AN CHÚIRT UACHTARACH
THE SUPREME COURT

S:AP:IE:2020:000131

S:AP:IE:2020:000132

O'Donnell J.
McKechnie J.
Dunne J.
O'Malley J.
Baker J.

IN THE MATTER OF J.J.

Judgment of Mr. Justice O'Donnell, Ms. Justice Dunne, Ms. Justice O'Malley, and Ms. Justice Baker, delivered on the 22nd day of January, 2021.

I – Introduction

A. Background

1. From time to time, this court has had to consider issues arising in cases which can truly be said to engage matters of life and death. The first such case to come before this court was the case of *Re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 ("*Re a Ward of Court*"), in which the court had to consider the circumstances in which water and food could be withheld from the ward of court, who had been in a persistent vegetative state for many years following a medical mishap during routine medical surgery, with a view to allowing her to die naturally. The issues that arose in that case were described by Hamilton C.J. as "momentous issues of great public concern". The issues arising in this case are no less momentous. Although the issues raised in these proceedings are difficult, complex, and troubling, it is important not to lose sight of the

fact that at the heart of this case is a young boy, who is much loved by his mother and father, by his siblings and his extended family. For them, the circumstances of this case are nothing short of a tragedy, with which they have had to come to terms over the course of the last number of months and will have to deal for the foreseeable future.

2. The events which have led to these proceedings are, to say the least, very sad. Towards the end of June, 2020, catastrophic injuries were suffered by the young boy in an accident which have led to his treatment in hospital since the date of his accident. Differences have now arisen between his parents and the medical team charged with his care over the appropriate approach to adopt should his condition worsen, as his medical team believe is inevitable. The circumstances are set out in more detail in the High Court judgment of Irvine P. In that judgment, Irvine P. sought to protect the privacy of the boy and his family by giving a general account of the accident and describing the boy as "John" and his treating hospital as "the Hospital", and we will adopt the same approach.

3. In the accident, John suffered numerous injuries. He sustained catastrophic brain injuries, together with other significant physical injuries, including a fracture of his left clavicle, multiple rib fractures, a fractured right humeral shaft, pulmonary contusions and pulmonary haemorrhage, a grade 1 splenic laceration, fractured pubic rami, maxillary fractures and a left greater wing of his sphenoid fracture. Following the accident, John was treated initially at a regional hospital close to his home, before being moved the following day to the Hospital, where he has been treated since.

4. On admission to the Hospital, John required treatment in the Paediatric Intensive Care Unit ("PICU"), where he remained for several weeks. He was required to be on a ventilator until the end of July when he was successfully extubated following a previous unsuccessful attempt to extubate him. As a result of his injuries, John is currently fed by a nasogastric tube, has a long-term catheter to facilitate the delivery of medications, and his lungs need intermittent suctioning to remove secretions. Further, he had a urinary

catheter and is doubly incontinent. The medical evidence presented both by John's medical team and by Dr. L., the independent expert instructed by John's guardian *ad litem*, is not in conflict. Following admission to the Hospital, John had a reduced Glasgow Coma Scale of 4 out of 15 which was described as a persistent finding. It is not expected that John will ever walk, talk, develop any meaningful awareness of his surroundings, be able to communicate or process information, nor will he ever be capable of performing any voluntary movements.

5. While John suffered a number of significant physical injuries, he also suffered what has been described in medical reports as "devastating brain injuries". It is not necessary to outline the full extent of these injuries in detail. However, a Consultant Paediatric Neurologist expressed the opinion that the neurological injuries suffered by John are permanent and irreversible. As a result of the neurological injuries suffered by John, he has developed dystonia. The current dispute between the Hospital and John's parents arose because of differences between them as to the treatment of John's dystonia. Dystonia is a hyperkinetic movement disorder which can arise for a number of reasons, including an acquired injury to the brain, in particular, the basal ganglia which are important to movement. This causes abnormal electrical signals to be sent to the muscles. In turn, these signals trigger painful, prolonged, and involuntary contractions of muscles.

6. The dystonia suffered by John is of a particularly severe nature. In less severe cases, this can be limited to some limbs only, but in John's case it concerns all four limbs. In the High Court, Dr. W., a paediatric intensivist working at another Irish hospital, and who had worked for 9 years at Great Ormond Street Children's Hospital in London, described her experience working with sufferers of dystonia. In her experience – approximately 1,000 different patients – the severity of John's suffering was unparalleled save one patient. Between September 8th and 15th, John suffered in excess of 7 hours of dystonic episodes per day at worst, and just over 2 hours of dystonic episodes a day at best. One

particular episode took just under 3 hours to bring under control. His symptoms are brought on by anything which causes him discomfort, including noise and the delivery of medication.

7. While John's medical team have since succeeded in controlling John's dystonia – as will be detailed shortly – it is their professional opinion that the condition is merely hidden, not gone. The dispute in this case centres around the consequences when, as the medical evidence considers inevitable, John suffers a further dystonic episode or his condition worsens such that invasive ICU measures are necessary to save his life. If a dystonic episode causes pain triggering further dystonic episodes and possibly a dystonic crisis which is life-threatening, the medical team would wish to intervene through the use of painkilling medication as administered by means of a subcutaneous infusion. This course will, however, have the consequence of reducing or suppressing John's respiratory functions. This impairment could include John being unable to cough or clear his respiratory tract, which could – if left untreated – lead to his death. If, however, intervention is administered, the doctors believe it almost certain that the intensive care intervention will itself trigger a further dystonic episode by reason of the pain which any such aggressive intervention will unquestionably cause John. Even if successful, it is their professional opinion that, ultimately, John will suffer a dystonic crisis incapable of successful intervention. This is because, over time, John's cardiac respiratory reserves will decrease to the point of him being unable to withstand a dystonic crisis. There is no knowing how close or far away in time this crisis is.

8. It is at this point in the treatment – John's respiratory capacity failing due to the administration of painkilling medication to alleviate the pain brought on by a dystonic episode – that John's parents and medical team diverged as to the correct approach to be taken in his treatment. While John's parents maintained, and continue to maintain, that John's preference would be for his life to be continued for as long as possible by whatever

means necessary, his medical team differ. At the time of the initial application to the High Court, their concern was that this action would merely prolong John's suffering until he is ultimately unable to withstand a dystonic crisis at some undetermined point in the future. His medical team considered, therefore, that it would be in his best interests not to administer any intensive or aggressive intervention in such circumstances.

9. After over a month of unsuccessful attempts to initially control John's dystonia, and seeing him suffer what the medical team consider extreme and intolerable pain, the Hospital made an *ex parte* application to the High Court on August 28th for orders making John a ward of court and permitting the Hospital to administer the treatment they considered to be in John's best interests should the painkilling medication cause his respiratory function to cease. The President appointed Mr. Niall McGrath, solicitor, as John's guardian *ad litem*. Evidence was heard on September 15th and 16th as to John's condition, and the President, following, it seems, the course adopted in *HSE v. JM* [2017] IEHC 399, [2018] 1 I.R. 688 ("*JM*"), admitted John to wardship at an early stage of the proceedings and, at the conclusion of the hearing, indicated that judgment would be given on October 9th. However, on October 8th, the court was informed that John's condition had improved, and consequently further evidence was heard on October 14th, with further submissions heard on October 21st.

10. The improvement in John's condition had been brought about by the administration of clonazepam, a benzodiazepine to which John had responded positively, from September 29th onwards. This had the result of bringing the dystonia suffered by John under control for the first time since his admission to hospital over two months previously. As such, while the original application concerned an urgent situation – given that John's dystonia was uncontrolled – the situation evolved so that by late October, the application was essentially one concerning a contingency plan for a circumstance which his medical team believe to be inevitable.

11. In the light of the fact that there has been such an improvement in John's condition since these proceedings were first initiated, it would be useful to explain just how severe his condition was in the aftermath of the accident. Clearly, the medical team looking after John felt constrained to initiate these proceedings in the light of his parents' views that his life should be prolonged so far as possible, notwithstanding the fears of the medical team that this would merely prolong his pain and suffering.

12. The nature of dystonia has been explained above, but that description does not paint the full picture of what that condition meant for John in the first months of his treatment. His dystonia was described by Dr. G., a consultant paediatric neurologist, as characterised by stiffening and twisting of his upper limbs and lower limbs. It was triggered by environmental stimuli such as noise in his room, passing a bowel motion, chest physiotherapy, suctioning, dressing, bathing, or changing his position in bed. A dystonic episode could last from minutes to hours, requiring medication to terminate it by inducing sleep once other approaches had not succeeded. Other children suffering from dystonia in different contexts may be able to verbalise the pain they experience, or at least cry out for help. John cannot communicate what he is feeling in any way, but the objective physical indicators are that he is suffering intensely. It was noted that, during such episodes, John suffered from tachycardia – that is a heart rate that exceeds 150 bpm – and he became very sweaty. It was also indicated that he suffered from what is called a "dystonic storm" or a "dystonic crisis". It was further noted by Dr. G. that dystonia is known to be painful and, in his case, this was illustrated by the development of tachycardia and sweating with sustained periods of dystonia and the presence of creatine kinase ("CK"), a marker which illustrates skeletal muscle injury breakdown. It was felt at that stage that the dystonia was having a major negative impact on his quality of life, affecting his daily care, and that it was very painful. John's dystonia was also described by Dr. F., a consultant paediatric intensivist, as involving severe muscle contraction and

limb contortion. It was the view of his treating doctors at that stage that these contractions were causing John an unquantifiable amount of pain and suffering. He expressed the view on his own behalf, and on behalf of John's medical team, that invasive treatment only serves to cause pain and discomfort to John and that, given his overall condition, it was not in his interests to treat him by means of invasive therapies given their fear that such interventions would cause greater suffering to John.

13. Dr. W. also provided a report to the court and gave evidence. She is a consultant paediatric intensivist attached to a different hospital and retained by the Hospital to provide advice independent from the Hospital's treating team. She noted that John had an extremely severe drug-resistant form of dystonia. Side-effects of dystonia treatment include sedation and reduced respiratory drive. At the time of her examination, he was having regular, prolonged, and severe episodes of dystonia, both spontaneously and in response to minimal stimulation. She noted his elevated CK level which, she observed, told of episodes of whole-body cramps so severe that they are actually causing muscle damage and breakdown. She added that the use of invasive medicine to treat a deterioration, such as ventilation or CPR in the event of a cardiorespiratory arrest, are aggressive and invasive, and not without cost to the patient in the form of pain and suffering. She noted that such methods are used as a bridge to recovery and so the benefits usually outweigh the downsides. She expressed the view that, in John's case, his current suffering was then so great that to employ those methods to prolong his life would be cruel and would ultimately serve to prolong his very significant suffering. In the course of her direct evidence, she expressed the view that John's dystonia was very severe, compared to other cases of dystonia of which she had previous experience.

14. For completeness, reference should be made to the report of Dr. L., a consultant paediatrician/paediatric neurologist who examined John on behalf of the guardian *ad litem*. In the course of her report, she pointed out that she had not seen a dystonic episode,

but noted that John had had such an episode prior to her examination and was sedated prior to being seen by her. She agreed that episodes of pain and discomfort were likely to trigger dystonia, saying that it was like a reflex reaction to pain and discomfort. Dystonic episodes were themselves likely to be painful, as indicated by the change in heart rate reported and due to the associated force of muscular spasm. She also observed that John's dystonia was being managed as well as possible with a comprehensive pharmacological regime.

15. In short, the position of John's medical team at that stage was that John's dystonia caused him pain and suffering. At that time, his dystonia was not under control. In order to minimise the pain and suffering caused by dystonia, it was necessary to administer doses of medication to sedate John and the risk was that increasing doses of such medication could have an adverse effect on his cardiorespiratory functions. In the event that such an adverse effect occurred, requiring John to be readmitted to PICU and to have aggressive interventions such as intubation and ventilation and CPR, this would simply add to John's pain and suffering without any obvious benefit. His life would be prolonged but at the cost of increased pain and suffering. It was the prospect of such a recurring cycle of dystonia requiring increased medication, and the suppression of his cardiorespiratory function as a result of the medication necessitating aggressive intervention which caused such concern.

16. However, it should be noted that the dystonia was not the sole cause of concern. As Dr. W. stated in her report, patients with the type of injuries suffered by John are extremely vulnerable to chest infections or pneumonia. The body normally has a number of protective mechanisms to deal with these, but all of those mechanisms were compromised in John. He was likely to have repeated and significant respiratory events, which would require repeated intubations and PICU care, including invasive lines for medication. Such events would become more frequent and severe over time, causing progressive damage

to his lungs. Ultimately, chest infections are the most common cause of death in such cases.

17. The medical team was of the view that such aggressive medical intervention was not appropriate, bearing in mind that John's medical condition was not going to improve. His parents had a different view and it is the disagreement between the parents and the medical team that prompted the application to court.

18. It would be appropriate to give an outline of the parents' concerns at this stage. These are well articulated in the Affidavit of Mr. McGrath, the guardian *ad litem*. He met with John's mother on August 29th and with his father on August 30th, 2020. Her view was that the clinicians were always negative in relation to the prospects for John. It is apparent that she found it frustrating and upsetting that so much of the discussions with the treating doctors concerned the possibility of his early death. On the first day in hospital, she had been told he was going to die. She noted that his physical injuries had healed. She outlined some of the progress he had made. She commented that he just needed time. She made a number of observations as to improvements that she had observed in John's condition. Thus, she had been informed that there was a risk that John might die once he came off ventilation. At that stage, he had been off it for three weeks. He was now able to swallow. A urinary catheter was no longer necessary. Her view was that she wanted John to be given a chance of life. She accepted that John would most likely require a lifetime of care but, according to Mr. McGrath, "she believed that he could come out of it as a new born baby to the point where he would relearn each step". Nevertheless, she did not expect that he would walk, but rather that he would get through each night and that they would take one day at a time. Her abiding belief was that her son needed time. What she wanted was for John to be treated if he got sick. At that stage, John was still in PICU but was expected to be moved out of PICU a few days later, which did subsequently happen. It was apparent that she did not fully accept the assessment of the medical team as to the level of pain

being suffered by John. She accepted the limitations of John's wellbeing, but her view was that if there was a heartbeat and a pulse, then he was alive and "to take him away now was just murder".

19. Mr. McGrath also spoke to John's father. He had similar views to John's mother. He also questioned the analysis of the doctors as to their view that John was in significant pain. He expressed the view that John did not seem to be in a lot of pain and he described the situation of John as being like he was in a very long sleep. He noted that his heart, lungs, and liver were fine. He did not need oxygen or life support. Like John's mother, he emphasised a desire to give John a chance and to treat him in the context of further care needs. He did, however, accept that if that was not working, he would have to accept that situation.

