Neutral Citation Number: [2024] EWHC 1034 (Fam)

Case No: FD24P00098

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/04/2024

Before :

THE HONOURABLE MR JUSTICE COBB

- -

Between :

UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	**Applicant**
- and -	
J **K** **L**	**Respondents**

- -

Re J (Blood Transfusion: Older Child: Jehovah's Witnesses)

- -

David Lawson (instructed by **Bevan Brittan LLP**) for the Applicant
Jo Ansong (of **RCS Solicitors**) for the Respondents

Hearing dates: 11 April 2024
Post-Script (paragraph [48] below) added: 7 May 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 15 April 2024 by circulation to the parties or their representatives by e-mail.

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THE HONOURABLE MR JUSTICE COBB

The Honourable Mr Justice Cobb :

Overview

1. The young person who is the focus of my concern in this application is J. He is 17 years 7 months old, and will turn 18 at the end of September 2024. He is intelligent, engaging and thoughtful; he is currently undertaking an apprenticeship in electrical engineering. He is in many respects a fit and healthy young person, with a bright future.

2. J is currently awaiting surgery to remove an obstruction in the ureter leading from his left kidney. Surgery is booked for 24 April 2024; it is becoming increasingly urgent. J is content for the procedure (which I describe more fully at §12 below) to go ahead, but does not consent to the use of blood products in the event that he suffers a significant uncontrolled intra-operative or post-operative bleed. By 'blood products', J is referring to whole blood, and/or any of its primary components, namely red cells, white cells, platelets or plasma in any form.

3. J has been raised as one of Jehovah's Witnesses; he was baptised as one of Jehovah's Witnesses nine months ago. His parents are Jehovah's Witnesses. As I set out in a little more detail below, he has a strong religious objection to blood transfusion, and/or the administration of blood products, as an article of his faith; this objection is, he says, rooted in the scriptures, both the Old Testament and the New Testament. Receiving bloods would be fundamentally at odds with J's considered religious beliefs and would carry for him the potential considerable lifelong social, mental and spiritual harm. Some months ago he signed an 'Advance Directive' making clear that he would not under any circumstances wish to receive blood products. In relation to the proposed surgery he has refused to give his consent to blood transfusion or the administration of blood products in the event that this becomes necessary during the operation.

4. It is in this context that on 28 March 2024, the Applicant, the University Hospitals Plymouth NHS Trust, applied to the court for a declaration that it would be lawful and in J's best interests for him to receive blood products if required in the event of an emergency in the surgery. The application was listed before me for determination.

5. In that regard, I have received written and oral evidence from the consultant urologist Mr S who is scheduled to perform the operation, and consultant paediatric urologist Mr R who will be supporting him. I received two witness statements from J; he travelled to London from the West Country for the hearing, and gave oral evidence before me. I have witness statements from his parents; they too attended court and gave oral evidence. I have received helpful written and oral submissions from Mr Lawson for the Applicant and Mr Ansong acting for the Respondents.

6. Case management directions for this hearing were given by Henke J on 5 April 2024; among those directions, provision was made for Cafcass to appoint a guardian for J, who in turn was directed to prepare a report. Prior to the final hearing, Cafcass corresponded directly with the parties and the court advising that it saw no real value to the court in providing a guardian for J given his competence, and pointing out that he had a solicitor already acting for him. Having canvassed the views of the parties on Cafcass' stance, and with their agreement, at the outset of the hearing before me I discharged that part of the order.

The approach to resolution

7. The route by which I reach my determination in this case was helpfully charted by the Court of Appeal in its judgment in *E v Northern Care Alliance NHS Foundation Trust and F v Somerset NHS Foundation Trust* [2021] EWCA Civ 1888, [2022] Fam 130 ('*Re E & F*') at [45]-[49]. Thus, it is my responsibility:

   i) To establish the relevant facts; in particular, I must identify the risk or risks surrounding the medical condition and/or treatment. In this regard, it is necessary for me to evaluate the risk *of* an event occurring (i.e., its probability) and/or the risk *from* the event occurring (i.e., its consequences);

   ii) To decide whether, on the facts, it is necessary medically to intervene; in particular, whether immediate action is necessary, or whether a decision to intervene might better be postponed;

   iii) If immediate medical action is necessary, to undertake the all-important welfare assessment, looking at the situation from the individual's point of view; in this respect, the court will seek to identify his or her best interests in the widest sense (*Re E & F* at [49]).

