992) 55 MLR 569 .
[58] M Brazier, E Cave, *Medicine, Patients and the Law* (MUP, 2016), 467.
[59] I Kennedy, Consent to Treatment: The Capable Person' in C Dyer (ed) *Doctors, Patients and the Law* (Blackwell, 1992), p 60.
[60] D Archard, M Skivenes, 'Balancing a Child's Best interested and a Child's View' (2009) 17 *International Journal of Children's Rights* 1.
[61] M Brazier, C Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16(1) LS 84.
[62] S Gilmore, J Herring, ''No' is the hardest word: consent and children's autonomy' [2011] 23(1) CFLQ 3. Note that X was not refusing all treatment in this case: *X* (n 1) [4].
[63] *X* (n 1) [60].
[64] ibid [29].
[65] ibid [60].
[66] ibid [70].

overrule the competent or capacitous decision of a child, this decision brings a degree of clarity. In 1996 Margaret Brazier and Caroline Bridge argued that, 'If society is not prepared to allow adolescents to court unfavourable outcomes in judgments relating to medical treatment, we should say so openly.' Sir James has done just that. The combined effect of *X* recognising a power of veto on both consent and refusal, and the recent decision in *Bell* that children are unlikely to be found competent to consent to a class of treatment rather than a particular decision is a blow to children's rights to be heard, impacting both on their potential to be found capable of consenting and the authority of their capacitous decisions.