20. Before concluding the consideration of the views of John's parents at the point in time when proceedings commenced, it is, perhaps, useful to note some observations of the treating doctors about John's parents and, in particular, his mother. Dr. W., in her report, noted that when she spoke with John's mother, "she seems accepting that [John's] injuries are permanent, although of course she retains hope for some improvement. She expressed to me that "giving up on him" is unfathomable, and her only wish is to bring him home and care for him". Dr. L. made the comment in her report that:-

> "I would like to pay tribute to [John's] mother who has shown incredible fortitude in the face of [John's] injury. She explained her situation to me with great eloquence and passion when we met. She feels that [John] having always been a little bit behind just needs a bit more time in order to show that he can recover from this injury."

21. Reference should also be made briefly to the evidence before the High Court given by John's mother and father. At that stage, John was no longer in PICU. His mother noted that there had been some reduction in the episodes of dystonia. She had an understanding

of the condition of dystonia. She knew that it caused John pain, and that medicine had to be administered to control it. She stated that she would not allow him to be in pain if she knew that he was not "going to come out on the other side". However, she believed that increased experience as to the type of triggers that brought about an episode could result in their avoidance and, eventually, result in the medication becoming unnecessary. She emphasised that her son was a fighter. Perhaps her view can best be encapsulated by one comment she made:-

> "To say that [John] is not going to recover I will stand up and say they are wrong. He mightn't recover to the full extent that I want him to be, I know [John] won't be able to talk, I accepted that, I accepted he mightn't be able to speak, I accepted that, but also he has a heart beat and he has a pulse."

She added:-

> "But as a spiritual person, a faith person that I and I believe it in my heart that this Court is way too soon, three months after an accident that a child was traumatised in brain, body and spirit he still came back, they underestimated him, what everyone said about him. I believe that [John] would roughly need a year to show that he is well and recovered to be honest."

22. Submissions to this court on behalf of John's father have expressly stated that he has never refused to consent to pain relief medication. However, in the course of his evidence, he did question the extent to which pain was being suffered by John in the course of dystonic episodes. In his view, it was not possible to be sure about this. He also emphasised the fact that what John required was time. He explained to the court his views and said:-

> "Well, as his Mum said, he has the heart of a lion so I think [John] will keep fighting on as long as possible, you know, and that's what I want and I believe that's what [John] would want as well…"

There can be no doubt as to the depth of the love John's parents have for him. It is clear that they are anxious to do whatever they can for him. It is also clear that both of them are, to some extent, sceptical of the views of the treating doctors. Their hope is that John can recover to the extent that he can be brought home, and they believe that he should be given the chance of doing so.

23. Following the hearing before the High Court on September 15th and 16th, the matter was adjourned for judgment on October 9th. On the day before judgment was to be delivered, the court's attention was drawn to three further medical reports prepared the previous day which outlined a significant improvement in John's dystonia. A further hearing took place before the High Court to consider the implications for the case of the improvements in John's condition, given that the medical team had relied upon the fact that it was unlikely that his dystonia would be brought under control to support the application before the court. The improvement in John's condition and what it meant on a day-to-day basis was explained by Dr. F. in the following terms:-

> "I think it makes caring for [John] much easier not having the dystonic episodes. Because like we have been talking about we can do certain things like touch him and move him, those are things that would have triggered the dystonia in the past so we are in a much better position from the point of view of caring for him, whether that is nursing care or his family caring for him and his family provide a lot of his care. I think all of these things, you know, make that idea of implausible [*sic*] that he could be nursed closer to home in the hospital in… or potentially at home, I think that increases the plausibility of that happening, yes."

Asked about the best interests of John, he replied as follows:-

> "Again I think it is to ensure the best quality of life for [John] and for that to be as close to home as possible with his family. I think that remains unchanged from my opinion before, that is best served by excellent palliative care. I do not think

his interest would be best served by escalating with intensive care and interventions such as respiratory support or cardiovascular support or resuscitation. I think those are highly, highly unlikely to bring him any benefit and are very, very likely to be distressing and possibly to reenact the dystonia and to take him away from his family at a time when I think his family would like to have him there."

24. Dr. G. also gave evidence and explained how the dystonia had improved with the introduction of clonazepam. Nevertheless, Dr. G. feared that dystonia could be triggered again by something such as infection, reflux or a number of other problems. She discussed, at length, the effect of this medication on John and the benefits it had brought about but expressed concerns as to what could happen if the level of medication had to be increased in the event of a dystonic episode. She also expressed the view that dystonia was likely to re-emerge in the future.

25. Dr. L., on behalf of the guardian *ad litem*, also gave evidence. She described his condition at the present time in the following terms:-

> "He is less precarious but he is still precarious. If you look at the level of care that [John] requires, if a single one of those steps is neglected or missed then [John] is at risk of deterioration of his health. Every single aspect of every single minute of his day has to be managed. He can do nothing for himself. He cannot communicate. He can't even move voluntarily. So to say he is not a precarious position is not quite correct. He is less precarious than he was but he is still in an extremely fragile condition"

She went on to point out that only time would tell whether or not John's dystonia would remain under control.

26. It would be fair to summarise the evidence given on this occasion by saying that all of the doctors were satisfied that, in the previous fortnight, John's dystonia had been brought

under control, but all agreed that there was no guarantee that it would not recur and further concern was expressed as to what would occur in those circumstances, particularly if the level of medication had to be increased. John remained very vulnerable to dystonia. There was no change in John's medical team's view that invasive therapies in the event of a decline in John's condition would not be in his best interest.

27. Many of the witnesses stressed that, while the severity of the dystonic episodes had been a prominent feature of the application as originally presented, they did not consider that it was the only justification for the orders sought. The issue still remained as to the relative benefits to be gained from invasive treatments as compared to the burdens they would impose on John, in circumstances where such treatments would not provide a bridge to recovery. Any intercurrent illness, such as an infection or other medical event, could result in decisions having to be made as to whether intensive care treatment was in John's best medical interests, and it was better not to have to make such decisions in a high-pressure situation. Dr. L. had dealt with this situation in her report, where she considered the benefits and detriments of deferring a decision on future interventions. Deferring would have the benefit that it might allow the family to come to terms with John's situation and the ongoing nature of his physical and cognitive disabilities. However, if he had an acute deterioration due to resumption of his dystonia or a sudden unexpected medical event, the problem would have to be faced.

28. On this occasion, the focus of the cross-examinations conducted by counsel representing the mother, and the submissions made on her behalf, was on the contention that John had not been given sufficient time to establish how much progress he might make, or how long he might be able to have an improved quality of life before, or in between, needing intensive care interventions. To summarise the case being made, it was, in essence, put to the witnesses that it was acceptable to treat John with a high level of medication, provided the Hospital was also prepared to carry out the follow-up interventions. Otherwise, they

would be closing off the possibility, at the time of the first crisis, that he could come through the event and thereafter have a reasonably good quality of life.

29. The relationship between two of the reliefs sought by the Hospital was, therefore, of particular concern – the permission to administer such medication, sedation or anaesthesia as might be required to alleviate breakthrough or neurological symptoms, and the permission to withhold certain specified invasive treatments and therapies. The parents' position, in summary, was that they would not assent to a care plan that envisaged a scenario where medication might be administered to a level that caused a risk to John's life, but where certain resuscitation interventions would not be carried out to prolong his life if that risk comes about.

30. Finally, it would be appropriate to add that John's parents, especially his mother, strongly believe in his capacity to improve further. They have, as previously noted, referred to him as a fighter. Undoubtedly, the circumstances of his accident and its outcome must have been a profound shock to them. They have found it difficult to accept the view of the medical team that the best outcome for John in the future was that his care should be limited to palliative care. This is understandable. However, it is hard to reconcile their hopes for John, albeit sincerely held, with the reality as shown by the medical examinations and evidence. Whatever happens in the future, John has suffered a devastating brain injury which is irreversible. He will not be able to walk or communicate, and will require full-time care. At the heart of this case is the concern of the medical team not to prolong John's pain and suffering, on the one hand, and the concern of his parents that he should be allowed the chance to recover to the fullest extent possible by whatever means are available, on the other hand. At the moment, these positions are in a precarious – if uneasy – balance. However, these positions may prove to be irreconcilable in the event that John suffers from any further serious dystonic episode or, indeed, any other serious infection.

31. This is the dilemma at the heart of this very sad case.

32. For completeness, reference should be made to 2 further medical reports provided at the request of this court immediately in advance of the commencement of the hearing before the court for the purpose of updating the evidence given as to John's condition. In closing submissions, however, counsel for the Hospital contended that the court could not have regard to them, since oral evidence had not been given and there had been no cross-examination. However, one of these reports is from the Hospital itself and the other is from the expert retained on behalf of the guardian *ad litem*. Both witnesses had given evidence in the High Court and there had been no contest as to their primary evidence as to John's condition, the principal focus being as to what was to be inferred from that evidence. The question of any development in John's condition and prognosis is central to this case. It would be unfair to the parents, in particular, to disregard this evidence, since the possibility of improvement informs their view as to the treatment proposed. In any event, in the circumstances of this case, it appears highly unsatisfactory that the court would be asked to endorse, or perhaps overturn, orders made in the High Court with potentially serious consequences for John, on the basis of evidence as to his condition and a prognosis that might no longer be accurate. Accordingly, the court considered it was necessary to have regard to the reports and summarise their contents, while taking it into account that these were reports only and oral evidence had not been given.

33. Dr. F., in his report of December 14th, noted that, since the end of September, there has been a significant improvement in John's dystonia. This is the result of trialling several medications with a view to getting the best possible control over the dystonic episodes. It was noted, however, that the improvements in dystonia symptoms are not evidence of recovery. John continues to have a prolonged disorder of consciousness. Following control of the dystonia, there has been a noticeable increase in his level of wakefulness. John's family have also been reporting moments where they believe he is showing

awareness and responding. This has also been noted by nursing staff. As a result, further assessments were undertaken. An assessment on December 10th by Dr. G. noted that John's Glasgow Coma Scale score had improved, moving from a previous score of 4 out of 15 to 6 out of 15. This reflects his increased wakefulness; however, there was no evidence of non-reflexive awareness or movements observed at this time. There was no meaningful response to visual or auditory stimuli. John remains completely dependent on his carers to provide hygiene, toileting, dressing, skincare for the prevention of pressure injuries, and mouth care. He is hydrated and fed by nasogastric tube, which is well tolerated and he is growing. He can be seated for periods in a supported chair and can also be seated in a wheelchair, which has allowed him to leave the ward. He requires the use of a hoist to move him from chair to bed and back. He had an abnormal position of his feet. Following orthopaedic consultation, an operation to surgically release both Achilles tendons, followed by the use of ankle splints, was recommended and the procedure was performed successfully that morning under local anaesthetic and was well tolerated, with only brief dystonia.

34. Dr. F. concluded that, although there are improvements, they cannot be perceived as evidence of recovery. Even if there is a degree of awareness emerging, it does not alter the prognosis that John is very unlikely to regain a meaningful level of function. It was noted that this assessment would be difficult for John's family "who are committed to him and continue to engage in his cares around the clock with [the] team" in the Hospital. Dr. F. concluded by stating that it remained the opinion of all of the doctors involved in his care that excellent disability and palliative care was in John's best interest. It was their continued belief that, in the event of deterioration, intensive-care interventions, such as respiratory or cardiovascular support, or resuscitation would not be in John's best interests.

35. A further report was provided by Dr. L. on behalf of the guardian *ad litem.* Having outlined her observations in relation to John on the day of her visit on December 9th, Dr. L. noted that John remains entirely dependent on others in order to move, as he cannot move his trunk or limbs. He is not able to get himself into a seated position. He is not able to eat and is fed via a nasogastric tube. He is incontinent of both bowel and bladder. He remains at risk of pressure sores and skin infections, as well as chest infections due to his limited mobility. The current excellent care provided by the nurses and his family is helping to prevent these complications at present. He is likely to remain reliant on others in the area of feeding, oral hygiene, skin integrity, mobility, and toileting. She observed that John was more alert than when she first met him. She noted that his eyes did not fix on her or track her around the room. He was unable to follow a light when asked to do so. A nurse reported that, on occasion, he has turned his head to the sound of his name. She outlined a number of tests she performed and commented that, overall, her impression was that John's level of awareness had increased but is not at a normal level. She attached an MRI scan showing that many crucial areas of the brain, including the frontal lobes (important for executive function), and all the basal ganglia on the right (essential for the control of movement), show significant damage. The posterior limbs of the internal capsules were injured on both sides, meaning that normal voluntary movement is impossible. Since the brain has limited capacity to repair itself from traumatic injury, the loss of brain tissue shown on the scan was permanent. She observed that there may be a role for further, multidisciplinary, assessment of John's level of awareness, assuming his physical condition remains stable. Finally, she paid tribute to John's mother, who continues to lovingly and diligently care for him.

B. <u>The High Court Judgment</u>

36. Following that hearing, Irvine P. gave judgment on November 18th, granting the orders sought, which in practice were to permit the Hospital to move to palliative care should John's respiratory functions fail on the application of painkilling medication in the event of a future dystonic crisis. In this case, it is important to set out the precise terms of the orders sought, and which in the event were made.

37. The orders sought in relation to John's medical treatment were set out at para. 4 of the notice of motion as follows:-

> "An Order permitting the Clinical Director…of [the Hospital] to carry out such medical and nursing and ancillary treatment of the Minor in the exercise of their clinical judgment to be appropriate and in the best health and welfare interests of the Minor, including but not limited to:
>
> i. Permitting the administration of such medication, sedation or anaesthesia to the Minor by subcutaneous, buccal or enteral routes for the primary goal of treating severe breakthrough or neurological symptoms even though that [*sic*] the doses required to alleviate the Minor's suffering may have a secondary or terminating effect on the Minor's respiratory function.
>
> ii. permitting respiratory suctioning only when it is apparent to the treating nurses or clinicians that secretions are causing distress to the Minor;
>
> iii. permitting the insertion and re insertion of Nasogastric (NG) and/or Peripherally Inserted Central Catheter (PICC) and/or via Gastronomy (PEG) insertion for the delivery of feed or medications targeted at making the Minor comfortable and or alleviating distress to the Minor;
>
> iv. permitting the insertion and reinsertion of urinary catheter and ensuring urinary output;

v. permitting the administration of such medication to alleviate the minor's constipation.

vi. permitting the taking of swabs and the extraction of blood for testing;

vii. permitting delivery of oxygen via nasal prongs, canula or mask targeted at making the Minor comfortable and or alleviating distress to the Minor;

viii. permitting the taking of necessary x-rays, scans ultrasound, CT, MRI or other radiological imaging though necessary and appropriate in the Minor's best medical and welfare interests.

ix. Withhold life prolonging treatments or supports that are not considered to be in the best welfare and medical interests of the Minor including:

- The administration of hi-flow oxygen, continuous positive airway pressure or bi-phasic positive airway pressure supports;
- Rescue breaths delivered via bag or mask resuscitation;
- Intubation for the purpose of invasive mechanical ventilation;
- Mechanical ventilation;
- Inotropes for blood pressure instability;
- Cardiac compression for insufficient cardiac output or medical or electrical cardio diversion for cardiac arrhythmia;
- Invasive access including intraosseous and central venous access devices, or peripheral intravenous access save those permitted at (i) and (iii) above;
- Intravenous fluid replacement;
- The readmission of the Minor to an intensive care unit".