8. In this case, as in *Re E & F*, the declaration sought relates to blood transfusion, or administration of blood products, to be given *if* an emergency arises in the course of medical treatment. As in *Re E & F*, that event is statistically unlikely to happen, but if it does, and no consent or authorisation for the administration of blood products has been given, the consequences are potentially very grave indeed for the patient.

The Applicant's case

9. J presented to the medical services in the autumn of 2023 with a four-year history of intermittent loin pain. Medical investigations were undertaken, and in November 2023, J underwent an ultrasound scan of his kidney which showed "moderate hydronephrosis" – a left-sided obstruction of the pelvic ureteric junction (the connection between the renal pelvis, the part of the kidney where urine collects, and the ureter, running to the bladder).

10. It now transpires that this obstruction has caused a significant deterioration in the functioning of J's left kidney. Each kidney should take 50% of the kidney function but at the time of the scan, J's left kidney was functioning at 19%. It may now be functioning at a lower level. The Applicant's case is that this obstruction needs to be operated on reasonably urgently; if the blockage is not removed, the kidney is likely to lose function. Long term, if untreated, there is a risk of sepsis.

11. Last month, the consultant urologist (Mr S) explained the necessary procedures to J, who consented to the treatment proposed, but, as I have indicated, has expressly declined consent to blood or blood products in the operation.

12. There are two linked procedures contemplated within the operation. To minimise the need to administer blood products to J it is the view of Mr S that they should be conducted together. The procedures are:

    i) The insertion of a stent (a narrow drainage tube) into J's ureter to drain the kidney; this procedure would (even if performed independently of the pyeloplasty at (ii) below) need to be conducted under general anaesthetic; a stent will temporarily relieve the obstruction; however, it is as I say only a temporary solution, as the stent (if inserted on its own, without the pyeloplasty) will need changing every 6 months;

    ii) A pyeloplasty; this is laparoscopic (keyhole) surgery, in which the obstruction will be removed and the ureter will be reattached to the bladder in a way which avoids any further problem. This would also be conducted under general anaesthetic. It is the uncontentious medical view that pyeloplasty is needed to stabilise J's kidney function. After a pyeloplasty, kidney function will either become stable, or may indeed improve (as it does in 70-85% of patients).

13. If both parts of the procedure take place, the surgery is expected to take 2½ hours. Mr S told me that the surgery is performed using sophisticated and intuitive equipment controlled remotely.

14. It is common ground that the kidney obstruction should be treated now. If it were to be left untreated this would create unacceptable risks for J, including the risk of developing sepsis in the obstructed kidney and beyond, and the additional risk of nephrectomy (removal of the kidney). If a nephrectomy were to be required (i.e., where deterioration of kidney function falls below 10%), this would be a more complex operation with an elevated risk of significant intra-operative bleeding, and a correspondingly higher chance of a need for transfusion or other administration of blood products. Moreover, following a nephrectomy, there is a risk of cardiovascular problems, and an increased risk of the patient requiring dialysis if the remaining kidney fails.

15. The risks of the procedure have been described by Mr S and Mr R as follows:

    i) There is a "very low" risk of a significant bleed in the surgical procedure which involves merely the insertion of the stent (§12(i) above);

    ii) The risk of a significant bleed during pyeloplasty surgery (§12(ii) above) is said to be "low", or "very small" (Mr S); it would be a "rare event" (ibid.). Mr S reports that he has conducted over 190 similar procedures in the past and "cannot recall having to transfuse a patient previously"; there is a better outcome (i.e., there is a lower chance of serious intra-operative bleed) if the stent and the pyeloplasty are performed simultaneously rather than sequentially (i.e., separated by six months or more);

    iii) There is a risk of post-operative bleeding at any time within ten days of the procedure. A post-operative bleed is unlikely; if it occurs it is more likely to be

an ooze of blood rather than a sudden or significant bleeding event, but it may still be serious;

iv) A blood transfusion would probably, but not necessarily, save the life of a patient who is bleeding significantly intra-operatively or post-operatively. Not giving blood in this situation would allow the patient to die.

16. Mr S described the risks in the following section of his first report:

> "… there is still a small chance that the operation could lead to a significant bleed. The likelihood of severe surgical bleeding intraoperatively is very small. I cannot provide an exact risk. As a team we would minimise the risk of any bleeding through careful standard surgical approach, careful haemostasis using surgical techniques where possible, minimally invasive procedures, careful surgical positioning, and maintenance of normal temperature".

17. In their oral evidence to the court both Mr S and Mr R confirmed the risks outlined in §15 and §16 above. Mr R went further in saying that he thought it was "extraordinarily unlikely" that J would need a blood transfusion or other administration of blood products "but it could happen". He added "I don't want to be standing in the operating theatre watching a child die, when I could do something about it."

18. Mr S and Mr R indicated that they would make instantly available the equipment for undertaking cell salvage in the event of a relatively minor intra-operative or post-operative bleed. In this process, blood which may be lost during surgery is collected; it is then filtered, washed and returned to the body through a small tube into a vein. This form of treatment would only be possible if the bleeding is relatively slow. They also confirmed that they would consider the use of tranexamic acid pre-surgery to stimulate blood clotting; however, given the possible risks of thrombosis and/or clotting of blood in the urine, Mr S and Mr R wish to consider further the appropriateness of this medication in these circumstances.

The Respondents' case

19. J is the youngest of three children. He has an active and healthy life. He attained seven GCSEs at school, and is currently undertaking a level 3 electrical installation apprenticeship; he has obtained employment and has attracted plaudits from his employer. Occasionally he works away from home. Within the last few days he has passed his driving test, and has purchased a car with money which he has saved from his employment. About eighteen months ago he obtained a powerboat qualification, enabling him to operate a motorboat on open water. He told me that he leads a full life, with many friends, and has a keenness for sport; his "beliefs are the most important part of [his] life" and that he enjoys reading the bible, going to religious meetings and sharing his beliefs with others. He added "I believe and know that my religion is true".

20. He told me that he has suffered with kidney problems for about four years, and sometimes he can be "in agony". He accepted that he needed to have the treatment proposed by Mr S, indicating that he would prefer to have both procedures done together; he added that if there was a risk of blood products being administered to him

against his will, he would elect to have the stent operation alone done at this stage (altogether the safer of the two procedures) before having the pyeloplasty in six months time when he is 18 years old.

21. J's oral evidence from the witness box was given confidently and with great composure and clarity; he displays a maturity which belies his age. He described himself as a sensitive person, and indeed I sensed this from what he told me; he is plainly thoughtful. He gave his evidence immediately following the oral evidence of Mr S and Mr R; it was obvious to me that J had listened carefully to the expert clinicians' views. That said, he told me that he had dedicated his life to God, and that his "priority" is to live by God's will. He spoke of his fundamental opposition to receiving bloods or blood products, referencing the teachings of the Bible from which he derives his views. He told me of the anticipated psychological distress which he would feel (he spoke of feeling 'devastated') if he awoke from the operation to discover that he had been given blood products against his firm wishes; he told me that he was confident that this would cause him depression and he feared very greatly how he would end up feeling about himself for the rest of his life. He said that he would feel "violated" and "tormented" if given blood products, and genuinely anticipates the onset of serious trauma and suffering. Although not legally binding given his age (per section 24 Mental Capacity Act 2005), J arranged and signed an 'Advance Decision to Refuse Specified Medical Treatment' some weeks ago.