38. In her judgment, Irvine P. considered that six discrete issues had been raised: whether the exercise of the wardship jurisdiction was compatible with the constitutional rights of John's parents; whether the constitutional prohibition on euthanasia acts such as to

prevent the grant of the orders sought; the application of previous case law in circumstances where John's prognosis was uncertain; whether the best interests test provided sufficient protection in this case; if clear and convincing evidence had indeed been presented to justify the court exercising its wardship jurisdiction; and, whether the medical team were entitled – in the absence of such orders – to withhold measures they considered unethical.

39. In relation to the first issue – the compatibility of the exercise of the wardship jurisdiction with John's parents' constitutional rights as his parents – Irvine P. considered both Articles 41.1 and 42A, in addition to the established case law in coming to her decision. Having assessed the case law, she found it was clear that there was a rebuttable presumption that a child's rights were best vindicated within the family unit, which could be rebutted by a failure by the parents in this duty or by compelling reasons. Further, in any conflict between the parents' rights and those of the child, the best interests of the child must always be paramount.

40. While earlier cases, including *North Western Health Board v. HW & CW* [2001] 3 I.R. 622 ("*NWHB*") and *Re a Ward of Court*, had indicated a distinction between parental rights to decide on their child's behalf in cases where the court's wardship jurisdiction was engaged and those where it was not, Irvine P. declined to find that such a distinction should be maintained. In her view, the constitutional requirement to vindicate the rights of the child – which the parents normally enjoyed – was not affected by the child being a ward of court. Consequently, she held that the finding of the Supreme Court in *NWHB* – that there is a presumption to the effect that parents enjoy the right to decide as to their child's medical treatment – was applicable to the present case.

41. As the presumption that John's best interests would be best vindicated within the family unit had arisen, Irvine P. then moved to a consideration of whether the presumption had been rebutted. She rejected the proposition, advanced by counsel for John's mother, that

the State could *only* intervene to vindicate John's constitutional rights where his parents had failed in their duty to do so, finding that this proposition was supported neither by case law nor by the text of Bunreacht na hÉireann. Instead, it was possible for the State to intervene if there were compelling reasons to do so, *or* if the parents were objectively considered to have failed in their duty to vindicate the rights of the child. This objective test for the failure to vindicate the rights of the child was established in *Re Baby AB: Children's University Hospital, Temple Street v. CD & EF* [2011] IEHC 1, [2011] 1 I.R. 665 ("*Re Baby AB*").

42. On the facts of the present case, Irvine P. considered that the detailed and uncontroverted evidence that the invasive ICU treatment to which John would be subjected in the case of respiratory failure due to the use of painkilling medication to alleviate his suffering in the case of a future dystonic episode would not be a bridge to a better quality of life for him, but instead a path to prolong his suffering. The consequences for John of the scenarios detailed earlier were, she held, compelling reasons to rebut the presumption that John's rights were best vindicated within the family unit. Irvine P. also considered that the failure by John's parents – brought about solely by their unquestionable devotion to their son – to acknowledge the severity of his condition and his likely prognosis amounted to a failure to vindicate John's rights, which was similarly sufficient to rebut the presumption that his rights were best vindicated within the family unit and justified the intervention of the State in this rare case.

43. The case was distinguished from *Re a Ward of Court* as, in that case, the wardship had been put in place several years prior to any dispute arising, whereas in this case, John's medical team had sought to have him made a ward of court precisely because of the difference of opinion between them and John's parents. Further, the case was distinguished from *NWHB* on the basis that the threat to John's life in the instant case is

both real and immediate. In *NWHB*, the test to which the parents objected was only to check for a risk of illness at some point in the future.

44. As to the second issue, Irvine P. considered the *dicta* of Hamilton C.J. in *Re a Ward of Court*, where the then-Chief Justice noted that the Constitution protects the right to die a natural death, but does not confer a right to have life artificially terminated. Noting the evidence that palliative care, such as that sought to be put into effect for John, entails a long-term plan which ultimately extends the patient's life, President Irvine rejected the argument that the orders sought by the Hospital amounted to permitting euthanasia contrary to the Constitution. Rather than seeking to artificially terminate John's life, the orders sought were in fact seeking liberty to administer medication to John which would grant him a pain-free life and may, as a secondary (or terminal) effect, ultimately grant him a pain-free death. As such, she considered the orders sought to be fully in line with the constitutional prohibition on euthanasia.

45. The third and fourth grounds, being interlinked, were treated together by Irvine P. Analysing the basis of the wardship jurisdiction, she concluded that it in no way reduces the ward's rights, but merely transfers the vindication of such to the court as it is considered that the ward is no longer capable of vindicating these rights themselves. In this assessment of rights, the right to life is a central consideration, and there is a strong presumption in favour of maintaining life, as noted in both *Re SR (a Minor and a Ward of Court)*: *An Irish Hospital v. RH and JMcG* [2012] IEHC 2, [2012] 1 I.R. 305 ("*Re SR*") at p. 323, and *JM* at p. 713. However, as strong as this presumption is, Irvine P. noted that it can be rebutted where the court is satisfied that granting the reliefs would be in the ward's best interests.

46. As such, Irvine P. proceeded to consider the best interests test. This, she held, involved determining what the ward would consider to be in their best interests if they were able to view the circumstances and make a reasonable and informed decision as to the

management of their condition. It did not involve the court substituting its own view for that of the ward, or ignoring the evidence given by the ward's family as to what the wishes of the ward would be. Irvine P. then cited the list of factors to be considered in this determination as enumerated by Denham J. (as she then was) in *Re a Ward of Court*.

47. This list was extensive and detailed, but not exhaustive. Ultimately, these matters were best viewed as relevant factors to be taken into account alongside the totality of the ward's position:

i. the ward's current condition;

ii. the current medical treatment and care of the ward;

iii. the degree of bodily invasion of the ward the medical treatment requires;

iv. the legal and constitutional process to be carried through in order that medical treatment be given and received;

v. the ward's life history, including whether there has been adequate time to achieve an accurate diagnosis;

vi. the prognosis on medical treatment;

vii. any previous views that were expressed by the ward that are relevant, and proved as a matter of fact on the balance of probabilities;

viii. the family's view;

ix. the medical opinions;

x. the view of any relevant carer;

xi. the ward's constitutional right to:

a. life;

b. privacy;

c. bodily integrity;

d. autonomy;

e. dignity in life; and

f. dignity in death;

xii. the constitutional requirement that the ward's life be (a) respected, (b) vindicated, and (c) protected;

xiii. the constitutional requirement that life be protected for the common good – the case commences with a constitutional presumption that the ward's life be protected;

xiv. the burden of proof is on the applicants to establish their application on the balance of probabilities, taking into consideration that the court will not draw its conclusions lightly or without due regard to all the relevant circumstances.

48. After this analysis of the purpose of the wardship jurisdiction and the implementation of the best interests test, Irvine P. concluded that the exercise of the wardship jurisdiction was appropriate in this case, and that there was no reason why the existing case law on the matter should not apply. As to the argument that the best interests test provided insufficient protection at this comparatively early stage of John's illness, Irvine P. rejected this contention also, holding that the strong safeguards in the best interests test are no less effective at an early point in the illness than if applied at a later point in time. These safeguards – the strong presumption in favour of maintaining life, the test when determining the ward's wishes, and the checks and balances of the consultation required – were all sufficient safeguards. Consequently, Irvine P. held that the best interests test did adequately protect John's rights in the circumstances of this case.

49. President Irvine held that to be able to make a decision as to the ward's best interests, the court must have clear and convincing evidence on this matter, relying in this regard on the remarks of Kelly P. in *JM*, where he himself relied on a passage from the judgment of Blayney J. in *Re a Ward of Court*. While the new evidence was such that it was less likely that John would suffer a dystonic crisis in the immediate future, the consequences of such a crisis remained unaltered by this new evidence. Consequently, Irvine P. found

that the burden of adducing clear and convincing evidence in respect of the ward's best interests had been met.

50. Further, the President rejected the inference from the questioning of the medical team by counsel that they had sought the orders as they were unsure that the measures sought to be implemented would in fact be in John's best interests. Instead, Irvine P. considered that court orders had been sought due to a number of factors, including the impasse between the parents and medical team, the agreement between these parties that John's life would be prolonged by all means necessary until this application had been resolved, and the possible exposure of the Hospital to litigation should the medical team apply their clinical judgement. The case stemmed not from any uncertainty on the part of the medical team, but from the fact that John was unable to express his wishes, she held.

51. Having dealt with the above legal issues, Irvine P. then moved to an application of the best interests test to John's case. In doing so, she considered his likely preference if faced with the two scenarios outlined earlier: where his life was in danger such that only invasive ICU measures which would inflict further pain on him could rescue his life; and where a dystonic crisis arose necessitating a subcutaneous infusion which may impair his respiratory functions, ultimately hastening the end of his life.

52. Through this exercise, the learned President noted that she had to have regard to all she had been told about John in terms of his character, his interests, and his life: ultimately, what he would have voiced had he been in a position to do so.

53. Weighing up what John might, on the evidence, "consider to be a worthwhile and meaningful life", the learned President noted that people who willingly subject themselves to invasive treatments do so on the basis that they will ultimately lead to a better quality of life. On the other hand, in John's case, these invasive measures would prolong John's suffering solely to artificially extend his life. The knowledge of the pain which he currently suffers and would suffer should the Hospital not be permitted to

administer pain relief in the event of a life-threatening dystonic crisis must, she held, be imputed to John. As such, Irvine P. held that it would not be in John's interests to refuse the grant of the orders sought by the Hospital, as John would not choose to suffer a further prolongation of his pain without hope of recovery. Consequently, the orders were granted.

C. Leapfrog Appeal to this Court

54. This court granted leave to appeal direct from the High Court by determinations dated November 30th, 2020, to both the mother and father, and furthermore directed that the guardian *ad litem* be retained in the proceedings and that the Attorney General and the Irish Human Rights and Equality Commission ("IHREC") should be given notice of the proceedings and both parties attended the hearing and made submissions. All aspects of the case – procedural, evidential, and substantive – were challenged. It was argued on behalf of the mother that the decision to admit John to wardship at the outset of the proceedings ought not to have been made at that stage and in the absence of detailed argument. Furthermore, it was argued that this decision skewed the subsequent determination of the case and amounted to objective bias, leading to a perception that the decision on treatment was a foregone conclusion. Counsel also repeated the argument made in the High Court that the course of action sought and approved in the High Court amounted to an impermissible acceleration of death. It was further argued that the test of parental failure under Article 42A had not been satisfied. It was suggested that this case was unique, and that other cases where a withdrawal of treatment had been permitted, such as *Re a Ward of Court*, had been cases where the decision had been made by the family of the ward, and therefore there was no question of overriding their views. While the High Court had permitted blood transfusion of a child against the wishes of parents, in cases such as *Re Baby AB*, in those cases, the child's life had been in danger, which ranked higher in the constitutional hierarchy of rights than any rights of the parents.

55. Counsel on behalf of the father made it clear that the father, although separated from the mother for the past three years, wished to do all that was possible to support her and her decisions. Accordingly, he adopted the arguments advanced on behalf of the mother. Fundamentally, it was argued that the decision here could not be stigmatised as a failure on the part of the parents. Quoting the judgment of Hardiman J. in *N v. HSE* [2006] IESC 60, [2006] 4 I.R. 374 ("*N v. HSE*"), it was argued that matters which were neither culpable nor blameworthy and which could actually be described as laudable could not be relied on as establishing a failure of parental duty. The approach of the High Court, it was said, was incorrect in circumstances where the Constitution and the social order it protects recognised love as the surest foundation of parental decision-making. It was submitted that there was no grave moral failing here. It was also argued that the High Court had, following Hogan J. in *Re Baby AB*, adopted an objective view, which was contrary to the decision in *NWHB*, and, in particular, the decision of Murphy J., who had found that the decision of the parents in that case could not be overridden as a failure of parental duty, even though he described the defendants' judgement as one "for which they had not been able to articulate a rational basis that would satisfy the objective observer as to its wisdom. From an objective point of view, it is manifestly unwise". The question, it was said, was rather whether the decision lay within a range of responsible decisions a family could take. Counsel relied on the following passage from the judgment of Denham J. in *NWHB* at p. 723:-

> "Even if acute medical care is advised by some medical experts and the parents consider that the responsible decision may be to refuse such care, it may be within the range of responsible decisions."

It was argued that the reverse must also be true: if medical experts consider that the responsible decision is to refuse further treatment, parents may properly decide that further treatment and care is required.

56. Finally, counsel on behalf of the father sought to argue that it had been established in Ireland as a matter of common law (*DH (a minor) v. Ireland* (Unreported, High Court, Kelly J. (as he then was), May 23rd, 2000), citing with approval a *dictum* of Balcombe L.J. in *Re J (A Minor)* [1992] 3 W.L.R. 507 ("*Re J*")), that a court did not have jurisdiction to require a doctor to adopt a particular course of treatment in relation to a child unless the doctor himself or herself was asking the court to make such an order. Balcombe L.J. considered that if a court were to order a doctor to treat a child in a manner contrary to his or her clinical judgement, it would place a conscientious doctor in an impossible position. Subsequently, in *Re SR*, Kearns P. had observed, *obiter*, that he could not conceive of any circumstances where an order could be made to direct a doctor to adopt a course of treatment which he did not consider to be in the patient's best interest. Counsel further relied on the *dicta* of Kelly P. in *JM,* and of McDonald J. in *King's College Hospital NHS Foundation Trust v. MH* [2015] EWHC 1920. It was suggested, therefore, that there was no necessity to seek the order sought at para. 4(ix) of the notice of motion in relation to withholding of life-sustaining treatment, if it was the case that the doctors in question considered that, in the circumstances, the treatment was not in the patient's best interest. It appeared to be suggested also that no real difficulty arose in relation to the treatment at para. 4(i) of the notice of motion: namely, the administration of sedatives and anaesthesia to address the symptoms of any breakthrough neurological pain, since the parents' only objection to this was that the life-saving treatments would not be made available. On this basis, it was suggested that the dispute, while real, was not really legal in nature, and that, while the orders sought might be useful in terms of facilitating care planning on the part of the Hospital, they were not necessary or required. Indeed, it was suggested that seeking such orders entailed significant expense for hospitals and distress for families already in difficult situations.