22. J has confirmed that he would accept cell salvage during his surgery if this were required and indeed possible. J is also in agreement with being given tranexamic acid prior to the surgery.

23. It became apparent in the evidence that in the last two years J had experience of the sudden and tragic death of a school friend; J had been supporting this young man through the final difficult period of his life. This tragic event exposed J directly to death and the impact of death on those who are emotionally close to the deceased.

24. There is no doubt that J is a competent young person with an understanding, maturity, and intelligence which equips him well to make his own decision, and give consent, in relation to the medical treatment issues, in line with the principles discussed in *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] AC 112 at 171 (Lord Fraser), and 186 (Lord Scarman). I consider that he is capable of appreciating fully the nature and consequences of the treatment which is proposed for him; all of these issues are questions of fact (*Gillick* at p.189/190). I am equally satisfied that the views which he expressed are authentically his own, free from influence of his parents or others.

25. Both of J's parents gave evidence; they again did so with dignity, frankness and with obvious care and concern for their son. They both want the best medical treatment for J, and they want J to live a full and happy life. They support J in his decision, and I detected in their evidence no hint that they have sought to influence J in his views.

26. It is notable that all the family have engaged both constructively and respectfully with the clinical practitioners in this case; all three members of the family expressed their appreciation for the way in which Mr S has explained the issues to them and sought to assist them to reach an informed view.

Legal principles

27. The legal principles engaged in this application are not contentious.

28. The application is framed in the form of an anticipatory declaration which would come into effect only if there is a medical emergency. Mr Lawson drew an analogy with this form of jurisdiction which is sometimes deployed in proceedings under the Mental Capacity Act 2005 – see *Guy's and St Thomas' NHS Trust v. R* [2020] COPLR 471 (see [36]).

29. The potential need for a declaration in respect of medical treatment in these circumstances is essentially founded upon the rights of a patient to give consent (or not) from what would otherwise be an assault or trespass or other tortious interference, and upon the medical profession to be protected from the charge of such action where the patient does not consent to the treatment proposed, in the absence of authority from the court: see *Re F (Sterilisation)* [1990] 2 AC 1 at p.55 (Lord Brandon).

30. Young people who have attained the age of sixteen (J in this case) have the right to *consent* to surgical or medical treatment (see section 8 of the Family Law Reform Act 1969). Such consent cannot be overridden by those with parental responsibility, but can be overridden by the court. This statutory provision does not however apply to young people who have attained the age of sixteen who *wish to refuse*, or *refuse*, medical treatment. It is in these circumstances that the inherent jurisdiction of the Court can be invoked (as it has been here) to determine refusal of treatment; the existence of this jurisdiction was confirmed by the Court of Appeal in *Re E and F*. It is, as the court in *Re E and F* made clear,

> "… settled law that the court has the power to intervene in the best interests of a minor even if the effect is to overrule a decision that would be conclusive if the young person had made it after reaching the age of 18" [5].

And at [44]:

> "… the inherent jurisdiction is available in all cases concerning minors, namely persons under the age of 18. That has always been so and any change must be a matter for Parliament."

And further at [73]:

> "… Once a young person becomes an adult, decisions about whether to accept or reject medical treatment become theirs absolutely, but before that age the court must act upon its objective assessment of the young person's best interests, even where this conflicts with sincere and considered views".

31. All welfare decisions in medical treatment cases concerning children and young people which come before the court must be made in strict accordance with their welfare; best interests are interpreted in the widest sense and from the perspective of the young person concerned, without rules or preconceptions. In determining the best interests of

the older child (with decision-making capacity) the court must balance, in particular, the "two transcendent factors: the preservation of life and personal autonomy" (*Re E and F*, at [53]).