57. The Hospital, for its part, supported the conclusions of the High Court. It also raised the question of the true interpretation of Article 42A 2.1°, quoting O. Doyle and E. Feldman in R. Byrne and W. Binchy (eds.), *Annual Review of Irish Law 2012* (Dublin: Roundhall, 2012), which suggested that there were alternative readings of the phrase "to such an extent that the safety or welfare [of the child] is likely to be prejudicially affected". On a textual reading, it is suggested that an additional criterion necessarily raises the threshold for State intervention. The other interpretation, more in keeping with the apparent intention of the Amendment to make the Constitution more child-centred, would read the requirement as merely delineating the type or nature of parental failure necessary before State intervention. The Hospital considered that the best interests test in wardship was objective in nature with a subjective element. The court had to assess what the ward would want and then, taking that into account, determine objectively what was in the minor's best interest, having regard to the totality of the situation. The Hospital defended the decision to admit John to wardship at the outset of the process, but submitted in the alternative that the treatment orders would, in any event, still be valid since they were orders granted after a full and fair hearing at which all the parties were given the opportunity to adduce evidence, cross-examine witnesses, and make submissions.

58. The Attorney General submitted that the constitutional protection of Article 41 extends only to the marital family, and the principal focus of the Constitution is to protect the institution of marriage rather than individual marriages. Therefore, it was considered that the question of the marital status of the parents in this case did not arise. It was submitted that, apart from Article 42A.2, it was possible that Article 42 in general was also relevant. The recognition of the rights of the child under Article 42A.1 was important. That Article could be seen as a constitutional recalibration to provide for a more child-orientated approach to matters of constitutional interpretation. It was arguable that the rights of the child were engaged in these proceedings, and that fact might provide a separate basis for

intervention, even if the court were to conclude that the parents' decision was not a failure of duty within the meaning of Article 42A.2.1°. It was submitted that, if the court concluded that the relief sought by the Hospital did not constitute treatment which would accelerate death, then there was a constitutional basis for the grant of the reliefs sought.

59. The submissions of IHREC focused on certain procedural matters. In particular, the Commission was critical of the use of the wardship jurisdiction. The admission to wardship had the effect of sweeping away all autonomy and the capacity to make any decisions. Counsel acknowledged, realistically, that this objection was more theoretical than real in the present case since, in the tragic circumstances that applied here, there was only one decision which was to be made in relation to John, and that was in relation to his future treatment. It was also argued that the order sought was too wide in any event. Not only were very detailed reliefs sought without necessary evidence that some of them were required or indeed disputed, but the terms of the orders sought and granted allowed treatment as the clinical director and the medical and nursing staff considered in the exercise of their clinical judgement to be appropriate and in the best health and welfare interests of John, including *but not limited to* the specific orders sought. This was a very wide authorisation that transferred all decision-making in relation to John to the Hospital.

60. Separately, it was contended that Article 42A.2 was not self-executing (in contrast to Article 42.5 which it replaced) and, therefore, that State intervention could arise only by proportionate means provided for by law, which, it was argued, meant legislation. While the Commission acknowledged that wardship jurisdiction was technically provided for in legislation, and specifically by s. 9 of the Courts (Supplemental Provisions) Act 1961, it was argued that an issue arose as to whether the law was sufficiently clear. The Commission considered that the inherent jurisdiction of the court was a preferable route. It was argued that where there was a *lacuna* in a statutory scheme, the court had an inherent jurisdiction to make positive orders and vindicate constitutional rights. It was

suggested that, if a decision was made by way of declaratory order or inherent jurisdiction, the issue of the best interests test being provided for by law did not arise as the court was not proceeding by way of a statutory mechanism. Reliance was also placed on the observations of the UNCRC Committee that full application of the concept of the child's best interests required the development of a rights-based approach. The Commission did not take any view on what specific treatment John should or should not receive. The decision must, however, be made in a manner which placed John's constitutional rights and those of both of his parents at the centre of the analysis.

61. At the heart of this case is a difficult question of the interpretation and application of Article 42A of the Constitution in the light of the evidence, both in respect of John's condition when the application was brought, and as it has subsequently developed. However, the parties have also raised a large number of issues, both procedural and substantive, which are significant and important, and require to be addressed. These issues include: the use of the wardship jurisdiction; the procedures adopted; and, the test applied. In relation to the constitutional issue, additional questions arise as to: whether the course of treatment proposed amounts to an impermissible acceleration of death and, therefore, euthanasia; the status of John, his mother, and father as a family; the interpretation of judicial decisions in relation to Article 42.5 of the pre-existing Constitution, and, in particular, the decision of this court in *NWHB*; whether the test for intervention under Article 42A of the current Constitution requires both a showing of exceptionality *and* parental failure; whether, if the test for intervention under Article 42A is not satisfied, intervention can be justified either by reference to a compelling reasons test, or on the basis of the vindication of the personal rights of the child; and, finally, the meaning of "provided for by law" when used in Article 42A.

II – Wardship

62. There are, undoubtedly, difficulties in applying the ancient common law jurisdiction in wardship in a fashion which is compatible with modern ideas of fair procedures, autonomy, incapacity, and the desirability of proportionate and assisted decision-making. Some of these issues have been recently explored by the judgment of O'Malley J. in this court in *AC v. Cork University Hospital* [2019] IESC 73 (Unreported, Supreme Court, O'Malley J., October 17th, 2019) ("*AC*") and are the subject of further consideration in the separate judgment being delivered by Baker J. in this case. However, we do not accept that the procedure is so constitutionally flawed as to be impermissible, and still less that the wardship process is any less satisfactory than plenary proceedings seeking declarations, or the exercise of the inherent jurisdiction, both of which were presented as preferable routes for the decision in this case. We appreciate that wardship has developed somewhat differently in Ireland than in the parallel jurisdiction in England and Wales, and that in that jurisdiction it has become the norm to invoke the inherent jurisdiction of the court, and/or to seek determination of urgent medical matters by way of declaratory relief. But we cannot see that, in a case such as this, these routes are any more secure, or immune from challenge on the basis of principle than wardship. Instead, we would see the developments in both jurisdictions as an illustration of the fact that, perhaps, some flexible jurisdiction in this regard is both unavoidable and necessary.

63. There is, however, in our view, no measurable disadvantage, still less constitutional flaw, in the fact that while pleadings are necessary in plenary proceedings, these proceeding were commenced by notice of motion with affidavits from the medical witnesses. This is, if anything, both a speedier and preferable procedure since it ensures that the detailed case being made is notified well in advance of the hearing. It was acknowledged in the course of argument that the processes in wardship involved a number of beneficial features, such as the capacity for regular and relatively informal review, the expertise and

capacity to appoint a guardian *ad litem*, the potential involvement of the General Solicitor, and the fact that the proceedings did not take the form of a *lis inter partes*. This latter feature is useful, in particular because it meant that the court would not be limited either in theory or in practice to the evidence and argument thought capable of being adduced by the principal parties, and where, almost of necessity, there is a significant imbalance in expertise and knowledge between the Hospital on one side, for its part, and the parents on the other. In dealing with a multi-faceted problem such as the present, these features are, if anything, a positive advantage.

64. However, it is undesirable in theory, and perhaps also in practice, that the entire decision-making function of the minor, and his family, should be overborne, particularly when the wardship jurisdiction is invoked for the purposes of effecting a single decision. It was argued, for example, that the effect of the decision was to make the President of the High Court the ultimate decision-maker in every matter concerning the treatment of the ward, including routine or less significant medical treatments (such, indeed, as the operation to release both Achilles tendons carried out in December), decisions on transfer from hospital and, ultimately, the decision as to where John might live. Where it is contended that wardship was necessary not because of a general failure of care, but because of the manner in which parents have addressed a single – albeit extremely serious – decision, it is neither desirable nor justifiable that the parents should be disabled as decision-makers in all other respects. However, the wardship procedure in respect of minors is sufficiently flexible, in our view, to be capable of at least reducing, if not resolving, this difficulty. We have read the judgment to be delivered by Baker J. in this regard and agree with it. The wardship would remain in place and available in the event of any serious dispute, but it would encroach only minimally in reality on John and his parents in any area of his life not captured by the treatment decisions which are sought to be determined in this case. Regrettably, however, that is the central decision now facing John, and it must be

addressed, whether under the wardship regime or under the inherent jurisdiction of the court, as McKechnie J. proposes in the judgment he delivers.

65. We agree also with the arguments advanced on behalf of John's parents that John should not have been admitted to wardship on September 15th on the first day of the hearing. Although it is clear that this was largely a procedural step designed simply to create a forum within which the decision on John's best interests could be made, the admission of any person to wardship is a serious matter, particularly when it is against the wishes of his or her family. The issue requires to be separately addressed, and the opportunity given to advance evidence and submissions against the course of action. It would have been preferable to have deferred a decision on admission to wardship until the close of the proceedings. It was a matter of fair procedures that an order of this nature, even if limited in the way now suggested, but which had nevertheless the effect of supplanting the decision-making function of John's parents in respect of truly critical medical treatment, should have only been made after a consideration of evidence and argument. We consider that, in this respect, the arguments of the parents are correct.

66. However, this conclusion does not, in itself, invalidate the treatment orders made. If the admission of wardship had led to a different (and lower) standard being applied to the question of consent to treatment (as, indeed, had been suggested in some of the judgments in *NWHB*), then this flaw in the procedure would be fatal to the validity of the final orders. However, Irvine P., correctly in our view, rejected the argument that once John was admitted to wardship, the court was entitled to consider simply what was in the best interests of John. Instead, the President considered that she should apply the same test for the overriding of parental refusal as would have arisen in plenary proceedings, or in proceedings instituted seeking declarations pursuant to the inherent jurisdiction of the court. It follows that the decision on admission to wardship at the outset of the proceedings had no necessary impact on the decisions as to the treatment orders, which

must be considered in their own terms by reference to the appropriate constitutional standard. If the constitutional threshold for intervention was not reached on the evidence, then the orders should be set aside, whatever the procedural route by which they were reached, but if the threshold was passed, then the early admission to wardship could not deprive them of validity. Put another way, we consider that the correct course would have been to open the wardship proceedings, which would have meant that the court could have available to it the protective powers of the court in respect, for example, of seeking an independent medical expert to report on the ward, or perhaps to grant injunctions if necessary, but that the formal order admitting John to wardship should only have been made at the close of the proceedings, and then only if the High Court was satisfied that it had been established that the constitutional threshold for overriding the parental decision-making function was met. But in this case, that conclusion *was* reached after a hearing that fully complied with fair procedures. That conclusion was not influenced or affected by the existence of the earlier order. If that conclusion was incorrect on the evidence or law, then the appeal must succeed. If, however, it was correct, then the defect in the order admitting to wardship becomes an issue of timing rather than substance.

67. It is, perhaps, for this reason that counsel on behalf of the mother sought to argue that the decision on admission to wardship amounted to objective bias, undermining the subsequent decision. No authority was cited for this proposition and no example given of a decision being set aside on this basis. We would unhesitatingly reject the argument. If the decision on treatment was legally or logically flawed, then it is capable of review in these proceedings. If, however, it is sound, then it cannot and should be not invalidated because of an earlier procedural error which did not affect the decision.

III – Constitutional Issues

A. End of Life

68. The contention, made both in the High Court and this court, that the orders made were simply constitutionally impermissible, because they amounted to an acceleration of death, deliberate killing, and therefore euthanasia, is a striking one. Robust argument can be of considerable assistance in any case. Language in this area is important. There are occasions upon which it may be essential to bluntly confront euphemism, especially when it conceals an ugly and unpalatable reality. But we do not think that this argument was justified here, and was, if anything, unhelpful to the just resolution of the issues in this case and, indeed, to the practical relationship between John's parents and his treating doctors.

69. The evidence was to the effect that John's medical team were of the view that it was better to proceed to palliative treatment to treat his symptoms to maintain him insofar as possible both comfortable and pain-free, and to refrain from invasive or regressive techniques maintaining life at all costs. The evidence was, indeed, to the effect that, if anything, patients receiving palliative care lived longer than patients with terminal illnesses and who were subjected to invasive life-maintaining treatment. The decisions being confronted in this case are dramatic and tragic; but the same difficult choice is being confronted by families of loved ones in different cases in homes, hospitals, hospices, and nursing homes every day. If, however, the argument made on behalf of John's mother is correct, then in all such cases euthanasia has been practiced, the families concerned are involved in criminal offences, and the doctors and nurses are committing crimes, torts, and serious breaches of important and long-standing rules of their profession. It would also follow logically that the treatment outlined by the Hospital could not be carried out in this case, even with the agreement of John's parents. Yet, however, it was submitted on behalf of John's mother that "if such treatment were to be permitted, it is such an

intimate and fundamental nature, that it is a decision for the parents of the family, acting in a *bona fide* belief of the Minor's best interests, not a decision for the treating hospital". It is difficult to reconcile the two submissions.

70. The argument made on behalf of John's mother also appears to be inconsistent with the outcome of a number of decisions of this court and the High Court. Perhaps the most important of these is the decision in *Re a Ward of Court*. In that case, the High Court and the Supreme Court on appeal held that it was permissible to withdraw nutrition characterised as artificial life-sustaining treatment from a ward of court. Death was, and was recognised to be, the inevitable consequence of that step. A dignified and natural death was, indeed, the desired outcome of the application. Hamilton C.J. adopted, with approval, a statement of Sir Thomas Bingham M.R. (as he then was) in *Airedale Trust v. Bland* [1993] A.C. 789 at p. 808 of the report of the English case:-

> "It is… important to be clear from the outset what the case is, and is not, about. It is not about euthanasia, if by that it meant the taking of positive action to cause death. It is not about putting down the old and infirm, the mentally defective or the physically imperfect… The issue is whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die."

At p. 130 of the report, O'Flaherty J. said explicitly:-

> "This case is not about euthanasia; euthanasia in the strict and proper sense relates to the termination of life by a positive act. The declarations sought in this case concern the withdrawal of invasive medical treatment in order to allow nature to take its course".

71. In concluding that it was lawful to withhold the artificial nutrition and hydration, Hamilton C.J. concluded explicitly that "the true cause of the ward's death will not be the withdrawal of such nourishment but the injuries which she sustained on 26th April, 1972".

72. In *Fleming v. Ireland* [2013] IESC 19, [2013] 2 I.R. 417 ("*Fleming*"), this court had to address the question of the statutory prohibition of assisted suicide. In that case, it was argued that there was no legitimate distinction between the withdrawal of medical treatment with the effect that death ensued and active participation in achieving that object. The court in that case adopted, with approval, the observations of Sopinka J. in a Canadian case, *Rodriguez v. British Columbia AG* [1993] 3 S.C.R. 519, (1993) 107 D.L.R. (4th) 342, (1993) 50 B.M.L.R. 1, which recognised a distinction between palliative care being delivered to terminally ill patients on the one hand and assisted suicide on the other. The distinction was based on intention. In the case of palliative care, the intention is to ease pain which may have the effect of hastening death, while in the case of assisted suicide the intention is, undeniably, to cause death. Sopinka J. observed that, regardless of one's own personal views, "the fact remains that these distinctions are maintained and can be persuasively defended". This distinction was explained in this case by the evidence of the consultant in Paediatric Palliative Medicine:- "The intent is never to shorten life. The goal of palliative care is to live well, but it also encompasses the potential to die well". Later, she said:- "So, the intent is never to hasten death or shorten life. The intent is only to relieve suffering" (Day 2, p. 79). It is possible to argue that the distinction is no longer feasible, or should no longer be maintained, but so long as the law retains an absolute prohibition on euthanasia, it remains a critical and valid distinction both for medicine and the law.

73. It may be, however, that the contention on behalf of John's mother that the course of treatment proposed here amounts to euthanasia stems from a recognition that, in a number of cases, courts in this jurisdiction (and in other jurisdictions with similar legal

prohibitions on euthanasia) have made orders permitting the withdrawal or withholding of life-sustaining measures, and permitting the treatment of a patient by palliative measures only, sometimes over the objections of the patient's family.

74. *Re SR* concerned a boy who suffered irreversible brain injuries as a result of a near-drowning incident in 2007 when he was less than two years old. He was completely dependent for all his care needs and experienced significant feeding difficulties and, subsequently, respiratory tract infections. He required numerous admissions to the emergency department. He had a significant chronic illness and although, up to the time of the court application, he had received non-invasive respiratory support and intravenous antibiotics, there was a possibility his condition could deteriorate at any time. Kearns P. observed that:-

> "in the event of a severe deterioration of his condition a decision must be made whether to resuscitate him and to decide whether it is in his best interests to be intubated and placed on invasive ventilation in circumstances where it may not be possible to wean him off ventilation and the use of such invasive measures will neither restore health or confer any real benefit to the child and will cause him pain and suffering".

The boy's father was opposed to the course proposed by the hospital and believed that the child would benefit from stem cell transplantation therapy, which he considered was available in the Dominican Republic or Mexico. The consultant treating the ward advised that there was no basis for believing that such treatment could have been of benefit to the ward or, indeed, that the child would have been fit to travel for that purpose.

75. Kearns P. reviewed a series of cases in the courts of England and Wales in which the courts had authorised the withdrawal of treatment or a decision not to engage in invasive life-sustaining treatment. He followed the approach of Lord Donaldson of Lymington M.R. in *In Re J*, where it was considered that the correct test was to consider what the

ward would choose if in a position to make a sound judgment. Kearns P. considered that the ventilation of the child in the circumstances would inevitably involve the prolongation of life with no prospect of improvement. There was no medical support for the treatment proposed by the father. Accordingly, Kearns P. granted the hospital's application and observed, *obiter*, that he could not conceive of circumstances where a court could positively order medical practitioners to follow a course of treatment which, in their *bona fide* clinical judgement, was not in the best interests of the patient. The case was dealt with with considerable speed under the circumstances and it does not appear that the question was analysed by reference to the constitutional standard for overriding a parental decision. That may have been because the child had already been admitted to wardship as a result of his injuries and the application was made in the course of the wardship. While this distinction might be relevant to other aspects of this case, it is not relevant to the present issue: if withholding invasive treatment with the possibility that death will ensue amounts to impermissible euthanasia then it could not be approved by the court, whatever jurisdiction was being exercised and whatever the test applied.

76. More recently again, in *An Irish Hospital v. RF* [2015] IEHC 608, [2015] 2 I.R. 377, a child was profoundly physically and intellectually disabled as a result of a non-accidental injury sustained while four months old. The child had been taken into care in 2004. However, her health subsequently deteriorated and she suffered severe pneumonia which had not cleared despite a prolonged course of broad spectrum antibiotics. The hospital sought a declaration that it could refrain from further aggressive treatment in the nature of resuscitation or artificial ventilation and, instead, that it should provide her with a programme of palliative care. The application was supported by the child's mother, not opposed by her father, and supported by the guardian *ad litem*. O'Malley J., referring to the decision of Kearns P. in *Re SR*, made the order sought.

77. An important case is *JM*. It is yet another tragic case. It concerned a young man of 36 years of age. He had been born prematurely and experienced a somewhat troubled childhood and suffered psychiatric difficulties, which led to him living in a community residence. In 2011, he suffered head trauma causing some brain injuries. In 2012, he presented in hospital with haematemesis and was transferred to another hospital for continued resuscitation and admitted to an intensive care unit for multi-organ support. While his condition stabilised initially, he remained in hospital and was still in hospital five years later at the time of the High Court application.

78. By the time of the High Court hearing, JM had been diagnosed as being in a minimally conscious state ("MCS"). This condition was explained by Kelly P. in his judgment, in which he drew on the working party report of the Royal College of Physicians on *Prolonged Disorders of Consciousness: National Clinical Guidelines* (London: Royal College of Physicians, 2013). That paper set out three different distinct disorders of consciousness: coma, vegetative state ("VS") and MCS. JM did not come within the definition of VS being:-

> "a state of wakefulness without awareness and which there is preserved capacity for spontaneous or stimulus induced arousal, evidenced by sleep wake cycles and a range of reflexive and spontaneous behaviours. VS is characterised by complete absence of behavioural evidence for self or environmental awareness".

MCS was defined, by contrast, as:-

> "A state of severely altered consciousness in which minimal but clearly discernible behavioural evidence of self or environmental awareness is demonstrated. MCS is characterised by *inconsistent, but reproducible,* responses above the level of spontaneous or reflexive behaviour, which indicates some degree of interaction with their surroundings." (*Emphasis in original*.)

79. Kelly P. found that JM suffered from severe non-traumatic irreversible brain injury. He noted that a diagnosis of MCS had to be approached with caution, since it covered a spectrum from just above VS and up to and including a state bordering on full consciousness.

80. In JM's case, the position was set out at para. 23 of the judgment:-

> "JM is unable to speak. He cannot feed himself. He is tube fed. He cannot walk. He is only able to move his right upper limb and when he does so it is in an uncoordinated fashion. He breathes through a tracheostomy. He needs high level nursing support at all times."

81. Kelly P. heard extensive expert evidence. He concluded that JM was in a minimally conscious state, and one which was very far from bordering on wakefulness. His level of consciousness was set out at para. 54 of the judgment and summarised at para. 55 as follows:-

> "I am prepared to accept that his level of consciousness is such as to on occasion give him an awareness of the presence of persons and some ability to enjoy the company of those with whom he is familiar as well as music or television sports broadcast. By the same token, adopting Dr M2's approach one ought to presume the potential for distress, discomfort, anxiety and fear"

His condition was disimproving with time and there was no realistic prospect of any improvement in JM's condition.

82. In 2017, the treating doctors concluded that JM's condition was such that, in the event that his condition deteriorated, it would inappropriate to engage in aggressive life-sustaining treatment such as an increase in the existing ventilation support, in the event that he suffered respiratory deterioration, or vasopressor support, cardiopulmonary resuscitation cardioversion, defibrillation and the insertion of arterial or central venous lines for monitoring of cardio vascular variables. JM's parents, who were conscientious

and devoted to him, were unwilling, however, to give their consent to this course. In those circumstances, the hospital applied to have him made a ward of court, and thereafter sought the court's consent to the course proposed.

83. Kelly P. delivered a careful and detailed judgment. He recorded the evidence of the treating doctors and the further expert evidence which had been sought, including expert evidence adduced by JM's parents. That evidence was to the effect that the treatment set out above, which the hospital wished to withhold, was not in the interests of JM. For example, Professor B., who had been retained by JM's parents, said that he would not increase ventilation support in the event of respiratory deterioration. He would be very disappointed if he could not persuade the family and bring them on board, but if he could not, he would still take that decision. Other witnesses expressed the view that they believed that to provide the intensive life-supporting procedures identified would create ethical difficulties for them and involve behaving in a manner inconsistent with their medical judgement.

84. Kelly P. recognised that the starting position for any analysis was the strong presumption in favour of preservation of life, quoting Hamilton C.J. in *Re a Ward of Court*, and the statement of Munby J. in *R (Burke) v. General Medical Council* [2004] EWHC 1879, [2005] 2 W.L.R. 431, that there was a "very strong presumption in favour of taking all steps which will prolong life". However, that did not preclude the court from finding that, in the circumstances of the particular case, it was in the ward's best interests that the court should refuse to give consent to a particular course of medical treatment, even treatment which might become necessary or desirable in order to prolong or to attempt to prolong the ward's life:-

> "there is no absolute duty imposed on the court to consent to medical treatment on behalf of a ward of court in order to attempt to prolong life at all costs and without regard to any other consideration or circumstance of the ward's best

interests. Neither is there any absolute duty on a doctor to provide, or on a patient to consent to, medical treatment in order to attempt to prolong life at all costs and without regard to other matters concerning the patient's best interests".

85. Kelly P. considered that the best interests test on a prospective refusal of consent to life-saving or life-sustaining treatment did not equate to a question of whether it would be in the best interests of a patient that he or she should or should not die. The correct position was that set out in s. 4(5) of the England & Wales Mental Capacity Act 2005, which provided that a decision-maker, when considering whether the treatment was in the best interests of the person, should not be motivated by a desire to bring about his or her death. Kelly P. referred to the observations of Baroness Hale of Richmond in *Aintree University Hospital NHS Trust v. James* [2013] UKSC 67, [2013] W.L.R. D. 421 ("*Aintree University Hospital*") that:-

> "The question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuation of this form of treatment… Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

86. Kelly P. also considered the question of the standard of proof and noted a divergence of opinion among judges on the topic. He adopted the view of Blayney J., that the issue was not a *lis inter partes* and it was not an adversarial hearing in which there was any question

of an onus of proof or a standard of proof. Instead, however, he considered that the decision would fall to be made only upon evidence that was "clear and convincing".

87. In considering the relevant factors, Kelly P. set out the 14 factors identified by Denham J. in the course of her judgment (as enumerated at para. 47 of this judgment), and quoted those identified by Kearns P. in *Re SR*, as follows:-

> "In determining whether life-saving treatment should be withheld, the paramount and principal consideration must be the best interests of the child. This gives rise to a balancing exercise in which account should be taken of all circumstances, including but not limited to: the pain, suffering that the child could expect if he survives; the longevity and quality of life that the child could expect if he survives; the inherent pain and suffering involved in the proposed treatment and the views of the child's parents and doctors."

88. The Royal College of Physicians noted that the decision about care of patients who lack capacity would need to take account of:

- The likelihood that the treatment would be effective or futile
- The benefits, burdens, and risk of treatment – the best and worst outcomes
- The patient's likely wishes, based on what is known of their values and beliefs.

89. Finally, the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners in Ireland* (Dublin: Medical Council, 8th Ed., 2016) ("*Guide to Professional Conduct*") produced by the Medical Council stated that:-

> "Usually you will give treatment that is intended to prolong a patient's life. However, there is no obligation on you to start or continue treatment, including resuscitation … if you judge that the treatment:
>
> - Is unlikely to work; or
> - Might cause the patient more harm than benefit; or

- Is likely to cause to the patient pain, discomfort, or distress that will outweigh the benefits it may bring.

You should carefully consider when to start and when to stop attempts to prolong life. You should make sure that patients receive appropriate pain management and relief from distress, whether or not you are continuing active treatment."

90. Kelly P. considered that the approach should be to consider what the ward would choose if he were in a position to make a sound judgement. It followed that the decision-maker should not impose his or her own views on whether the quality of life which the child would enjoy would be intolerable, but should determine the best interests of the child subjectively. In the circumstances of the case, Kelly P. concluded that it was not in JM's best interests that he should have the invasive treatments identified: namely, resuscitation and vasosuppressive support cardioversion defibrillation. Indeed, counsel on behalf of the parents did not argue against those reliefs. However, it was argued that the court should not grant the first reliefs: namely, to consent to the proposal that, in the event of respiratory deterioration, the hospital would withhold an increase in the existing ventilator support. Nevertheless, Kelly P. concluded that this too was in the overall best interests of the ward:-

> "The risks involved in so doing [increasing ventilator support] are substantial. No doctor supports the provision of the therapy. No improvement of his underlying condition will be effected. No lessening of the burden of JM's illness will be brought about. No clear medical benefit will be achieved. The burden of the treatment outweighs such limited benefits as may accrue from it."

Accordingly, and notwithstanding the wishes of the parents, the relief was granted.

91. There are a number of points of similarity between the *JM* case and the present. It should be noted, moreover, that the position of John in this case, even though improved since the period after the accident and when the application to court was initially made, appears

much less responsive than JM. In evidence, Dr. G. was reluctant to put a specific label on John's condition, both because of his age and the length of time since the accident. However, his condition was consistent with VS, and possibly might reach MCS, but would likely remain in VS, though it was too soon to say with 100% confidence. (Day 2, p. 92). On the other hand, JM's condition had been monitored over a long period of time before the application was made. Finally, it is apparent that that case was dealt with under the wardship jurisdiction and, while very careful consideration was given to the position of the parents, the matter was not addressed by reference to any question of the constitutional position of the family. While these distinctions need to be kept in mind, the case does, however, provide considerable assistance.

92. John's mother does not argue that any of these cases or, indeed, some similar cases in the courts of England and Wales referred to by Kearns P. in *Re SR* were wrongly decided. However, it is argued that this case is unique in that consent is sought to positive treatment permitting the administration of medication pursuant to para. 4(i) of the notice of motion, permitting the administration of medication, sedation or anaesthesia, even though the doses required to alleviate the minor's suffering may have a secondary or terminating effect on the minor's respiratory function, *together with* authorisation pursuant to para. 4(ix) withholding life-prolonging treatments or supports. It seems, therefore, that, for the purposes of this argument, the application is being read as authorising the pain-relieving treatment *with a view to* causing a terminating effect of respiratory function which *it is intended* would not then be treated so as to restore respiratory function so that John would inevitably die.