32. The judgment of the Court of Appeal in *Re E & F* draws heavily from a decision of "direct relevance" ([57]) which is of more than three decades standing, namely *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 ('*Re W*'). *Re W* concerned the admission of a sixteen-year old to an anorexia treatment unit; Balcombe LJ had said at p.88A:

> "Since Parliament has not conferred complete autonomy on a 16-year-old in the field of medical treatment, there is no overriding limitation to preclude the exercise by the court of its inherent jurisdiction and the matter becomes one for the exercise by the court of its discretion. ….
>
> It will normally be in the best interests of a child of sufficient age and understanding to make an informed decision that the court should respect its integrity as a human being and not lightly override its decision on such a personal matter as medical treatment, all the more so if that treatment is invasive. In my judgment, therefore, the court exercising the inherent jurisdiction in relation to a 16- or 17-year-old child who is not mentally incompetent will, as a matter of course, ascertain the wishes of the child and will approach its decision with a strong predilection to give effect to the child's wishes.
>
> … Nevertheless, if the court's powers are to be meaningful, there must come a point at which the court, while not disregarding the child's wishes, can override them in the child's own best interests, objectively considered. Clearly such a point will have come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury. An example of such a case was *In re E. (A Minor)* (unreported), which came before Ward J. on 21 September 1990. There a 15-year-old Jehovah's Witness, and his parents of the same faith, were refusing to allow doctors to give the boy a blood transfusion without which there was a strong risk (on the medical evidence) that the boy would die. Ward J. authorised the blood transfusion. In my judgment he was right to do so. In the course of his judgment he said:
>
> > "There is compelling and overwhelming force in the submission of the Official Solicitor that this court, exercising its prerogative of protection, should be very slow to allow an infant to martyr himself."
>
> I agree." (Emphasis by underlining added).

33. Mr Lawson suggested that in *Re E & F* the court contemplated that a point can be crossed in cases of this kind where the discretionary *powers* on the court to intervene convert into a *duty* on the court to intervene to preserve the young person's life. In this regard he relied on the passage at [50] of *Re E & F* where the Court of Appeal refer to "the greatest value" (i.e. the superlative value) being given to the preservation of life, and to [57] in which it was said that each member of the Court of Appeal in the previous case of *Re W* had:

> "…asserted the primacy of the welfare principle, while emphasising the importance of the decision of a capacitous young person. Such decisions will doubtless prevail in the great majority of situations, whether or not in the medical context, and the court will simply not be involved. At the same time, each member of the court explicitly referred to cases where the irreparable and disproportionate consequences of a refusal of treatment places the court under a duty to intervene. In our view, this approach remains good law. It survives the Human Rights Act 1988 and the Mental Capacity Act 2005, and it has not been overtaken by subsequent decisions, by the passage of time, or by the evolution of societal values". (Emphasis by underlining added).

34. I was also taken also to *Re E & F* at [63]:

> "*Re W* does not establish a presumption in favour of the mature adolescent's decision, but instead affirms welfare as the overriding principle. It speaks for the young person's decision to be upheld where possible but also speaks of those rare circumstances where the gravity of the consequences and the imperative to preserve life may require the court to intervene" (Emphasis by underlining added).

These comments appear to have been drawn from the judgments in *Re W*, including that of Nolan LJ in *Re W* at p.94B:

> "… In general terms, however, the present state of the 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"… "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". (Emphasis by underlining added).

35. I do not interpret the remarks in *Re E & F* set out in the foregoing paragraphs (§33/34) to mean that where proposed medical intervention carries with it any risk of loss of life, the court is *obliged* to authorise treatment so as to preserve the young person's life. That would be to negate the lodestar of welfare in the widest sense. Nor do I believe that those remarks are intended to contradict the earlier remarks about the two

transcendent factors in play when considering the welfare of a mature young person (see [50] *Re E & F*, and §31 above). When considering authorising medical treatment which is opposed by a competent young person (using 'competent' in the context of *Gillick* above), it is crucial that the court should consider, among other factors, the chronological age and level of maturity of the individual young person, their intelligence and understanding of the issues and risks, the nature of the specific decision to be made, objectively the full set of risks involved both ways (of having or not having the treatment and its consequences), the reasons given by the young person for their decision, and the prospective quality of the life to be lived should the unwanted treatment be successful in preserving the minor's life. As the Court of Appeal made clear in *Re E & F* it is important that the court identifies:

> "… the factors that really matter in the case before it, gives each of them proper weight, and balances them out to make the choice that is right for the individual at the heart of the decision" ([52]).