93. It is perhaps understandable why, particularly in a crisis situation involving engagement with unfamiliar, and perhaps bewildering, medical and legal terminology and procedures, John's mother might understand the application in this way if, indeed, she does so. However, to do so does not reveal a blunt truth. Instead, it removes critical details of fact,

emphasis, and nuance which are indeed central to an understanding of this case and the legal position. Some issues are complex and require careful consideration, and to reduce them to cruder contentions is not to simplify, but to confuse.

94. It is, at this point, possible to consider that the legal process has accentuated differences between the parents and the doctors rather than contributed to their resolution. The fact that the parents are unwilling to consent to the course of the treatment recommended by the doctors has led the Hospital to set out the possible treatments and steps that might be taken in more specific terms and in greater detail than would normally be the case in any discussion between doctors, patients, and their families. Some of the steps involve positive treatment and, therefore, consent to be given either by John's parents or by a substitute decision-maker. Other steps involve the withholding of aggressive life-sustaining treatment and do not, themselves, require consent but, as the cases referred to above illustrate, it has been considered prudent in the absence of consensus to seek authorisation from the court. But the detailed enumeration of the reliefs sought is capable of being misunderstood and perhaps has been.

95. When this application was brought, John suffered from uncontrolled dystonia causing very severe pain. There is no doubt that the appropriate treatment was to seek to control and relieve that pain by a combination of drugs including sedation, anaesthesia, and relaxants. Indeed, it is the case, as we understand it, that John's mother did not object to this treatment in itself, but rather was only unwilling to consent because of the Hospital's view that, in the event of respiratory failure caused during such treatment, or indeed as a result of some other crisis, it would not be appropriate to engage in aggressive life-extending measures. Fundamentally, therefore, this case raises the same issues as raised in the earlier case law; that it is the Hospital's wish to follow a course of palliative care for John and to refrain from aggressive or invasive life-sustaining measures.

96. The course proposed by the Hospital, however, does not amount to euthanasia or the impermissible hastening of death by direct intentional measures any more than palliative care in the cases discussed and, indeed, as practised on a daily basis. It is, perhaps, regrettable that the argument was advanced and expressed in this way since that has served only to distract from the complex factual issues in this case and to increase the area of disagreement between the doctors and John's family whilst minimising the possibility of agreement between them. The suggestion that the treatment here amounts to euthanasia is a serious one. It could lead to the doctors involved to be more cautious and defensive in their approach and either to seek court authorisation for every individual step in John's treatment or to engage in treatment they consider unwise and distressing, but which will not be capable of criticism from John's parents' perspective.

B. Family Decisions on Health Treatment

97. These considerations lead to the central issue in this case: may the conscientious decision of loving and engaged parents be overridden when a consequence of the course of treatment proposed may be that the child may die?

98. The learned President concluded that the question she had to address was whether the refusal of John's parents to consent to the treatment amounted to a failure of parental duties such that the State, through the court, was obliged to supply the place of the parents and provide such consent pursuant to Article 42A of the Constitution. We consider that this was the correct and difficult question posed in this case. Irvine P. considered that the conduct of the parents in the particular circumstances did amount to a failure requiring the State, through the court, to supply the place of the parents. In considering whether this conclusion is correct, it is necessary to review the provisions of the Constitution as originally enacted, the subsequent interpretations of Articles 41 and 42 of the Constitution, and the consequences of the Amendment effected by the deletion of Article

42.5 of the original Constitution and the introduction of Article 42A. While Irvine P. addressed other possible bases for the court's decision, such as the State's obligation to vindicate the rights of the child, and the question of compelling reasons to consider that the presumption that the best interests of the child was achieved within the family had been discharged, it will be convenient to consider first whether the express provisions of Article 42A permit the court to grant the relief sought, since a positive conclusion on that issue might dispose of the case, and a negative conclusion would be a relevant factor in considering any other basis for the orders sought.

99. The Constitution of 1937 contains an emphatic statement of the position of the family. So far as is relevant, it provides as follows:-

> "ARTICLE 41
>
> 1 1° The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law.
>
> 2° The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.
>
> …
>
> 3 1° The State pledges itself to guard with special care the institution of Marriage, on which the Family is founded, and to protect it against attack."

100. John's mother, in the course of her submissions, recognised that John's family was not a marital family as understood by the use of the word "family" in Article 41, but nonetheless argues that the inalienable and imprescriptible rights of the Family under Article 41 inhere in her family and in John as a member of that family. It is further argued that Article 42A protects, in similar terms, John's inalienable and imprescriptible rights as a member of his family unit in which authority for decision-making in respect of

medical matters rests with his parents. It is contended that Article 41, together with Article 42A, protects the authority of the family unit and the child's inalienable and imprescriptible rights within that unit. The respondents, in their submissions, noted that John's parents are not married and conclude, therefore, that Article 41 does not apply. They contended that any parental rights in this case are derived from the provisions of Article 40.3 and 42 of the Constitution, and possibly indirectly from Article 42A. For the purpose of this discussion, the status of John's family has no bearing on the outcome of the case because, as will be seen, Article 42A is expressly stated to apply to children, regardless of the marital status of their parents. We note that Mr. Justice McKechnie's concurring judgment contains a detailed and thoughtful discussion of the broader issues involved in the treatment under the Constitution of marital and non-marital families, and which will be valuable in any further consideration of those issues. However, perhaps for the reasons set out above, this case has been approached by all parties on the basis that, insomuch as the issue before the court is concerned, the test to be applied to the parental decision does not, in any way, depend upon the marital status of the parents, and accordingly we do not consider it necessary to express any view upon the wider issues.

101. It is noteworthy that, in Article 41, the Constitution treats the Family as a collective unit and having collective rights. It does not expressly refer to children as having such rights, although that follows by implication from the terms of Article 42.5 when, in referring to the circumstances in which the State may endeavour to supply the place of parents, it is required to do so "with due regard for the natural and imprescriptible rights of the child".

102. It is obvious that, under the Constitution, which in this respect has not been amended, the Family as a collective unit has rights. However, a collective unit is made up of individuals who themselves have rights. One issue which may, therefore, arise is the relationship of the collective unit with the State. But, particular difficulties which have arisen in the case law are a perceived clash between the rights and interests of different members of the

Family and, in particular, a tension which may arise between the rights and duties of the parents and the rights of the child. This issue is not addressed or resolved by reference to the collective rights of the family unit. This tension was addressed explicitly in Article 42.5 of the Constitution in 1937:-

> "In exceptional cases, where the parents for physical or moral reasons fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child."

As Irvine P. observed in this case, it might at one time have been argued that the text of the Constitution should be read as confining Article 42.5 to the provisions of Article 42 and, therefore, to the context of education. On this reading, it might be said that the State could intervene to protect children and their rights in areas other than education without satisfying the high threshold set by the text of Article 42.5, requiring not merely parental failure, but parental failure for physical or moral reasons: something which the Article acknowledges will be exceptional. However, it was well established before the Thirty-first Amendment that this reading of the Constitution was not correct and that Article 42.5 sets out the terms upon which the State could intervene in families: that is, the family based on marriage, which the same Constitution recognised as the natural and primary unit in Society and the primary and natural educator of the child.

103. *In Re JH* [1985] I.R. 375 ("*Re JH*") was one of a series of cases in the mid-to-late 20th century involving heart rending-disputes where a child had been placed for adoption with prospective adoptive parents but, before a final order had been made, the natural parents had married and sought custody of the child. In the High Court, Lynch J. refused the prospective adoptive parents' applications to dispense with the natural parents' consent to adoption but, in the light of evidence that the child had formed an attachment with the prospective adoptive parents and would suffer some psychological trauma if separated

from them, made an order awarding custody of the child to them pursuant to the Guardianship of Infants Act 1964 ("the 1964 Act"). He did so on the basis that s. 3 of that Act provided that, in proceedings involving children, including custody, "the court… shall regard the welfare of the infant as the first and paramount consideration". The issue on appeal to the Supreme Court was whether this provision was to be given its literal interpretation, on which basis it was said that the High Court order should be upheld, or whether, as the court ultimately found, it was to be interpreted as involving a constitutional presumption that the welfare of the child (which, as the court noted, was defined in s. 2 of the 1964 Act in terms identical to those contained in Article 42.1 of the Constitution) was to be found, as noted at p. 395 of the report, within the family:-

> "unless the Court is satisfied on the evidence that there are compelling reasons why this cannot be achieved, or unless the Court is satisfied that the evidence establishes an exceptional case where the parents have failed to provide education for the child and to continue to fail to provide education for moral or physical reasons".

This appears to be the genesis of the "compelling reasons" test discussed in later decisions and in the argument in this case.

104. Although Finlay C.J. in the Supreme Court did paraphrase Article 42.5 so that the evidence of an exceptional case was a failure "to provide education for the child", the 1964 Act nevertheless concerned issues beyond the traditional understanding of education and, accordingly, the finding that the s. 3 welfare principle was subject to the provisions of Article 42.5 was a conclusion capable, it seemed, of broader application.

105. In any event, this conclusion was put beyond doubt by the decision of the Supreme Court in *In Re Article 26 of the Constitution and In the Matter of the Adoption (No. 2) Bill 1987* [1989] I.R. 656. The case involved a reference to the Supreme Court by the President of the provisions of the Adoption (No. 2) Bill 1987 which was passed by the Oireachtas to

provide for the possibility, for the first time, of the adoption of children of a married couple. The Act expressly provided that it was to provide for the adoption of children "in exceptional cases, where the parents for physical or moral reasons have failed in their duty towards their children" and thus explicitly echoed Article 42.5 of the Constitution. Finlay C.J., writing for the court, said the following at pp. 662 to 663:-

> "The rights of a child who is a member of a family are not confined to those identified in Articles 41 and 42 but are also rights referred to in Articles 40, 43 and 44.
>
> The terms of Article 42, s. 5 are reflected both in the long title to the bill and in many of the provisions of section 3. Counsel for the Attorney General placed considerable but not exclusive reliance on that section as justifying the proposals in the bill. In addition they submit that the State had the duty and right to protect and to vindicate the rights of a child who by reason of its parents' failure has lost, and is likely permanently to lose, not only its rights as identified in Articles 41 and 42 of the Constitution, but also other personal rights which, though unenumerated, derive from the Constitution. It has been submitted that in some circumstances adoption would be the method necessary to afford that protection and vindication.
>
> Article 42, s. 5, should not, in the view of the court, be construed as being confined, in its reference to the duty of parents towards their children, to the duty of providing education for them. In the exceptional cases envisaged by that section where a failure in duty has occurred, the State by appropriate means shall endeavour to supply the place of the parents. This must necessarily involve supplying not only the parental duty to educate but also the parental duty to cater for the other personal rights of the child.
>
> …

The State would, in any event, by virtue of Article 40, s. 3 of the Constitution be obliged, as far as practicable, to vindicate the personal rights of the child whose parents have failed in their duty to it." (*Emphasis added*.)

106. It may be useful to pause here and explain why we consider this conclusion was not only correct, but is now beyond doubt. It is clear that Articles 41 and 42 as enacted were interconnected. The linkage is, for example, apparent from Article 42.1 itself which refers to the institution of the Family (which was the subject of Article 41) as the primary and natural educator of the child. Article 42 could not, therefore, be read in isolation from Article 41. Furthermore, education – even a narrow sense of scholastic education – is one of the primary areas that might be said to be within the authority of the Family as contemplated in Article 41.2 and which the State is obliged to uphold. Moreover, education in Article 42 is expressed in notably broad terms capable of covering much of a child's life and experience. It was also a significant feature of the 1937 Constitution that it placed such emphasis on education being the only socio-economic right not contained in Article 45, and made justiciable, reflecting, perhaps, the high value traditionally placed on education in Ireland. In all the circumstances, it would be difficult, therefore, to comprehend why the Constitution would provide a notably higher threshold for State intervention to protect the child's right to education (as broadly defined in Article 42) than in other areas of a child's life.

107. In any event, the conclusion that Article 42.5 defined the circumstances under which the State could and should intervene in a family to protect the interests of the child was part of the background against which that provision was itself removed from the Constitution, and a new separate Article, Article 42A, introduced. It is clear that that Article – and in particular Article 42A.2.1° – cannot be read as merely qualifying the terms of the now-truncated Article 42, but rather applies more generally. We consider, therefore, that the President was quite correct to approach this case by reference to the terms of Article 42A.

It may be noted that in the decision in *JH*, Finlay C.J. made reference to State intervention where there were "other compelling reasons" and that it has been submitted that there is a general jurisdiction to intervene to vindicate the rights of children. As discussed above, it may be necessary to consider the nature and extent of any such jurisdiction in due course. However, in the first place, it is necessary to decide whether the circumstances of this case are sufficient to justify State intervention under Article 42A.

C. Interpretation of Article 42.5 Jurisprudence

108. Much of the argument in this case has focussed on the decision in *NWHB*, which can be analysed as a case in which the majority of the court found that the test under Article 42.5 for State intervention in family autonomy was not satisfied, and, to a lesser extent, on the decision of the High Court in *Re Baby AB*, in which the High Court (Hogan J.) found that, in the particular circumstances of that case, the test was satisfied. Both these cases provide assistance in resolving the issue in this case. There is, however, a twofold difficulty in drawing clear, linear conclusions from these decisions: first, the facts in this case are quite distinct from the facts which presented in either of those cases; and, second, those cases were decided by reference to the Constitution as originally enacted, whereas this case falls to be decided by reference to the relevant provisions of Article 42A.

109. While the facts of both cases are quite different, and although the judgments in *NWHB* take a number of different approaches, there are nevertheless some important common points of reference. Each case concerned a single decision of parents who were otherwise acknowledged to be conscientious, caring, and loving parents, and there was no question of any general abandonment of parental duties. Instead, it was not suggested in either case that the decision of the parents would ignore the interests of the child. Rather, it is clear that each decision was taken in what the parents perceived as the interests of the child, both psychological and spiritual, but was a decision, in each case, which the consensus of

medical opinion viewed as not merely wrong but foolish and wrongheaded (although clearly the consequences of the decision in Baby AB's case was potentially much more serious for the child in question). Second, it was at least implicit in the decision in *NWHB*, and is explicitly the basis of the decision in the case of *Re Baby AB*, that there can be circumstances in which a single decision by parents, otherwise conscientious, careful, and attentive, may yet amount to a failure of parental duty such as to require the State to intervene and override the parental decision. It is, perhaps, more difficult to speculate as to the precise point at which, in particular, the majority in *NWHB* might have found such a decision to amount to a failure of parental duty, but it seems clear on analysis that all the judgments accepted that such a circumstance could arise.

110. First, the dissenting judgment of Keane C.J. approached the case on the basis that there was a jurisdiction to vindicate the constitutional rights of the child. The parents, in his view, had refused to protect and vindicate the child's rights to be guarded against unnecessary and avoidable dangers to his health and welfare and the courts could and should do so.

111. In relation to the judgments of those judges in the majority, it is important to recognise first that a significant feature of the argument in that case was characterised as one raising questions under the separation of powers. A decision in favour of the health board would, it was agreed, have the effect of making the PKU test compulsory, yet that was something which the legislature had, until that point, refrained from doing. Hardiman J., in particular, emphasised that if it were the judgement of the Oireachtas that such a test should indeed be mandatory, with all the issues of compulsion and loss of voluntarism that would be involved, then such legislation might be the subject of constitutional scrutiny. It was not suggested, however, that any such legislation would be inevitably unconstitutional. Not only, therefore, is the separation of powers aspect of that case absent in this case, but it must necessarily follow from the argument that it was at least conceivable that there could

be circumstances in which the State might lawfully interfere with family autonomy by requiring the PKU test, or another screening test to be administered. This suggests that the area of family autonomy in relation to health decisions is not extensive, and certainly not unlimited.

112. It was also a significant feature of that case that the PKU test was a screening test designed to identify some very rare conditions, and, moreover, that there was no reason to believe that the child in the case was particularly at risk from any of the conditions. This was explicitly distinguished from cases involving treatment decisions of an individual child. This emerged clearly from an exchange between Murphy J. and counsel for the parents as follows:-

> "Murphy J.: If you find on medical facts that the decision of a parent is so unsupportable, then the parent could be deemed to fail in their duty?
>
> Counsel: Yes, in a treatment case, but this is different as it is a screening programme."

113. This distinction was to the forefront of the decision of Denham J. She emphasised the constitutional rights of the child. There was, however, a presumption that such rights were protected within the family structure:-

> "The people have chosen to live in a society where parents make decisions concerning the welfare of their children and the State intervenes only in exceptional circumstances. Responsibility for children rests with their parents except in exceptional circumstances. In assessing whether State intervention is necessary the fundamental principle is that the welfare of the child is paramount. However, part of the analysis of the welfare of the child is the wider picture of the place of the child in the family; his or her right to be part of that unit. In such a unit the dynamics of relationships are sensitive and important and should be

upheld when possible as it is usually to a child's benefit to be part of the family unit."

However, that statement of principle was immediately qualified and it was recognised that there was a threshold for State intervention which would depend on the circumstances of the case:-

"Thus, if the child's life is in immediate danger (e.g. needing an operation) then there is a heavy weight to be put on the child's personal rights superseding family and parental considerations."

This focus upon the rights of the child resonates with the terms of Article 42A.

114. Denham J. considered that it would be relevant if there was a real or significant chance of the child having a disease for which he was being screened. For example, she considered that the PKU case was distinguishable from a case where, for example, a hospital sought to carry out a HIV test on a baby born to a HIV positive mother, in circumstances where breastfeeding is known to have be a risk factor in HIV transmission. She also explained that:-

"In exceptional cases – such as where a child needs acute medical or surgical care – the expert may be part of an application for a court order to protect the welfare of the child by seeking a judicial decision different from that of the parents."

While contemplating some considerable scope for State intervention, Denham J. considered that there remained an area for parental decision-making. In a passage emphasised in the submissions on behalf of the parents in this case, she explained that even if acute medical care was advised by some medical experts, the parents might consider that the responsible decision would be to refuse such care where a child was suffering from a terminal illness. Parents in such a case might decide that he or she had suffered enough medical intervention and should receive only palliative care. However, for present purposes, it is noteworthy that, even under the rubric of Article 42.5, it was

clearly contemplated that a *single* decision by parents in relation to medical treatment could amount to failure of parental duty under Article 42.5. Thus, some treatment decisions (and indeed some health screening decisions) made by parents in respect of their children could be overridden. The relevant consideration was the rights of the child. However, any decision had to be taken in the context of "the delicate filigree of relationships within the family". Part of the analysis of the welfare of the child was the wider picture of the place of the child in the family unit. The dynamics of relationships were sensitive and important, and should be upheld when possible as it was usually to the child's benefit to be part of the family unit.

115. Murray J. (as he then was) approached the case explicitly by reference to Article 42.5. He considered that what was in issue was whether the defendants had acted in such a manner that exceptional circumstances arose by reason of a breach of duty on their part which would justify the State overriding their personal decision with regard to their child in this case. That could not be achieved simply on the basis that the parental decision was not objectively the best decision in the interests of the child, since that would involve the State and, ultimately, the courts in a micro-management of the family, and parents with unorthodox or unpopular views or lifestyles might, for that reason alone, find themselves subject to intervention by the State or one of its agencies. While he did not consider it possible or desirable to define in one neat rule or formula all the circumstances in which the State might intervene in the interests of the child against the express wishes of the parent, it seemed to him:-

> "that there must be some immediate and fundamental threat to the capacity of the child to continue to function as a human person, physically, morally, or socially, deriving from an exceptional dereliction of duty on the part of parents to justify such an intervention".

This suggested a more exacting test for State intervention than Denham J., but nevertheless contemplates that the State may intervene and override a single, though serious and fundamental, decision by parents in respect of medical treatment. Murphy J. went perhaps furthest, in contemplating that what was required was "general conduct or circumstances of the parents", rather than a particular decision made in good faith which could have disastrous results. However, even then, he did contemplate circumstances where "the disastrous consequences of a particular parental decision are so immediate and inevitable as to demand intervention".

116. In summary, therefore, the decision of this court in *NWHB* must be understood as concluding that, while there is a significant area for autonomy in family and, in effect, parental decision-making in respect of medical procedures, a single decision by parents may be such as to amount to a failure of parental duty – even in the terms of Article 42.5 – such as to require the State to supply the place of the parents and make a decision that vindicated the child's rights. On the facts of that case, the decision to refuse the PKU test was not such a decision.

117. Looked at in this way, the decision in *Re Baby AB* can be seen as one of the cases contemplated in the judgments in *NWHB* and where the court was prepared to find that a particular decision made in relation to the treatment of a child – although made by conscientious, careful, and loving parents – nevertheless amounted to a failure of parental duty under Article 42.5. In that case, a three-month old baby was very unwell by reason of acute bronchiolitis. At one point, he had stopped breathing and had to be resuscitated. He had been treated by the administration of some blood products, but the point was rapidly reached where the medical evidence was that blood transfusion was absolutely necessary. However, the child's parents – while clearly anxious for his welfare and having sought the very best medical care – were, however, committed Jehovah's Witnesses, who were steadfast in their opposition to blood transfusion. Hogan J. held that the parents

wanted the best for the child and were delighted with the quality of the medical care which he had received and were completely sincere in their religious beliefs. They were wholesome and upright parents, anxious for the welfare of their child.

118. Hogan J. referred to Article 42.1 and Article 42.5. He concluded that there was no doubt at all that the parents had the constitutional right to raise their children by reference to their own religious and philosophical views. Nevertheless, Article 42.5 made it clear that that right was not absolute. However, the right of the State to intervene and override the constitutional right of the parents was expressly circumscribed by the language of Article 42.5. The use of the term "failure" in that context was, perhaps, a somewhat unhappy one since there was no doubt that the parents had behaved in the light of their own deeply held religious views in a conscientious fashion *vis-à-vis* their child. However, he considered that the test was an objective one judged by the standards of society in general. Accordingly, he granted a declaration to the effect that it would be lawful for the hospital to administer a blood transfusion. However, he made it clear that the decision was limited to those clinical events and was not to be construed as conferring an open-ended entitlement into the future to administer such treatments to the baby irrespective of the wishes and beliefs of the parents.

119. Counsel for the mother does not criticise the decision in *Re Baby AB* but seeks to distinguish it on the basis that there the life of the child was at risk, which, she suggested, ranked higher in some assumed hierarchy of rights, whereas this case concerned a decision which could lead to the death of John. There is, of course, an obvious difference of context between the cases, but this does not address the issue of principle which emerges from the case, and is consistent with *dicta* in *NWHB*; namely, that if a Court is satisfied that a single decision by conscientious and loving parents could nevertheless amount to failure of parental duty requiring the State to supply the place of the parents, even under Article 42.5 as it stood prior to the Thirty-first Amendment.

120. One further case which should be noted is the decision of this court in *N v. HSE*, known as the "Baby Ann" case. The facts of that case were very similar to those of *Re JH* in that a baby had been placed for adoption but, before a final adoption order was made, the natural parents sought the return of the child, later married, and re-registered the child's birth. The child had been placed with prospective adopters for some time, and there was evidence in the High Court that the child treated the adoptive parents as her parents and bonded with them. The natural parents commenced an inquiry under Article 40 seeking the return of the child. As the High Court judge noted, the resolution of the case was not assisted by the form of the proceedings commenced. Nevertheless, MacMenamin J. refused the order sought, partly on the basis that the conduct of the parents in placing the child for adoption could, in the circumstances, amount to a failure of duty for the purposes of Article 42.5. The Supreme Court unanimously overturned the decision. Once again, however, and perhaps inevitably, a range of differing views were expressed. Five separate judgments were delivered. In referring in this judgment to judgments delivered by Hardiman and McGuinness JJ., it is important to keep in mind that they were two of five separate judgments and, moreover, that the expression of views in all of the judgments in any event amount to *obiter dicta*, since the *ratio* of that case was limited to a conclusion that the initial placing of a child for adoption could not amount to the failure of duty pursuant to Article 42.5 sufficient such as to disentitle parents from seeking the custody of their child.

121. Hardiman J. made some important observations on his understanding of the constitutional structure established by Articles 41 and 42. At p. 504 of the report, he said:-

> "The effect of our constitutional dispensation is that, presumptively, the right to form a view of the child's welfare and to act on it belongs to the parents. The facts of this case make it unnecessary to consider the difficulties which arise where the

parents themselves are in disagreement as to how the welfare of the child may best be secured.

There are certain misapprehensions on which repeated and unchallenged public airings have conferred undeserved currency. One of these relates to the position of children in the Constitution. It would be quite untrue to say that the Constitution puts the rights of parents first and those of children second. It fully acknowledges the "natural and imprescriptible rights" and the human dignity, of children, but equally recognises the inescapable fact that a young child cannot exercise his or her own rights. The Constitution does not prefer parents to children. The preference the Constitution gives is this: it prefers parents to third parties, official or private, priest or social worker, as the enablers and guardians of the child's rights. This preference has its limitations: parents cannot, for example, ignore the responsibility of educating their child. More fundamentally, the Constitution provides for the wholly exceptional situation where, for physical or moral reasons, parents fail in their duty towards their child. Then, indeed, the State must intervene and endeavour to supply the place of the parents, always with due regard to the rights of the child."

122. At p. 528 of the judgment, Hardiman J. considered the interpretation to be given to failure of duty in circumstances where, there being no question of a failure of duty for physical reasons, the only possible failure in parental duty could be a failure for moral reasons. He considered that the High Court judge's conclusion that there was such failure could not be sustained:-

"Although very kindly meant, it is not in the end a kindness to the applicants so to lower the requirements which must be met to establish a morally based failure in parental duty towards the child, as to include matters which are not merely not blameworthy but are actually laudable. By almost emptying the words of Article

42.5 of meaning this exposes the parents to a finding of failure in their duty to the child when they have been guilty of no such thing. A failure in duty to a child, for reasons other than illness or impossibility, is a grave moral failing which cannot be committed without personal fault. A "failure in duty" is the condition precedent, in Article 42.5 of the Constitution, to the supplanting of parental function by the State. This supplanting cannot take place except for grave reason. If one reads "failure in duty", in circumstances like those of this case, as not necessarily involving either incapacity or a grave moral failing, one seriously dilutes the protection which Article 42.5 was intended to confer on parents against their position as such being undermined by over ready State intervention in the family."

Counsel on behalf of the parents in this case laid understandable stress on this passage. It is noteworthy that both Geoghegan J. (at p. 560) and Fennelly J. (at p. 581) also were of the view that blameworthiness was an essential feature of a finding of failure of parental duty for moral reasons under Article 42.5.

123. For her part, McGuinness J. agreed only reluctantly with the decision of the court that the decision of the High Court should be set aside. She referred to the fact that, in his judgment, Geoghegan J. had observed that the decision in *Re JH* had been criticised in some quarters. She considered that the test of compelling reasons why the child's welfare could not be achieved within the marital family was so exacting that it would be difficult to see it being met other than in the most extreme circumstances. She agreed with Geoghegan J., however, that such criticism was misplaced in the sense that the judgment clearly reflected the unequivocal wording of the Constitution. She continued, however:-

"It would be disingenuous not to admit that I am one of the "quarters" who have voiced criticism of the position of the child in the Constitution. I did so publicly

in the report of the Kilkenny Incest Inquiry in 1993. The present case must, however, be decided under the Constitution and the law as it now stands."

This observation, together with the case law just considered, is a useful backdrop to a consideration of the terms of Article 42A of the Constitution.

D. Article 42A

124. Article 42.5 of the 1937 Constitution was removed and a new Article 42A introduced by the Thirty-first Amendment to the Constitution, which eventually took effect on April 28th, 2015.

125. The submissions on behalf of John's father have helpfully identified a number of the key textual distinctions between Article 42.5 and the provisions of Article 42A.2.1°. In particular, the reference to failure for physical or moral reasons is removed. Instead, it is provided that such failure may occur regardless of marital status, but to such an extent that the safety or welfare of any of the children is likely to be prejudicially affected. In such circumstances, State intervention must be by proportionate means as provided for by law. In the 5th edition of *Kelly, The Irish Constitution* (Dublin: Bloomsbury Professional, 5th Ed., 2018), it is stated at para. 7.7.272-3:-

> "The new text of Article 42A.2.1° differs from Article 42.5 in four respects. First, it makes clear that the State's duty encompasses both marital and non-marital children. Second, it specifies that the failure of parental duty must be to such an extent 'that the safety or welfare of any of [the parents'] children is likely to be prejudicially affected'. Third, it no longer refers to parental failure being for physical or moral reason. However, this deletion does not appear to effect any change in the State's power to intervene and so case law on this aspect of the interpretation of parental failure for the purposes of Article 42.5 is likely to remain relevant to the interpretation of Article 42A.2.1°.

> Finally, unlike Article 42.5 which was self-executing, Article 42A.2.1° states that the State may supply the place of the parents who have failed in their duty towards their child 'by proportionate means as provided by law'."