36. Finally, I should add that Mr Ansong addressed me on the multiple rights contained in the articles of the European Convention on Human Rights which are engaged on these facts. He first referenced the right to life (Article 2: "Everyone's right to life shall be protected by law"); as the Court of Appeal said in *Re E & F*, at [73]:

> "Article 2 of the European Convention provides that everyone's right to life shall be protected by law. Once a young person becomes an adult, decisions about whether to accept or reject medical treatment become theirs absolutely, but before that age the court must act upon its objective assessment of the young person's best interests, even where this conflicts with sincere and considered views."

Other articles of the ECHR which are engaged in these circumstances are Article 3 ("No one shall be subjected to … degrading treatment …"); Article 8 ("respect for private and family life"), and Article 9 ("Everyone has the right to freedom of thought, conscience and religion; this right includes freedom … to manifest his religion or belief, in worship, teaching, practice and observance). The court was referred further to *An NHS Trust v X* [2021] EWHC 65, especially from [105]-165]. I bear these factors, and the learning from the authority of *X*, much in mind.

Discussion and conclusion

37. *Facts/risks*: Following the route map which I describe at §7 above, I can confirm that the facts as I find them to be are set out in paragraphs §8 to §14 above. The risks are in particular described in §15 to §17.

38. I am conscious that the risk of intra-operative or post-operative serious haemorrhage in this case is said to be "very small"; this is of obvious comfort to J and his family, and to me, but it nonetheless is a risk. J is aware, his parents are aware, as indeed I am aware, that there are irreparable and disproportionate consequences for J in the event that he suffers a severe haemorrhage in the operation or in the post-operative period, and blood products are not administered. I also bear much in mind the description

which Mr R gave about his own distress as a surgeon if he found himself powerless to save J's life if he began to bleed severely on the operating table.

39. But I remind myself that if this operation were to be taking place in six months' time or thereafter, this court would have no jurisdiction to interfere with this patient's choice, and nor would the doctors. J has articulated clearly his opposition to this type of treatment, and has done so from a place of understanding and maturity. While the inherent jurisdiction offers "protective power" over children and young people (*Re E & F* at [46]), I am conscious that I should not exercise an *overly* protective or paternalistic authority over this responsible young man, when I am satisfied that he knows clearly and convincingly what he wishes in respect of the upcoming operation, can clearly articulate his choices, and can explain his reasoning.

40. *Need for intervention*: There is no real doubt that surgical intervention is now reasonably urgent. The operation has already been deferred once, and given the uncertain progression of deterioration of the left kidney, the surgeons do not wish to delay further. J accepts that the surgery must now take place in ten days' time.

41. Surgery will take place on 24 April 2024; J will still be a minor. An earlier suggestion that J may wish to defer the surgery (or part of it) for about five months (until he reaches his eighteenth birthday) has been abandoned. Unacceptable risks would be posed to J if the kidney obstruction were left untreated for very much longer, including (but not limited to) the development of sepsis. Moreover, J is in pain and occasionally acutely so to the extent that it has a significant impact on his life; he told me that he now seeks urgent relief from his physical distress. The additional complication which would arise from a delay is that a permanently and irreversibly damaged kidney may well need to be removed entirely in due course by nephrectomy. This procedure carries with it a higher risk of bleeding than pyeloplasty because the large vessels supplying the kidney need to be cut. Leaving the situation for any length of time now only seems to me to raise the risk of more intricate surgery which correspondingly raises the risks of intra-operative or post-operative bleeding.

42. I had considered whether J might elect a half-way house at this point by submitting to the more limited procedure (i.e., merely the insertion of the stent), involving the lowest risk of intra-operative bleeding, deferring the marginally more complex but definitive element of the procedure (i.e., the pyeloplasty) until he is an adult. The benefit of taking the operation in two discrete stages would be to relieve J of the symptoms of the obstruction now, and tide him over until he is 18 so that he can then, as an adult, make an unchallengeable decision about more definitive treatment which will not include the administration of unwanted blood products. However, the disadvantage of this course would be that the insertion of a stent is only ever a temporary 'fix'; the procedure would need to be repeated in 6 months time, and if the pyeloplasty is attempted at that stage there is an elevated (albeit still small) risk of severe surgical bleeding from the area of the renal pelvis and stented ureter. The surgeons do not recommend this option for J.

43. *Welfare*: Every decision concerning medical treatment for children and young people must turn upon its own facts; "[t]he court needs to focus on the factors that really matter in the case before it" (*Re E & F* at [71]). In all cases, the paramount concern of the court is to make a decision in the best interests of the individual subject young person, looked at in its widest sense.

44. I have found this to be an extremely finely balanced decision which directly and poignantly engages the "two transcendent factors" referred to in *Re E & F*, namely the preservation of life and personal autonomy. It is plain that the subject young people in *Re E & F* felt "aggrieved" ([5]) that their views were overridden, and I am satisfied that J would feel the same. Even though the body of case law to which I have been referred has generally concluded with a decision in favour of treatment, I am conscious that "that is not the invariable outcome" (per *Re E & F* at [65]). To be faithful to the rich seam of pronouncements in this area I wish to emphasise that judicial 'respect' for the 'views of the mature child' is not a tokenistic mantra; it must be given true meaning, and where appropriate, full effect. To some degree this is demonstrated by the decisions of Moor J in *A South East Trust v AGK* [2019] EWFC 86 and to the decision of Cohen J in *A Teaching Hospitals NHS Trust v DV (A Child)* [2021] EWHC 1037 (Fam), where the objections of young people to the administration of blood products held sway. However, the distinguishing feature between those cases and this is that in *AGK* and *DV* no significant opposition was offered by the medical profession to the minor's objections.

45. J is only a matter of weeks away from being an adult as a matter of law. He has limited – but nonetheless evolving – experience of mature decision-making; he has first-hand experience of the death of someone of whom he was fond. He already shows many attributes of adulthood. I found him to be an impressive young man with clear thoughts and expression. I am satisfied that he knows his own mind, and is aware of the risks to which he is exposing himself in declining blood products in the unlikely event that they would be needed in this operation. J's clear and unequivocal decision in this regard, and his reasoning, are rooted in his faith; I respect his well-recognised right under Article 9 of the ECHR to manifest and observe his religion. The Applicants recognise that J's beliefs about blood products are "long held and considered". I accept that if I were to accede to this application and blood products were therefore administered intra-operatively or post-operatively, this would be likely to affect J's sense of self-determination, his fidelity to the tenets of his religion, and the quality of his life going forward. I am satisfied that while blood products may save his life, their administration against his wishes would lead to him experiencing a much reduced quality and enjoyment of that saved life, and he would be 'tormented' by having other blood in his veins.

46. Having weighed all of the matters outlined above, I have concluded that in this case it is in J's best interests for his own decision to refuse the administration of blood or blood products in surgery to prevail, and I propose therefore to refuse the application for the court's authorisation to administer blood products in the event of emergency in the upcoming operation.

47. The order must reflect my conclusions about J's competence to participate in this litigation without a guardian, and to make decisions about the planned medical treatment. I shall declare that it is lawful, being J's decision and in accordance with his best interests, for his treating clinicians not to administer whole blood or primary blood products, even if in the opinion of the treating clinicians the transfusion of blood or blood products may preserve J's life, or prevent severe permanent injury or irreversible physical or mental harm. I shall further provide that if prior to the procedure J consents to having such blood or blood products, such treatment will be provided as long as his clinicians consider this to be clinically indicated.

Post-script – added 7 May 2024

48. On 24 April 2024, J underwent the planned surgery as described above. The procedure was a success. The ten-day post-operative period has passed without complication. J is making a good recovery.

[end]