126. This analysis is helpful, although, as we will explain in due course, we do not agree that the deletion of the reasons for parental failure has no impact on the interpretation of the State's power to intervene in families. It is, in our view, important not to focus solely on the textual changes between Article 42.5 and Article 42A.2.1° in order to understand the scope and application of Article 42A.2.1°. It is necessary to place Article 42A.2.1° in the context of Article 42A generally. In particular, it is of some significance that Article 42A.1 provides explicitly that "the State recognises and affirms the natural and imprescriptible rights of all children and shall, as far as practicable, by its laws protect and vindicate those rights". While, as already observed, the recognition that children had natural and imprescriptible rights was implicit in the provisions of the terms of Article 42.5, this is now made explicit. In doing so, the text crystallises and endorses a developing trend in the case law. As Denham J. observed in *NWHB*:-

> "[I]nitially cases were more protective of parental authority and the family in all but very exceptional cases. However, in recent times the child's rights have been acknowledged more fully."

The express statement in Article 42A.1 seems to cast some light in turn on the reference in the next subsection to the parental "duty" towards their children as, it seems, a correlative of those rights. This suggests that the parental duty includes protecting and vindicating those rights, and, moreover, that failure may be assessed by reference to the impact of the parental conduct on the rights of the child.

127. Article 42A.2.2° made provision for the adoption of any child where parents have failed for such a period of time as may be prescribed by law in their duty towards the child. This provision appears directed towards making it somewhat easier to permit the adoption of

children of a marital family. The same test is now to be applied to adoption of such a child, regardless of the marital status of the parents. However, an adoption is not permissible merely where it can be said that the best interests of the child so require. Instead, the language of parental failure is used, albeit that neither the formulae of Article 42.5 ("for physical or moral reasons") or of the preceding 42A.2.1° "to such an extent that the safety or welfare of any of the children is likely to be prejudicially affected" is used.

128. Article 42A.4 provides that provisions should be made by law that in all cases either concerning the adoption, guardianship, or custody of, or access to, any child, or in proceedings brought by the State for the purposes of "preventing the safety and welfare of any child from being prejudicially affected", the best interests of the child shall be the paramount consideration. There is a clear linkage between the language in this provision and that of Article 42A.2.1° and it follows, therefore, that in proceedings where Article 42A.2.1° is invoked, the best interests of the child shall be the paramount consideration, albeit that provision shall be made by law to give effect to this. Finally, in this regard, it is to be noted that Article 42A.4.2° also makes provision that, in all such proceedings, where possible, the views of the child shall be ascertained and given due weight.

129. In addition to the foregoing provisions which are, in our view, relevant to the interpretation of Article 42A.2.1°, it is also important to recognise that the essential structure of the Constitution was maintained. Thus, Article 42A removed Article 42.5 but did not seek to effect any amendment of Articles 41 and 42.1. Thus, the strong statement of the position of the Family as the natural, primary and fundamental unit group of society possessing inalienable and imprescriptible rights antecedent and superior to all positive law, and as such being the primary and natural educator of the child, is maintained. Article 42A as a whole, and Article 42A.2.1° in particular, must be interpreted in that context.

130. The interpretation of an individual constitutional amendment – and of any related provisions of the Constitution after the introduction of an amendment – can pose particular difficulties. In some cases, it may be apparent that the intention is relatively clear, such as when an amendment is introduced to give effect to an international agreement or to accede to a supranational body. In other cases, the meaning and objective of an amendment may be understood by a consideration of the prior case law. It may be reasonably clear, either from the terms of the Constitution itself or decided cases, that the Constitution produces an outcome which a majority of citizens no longer consider desirable. In such a case, a single clear-cut amendment may be intended to achieve the objective of reversing that outcome, and the amendment may be interpreted accordingly. However, here, it is apparent both from the complexity of the pre-existing case law, and the scope of the amendment contained in Article 42A that the objective of the Amendment was not a single clear-cut reversal of the direction of the law such as, for example, that achieved by the removal of the constitutional ban on divorce, but rather a more wide-ranging, though subtle, change to the posture of the Constitution in relation to child and family matters. In *In Re JB v. KB* [2018] IESC 30, [2019] 1 I.R. 270, O'Donnell J. set out his understanding of the background to the provision as follows:-

> "Article 42A was introduced to the Constitution by the 31st Amendment… Article 42A.4.1° does not stand alone. It was introduced as part of an amendment designed to ensure that the Constitution was more clearly child centred. For that reason, for example, a new Article 42A.1 states explicitly that the State recognises and affirms the "natural and imprescriptible rights of all children and shall, as far as practicable, by its law protect and vindicate those rights". As we understand it, the amendment as a whole was directed towards a perceived approach of statutory and constitutional interpretation as a matter of history, which was considered to be unsatisfactory in principle, and to give rise to potentially unsatisfactory results.

That is because it was considered that issues in relation to children could be skewed by the emphasis placed by the Constitution as originally enacted on the family as the natural and primary educator of children, and as a moral institution possessing rights anterior and superior to positive law, which might lead to cases being resolved in a way which subordinated the interests of the child to that of a family, and in effect, therefore, of parents… Article 42A can therefore be seen as a restating of the balance, acknowledging in explicit terms the individual rights of children… It is unnecessary at this stage to consider whether concerns as to the interpretation of the Constitution were justified, or to what extent any unhappy outcomes were the consequence of the text of the Constitution or the interpretation applied to it."

131. In some aspects, most notably in the recognition of the rights of children contained in Article 42A.1, it can be said that the change was one of emphasis rather than substance, or making explicit what was implicit, but that does not mean that the change was without significance or importance for constitutional interpretation. The Constitution has, since 1937, affirmed the central importance of the Family. The Family is, however, a collective body made up of individuals who themselves have rights. One aspect of the constitutional position of the Family is the right of a family collectively to make decisions, for example, in relation to lifestyle or life choices, sometimes as a result of religious or ethical beliefs, and the State must respect those choices within certain constitutional limits. However, some decisions made within the Family are decisions by parents in relation to their children, and where it is possible that the parental decision, or the absence of a parental decision can be said to be damaging to the interests of the child. Article 42A.1 is an emphatic statement of the rights of the child, and that there is, therefore, a corresponding duty on parents to uphold and vindicate those rights.

132. The question of medical treatment, of which this case is one dramatic example, is one area which can pose distinct problems. That is because parental decisions in relation to medical treatment are not necessarily an example of collective family decision-making about life choices. It may simply be that, as a matter of common law, any medical procedure requires the patient's consent, and that, since a child cannot lawfully provide such consent, a substitute consent is necessary. In such circumstances, the rights of the child come to the forefront. One of the objectives of Article 42A.1, and the express statement of the rights of the child, is, perhaps, to ensure that such cases were not approached by reference to the objective of maintaining the authority of the family, but rather through the lens of the rights of the child.

133. The constitutional Amendment embodied in Article 42A is subtle but its direction is clearly discernible. It seeks to maintain the essential structure of the Constitution and a balance – and, in some cases, a necessary tension – between the position and autonomy of the Family *vis-à-vis* the State, and the rights of an individual child. It also retains important parts of the language of Article 42.5 in its reference to and emphasis on the "natural and imprescriptible rights of all children", and in its provision that the State may supply the position of parents only in "exceptional circumstances", where there is something which can be properly described as "a failure" of parental duty. The use of language emphasises the fact that there must remain a significant and high threshold before the State can override parental decision-making.

134. On the other hand, due weight must be given to the changes effected by the Amendment. The statement of the rights of children, as already observed, is important in this regard. The reference to "*all* children" and to parental failure regardless of marital status, makes it clear that, so far as State intervention goes, the Constitution makes no distinction between marital and non-marital families. The same approach of treating all children and families alike is taken in relation to adoption in the cases of parental failure under Article

42A.2.2°. The removal of the reference to failure for "physical or moral reasons", and the new requirement that such failure must be to such an extent as to prejudice the safety or welfare of the child, is a significant change of focus from the *cause* of parental failure to its *effect*. To that extent, we consider that the existing case law on parental failure decided by reference to Article 42.5 cannot be directly applied to the position under Article 42A. Indeed, to do so would ignore the fact of amendment. One example is that, given the shift of emphasis just noted, it can no longer be said that blameworthiness is an essential feature of the type of parental failure justifying State intervention. In a comment, referenced in this judgment at para. 57, Doyle and Feldman observe that, taken on its own, and read both narrowly and literally, the fact that parental failure is now specified as being of such an extent as to have an effect on safety or welfare might be understood as somehow increasing the threshold, since the extent or nature of parental failure (as opposed to its cause) had not been identified under Article 42.5. However, when the provision is read as a whole, and understood in its context in the Constitution, and, in particular, having regard to the removal of the consideration of physical or moral reasons, we agree with the authors that this phrase is better understood as describing more clearly the type of failure which would always have triggered State involvement and to emphasise that the significance of any such failure is its impact upon the child, rather than the motivation or reasoning of the parents.

135. It is also clear that the failure under Article 42A.1.2° can be a failure in one single respect and need not amount to a persistent failure tantamount to an abandonment of the parental role. This follows from the limited case law decided in relation to Article 42.5 already considered but is, if anything, clearer under Article 42A.2.1°. The touchstone for State intervention is prejudicial effect on the safety or welfare of a child. This can occur in a single instance and as a result of a step taken or avoided by otherwise conscientious and attentive parents. It is also consistent with the requirement that any State intervention be

achieved by proportionate means, since any State intervention may, therefore, be limited to supplying the place of parents in respect of a single decision rather than more generally. It is also noteworthy that the failure of duty sufficient to permit adoption must persist for a period of time to be prescribed by law, whereas no such requirement is contained in Article 41A.1.2° in respect of any failure having a prejudicial effect on safety or welfare. Finally, due weight must be given to Article 42A.4. In disputes concerning, among other things, State intervention where it is alleged there has been a failure of parental duties to the extent specified, then the best interests of the child must be of paramount consideration. This does not permit the State, or a court, to simply decide what it considers is in the best interests of the child and, if necessary, substitute that decision for the decision of the parents, as the best interests of the child normally comprehends being part of a family with everything that that entails. However, Article 42A.4 does suggest that any dispute as to the impact of a decision or conduct on health or welfare must be approached through the lens of the interests of the child. Since the health or welfare, and therefore the rights, of a child can be put at risk by a single decision, it follows that it is possible that the threshold for State intervention can be reached in respect of a single isolated decision.

136. In 2006, Hardiman J. was able to reject, with some force, the suggestion that the Constitution preferred parents to children, and that, if anything, is more clearly the case after the 2015 Amendment. It also remains the case that, as he put it, the Constitution prefers parents to third parties, official or private, though that preference had limitations then which are even more clear now. Since the introduction of Article 42A, the point at which that preference ends – and at which the threshold for State intervention is met – is somewhat clearer. It is also the case, however, that while the Constitution maintains a preference for parental views over those of third parties such as doctors and social workers, and for the family over the State, the fact is that the rights of the child are

separate and individual and that the best interests of a child are capable of independent determination. At some point, therefore, the Constitution contemplates, and indeed requires, that the views of third parties be, in turn, preferred to parents.

137. It is, perhaps, inevitable that, in considering the application of Article 42A and legislation giving effect to it, recourse would be had to decisions in respect of Article 42.5. However, those decisions must be approached with some caution not just because of the distinctions between the facts in such cases, but also because of the changes made to the Constitution. It seems that the introduction of Article 42A was not expressly directed towards reversing the outcome of any particular judicial decision rather than, perhaps, and more importantly, altering the general impression, particularly within State bodies and in the approach taken in the Kilkenny Incest Report referred to by McGuinness J. in the judgment in the Baby Ann case (*N v. HSE*, at p. 498). We do not think it is possible or useful to speculate as to the outcome of those cases decided by reference to Article 42.5 if they were now to be decided by reference to Article 42A. In the first case, as already observed, a range of differing views were expressed in the individual judgments. No single test emerged. Furthermore, it is clear that all of these cases involved a close scrutiny of the particular facts. No simple rule of thumb emerges. It is, however, possible to discern the direction of travel, as it were, and to observe, for example, that the decision in a case such as that of *Re Baby AB* would, if anything, be made more readily today with regard to the provisions of Article 42A.

138. Both Article 42.5 and Article 42A use the language of exceptionality. This led counsel for the parents to argue that there was a two-fold test for State intervention: there must be parental failure to such an extent that the safety or welfare of the child is likely to be prejudicially affected and the case must be exceptional. However, this cannot be the case. If there is parental failure to the extent required by the Constitution and the rights of children were prejudicially affected, then it could not be the case that the State could be

precluded from acting to protect the child because there were other children in a similar situation. As has been observed on a number of occasions, exceptionality is not a legal test capable of determining this or any other case. As has been observed, it is potentially dangerous in that it "may lead to the wrongful downgrading of significant circumstances just because they happen not to be exceptional or to their wrongful upgrading just because they happen to be exceptional" (*HH v. Deputy Prosecutor Italian Republic, Genoa* [2012] UKSC 25, [2012] 4 All E.R. 539). Exceptional is better understood in descriptive terms – that is, describing the test of parental failure rather than adding a separate test. In *Minister for Justice & Equality v. JAT (No. 2)* [2016] IESC 17, [2016] 2 I.L.R.M. 262, O'Donnell J. said:-

> Thus, if a standard for such failure were advanced which, if applied, might lead to considerable, even routine, second-guessing of parental decision-making, then that would give rise to legitimate questions as to whether the standard was in truth that required by the Constitution.

139. Counsel for the parents, and IHREC, also addressed the terms of Article 42A.2.1° which permit the State to supply the place of parents by proportionate means "as provided by law" and observed, correctly, that this language is not used in Article 42.5, and accordingly Article 42A.2.1° could not be regarded as self-executing. A similar point was made in relation to Article 42A.4.1°, which states that "[p]rovision shall be made by law" that, in cases of alleged parental failure under Article 42A.2.1°, the best interests of the child shall be the paramount consideration. It was not entirely clear what the end point of this contention was, but it seemed to be suggested that "law" in each case was to be understood as legislation enacted by the Oireachtas as the sole and exclusive lawmaker for the State under Article 15.2.1°. It was acknowledged, by IHREC at least, that insomuch as the wardship jurisdiction had a statutory basis in s. 9 of the Courts (Supplemental Provisions) Act 1961 ("the 1961 Act"), this was a jurisdiction provided by

law, but a preference was expressed for the use of the inherent jurisdiction of the court which, it was said, was compatible with the ECHR, or the grant of a declaration.

140. It has been argued from time to time that the word "law", whenever encountered in the Constitution, means legislation enacted by the Oireachtas in accordance with Article 15.2. At its most extreme, this has led to a very narrow reading of the power of delegated legislation and a contention that the common law is frozen in time as that in existence in 1937, and is incapable of development without infringing the provisions of Article 15. We do not agree. It has been pointed out, at para. 19 of the judgment in *McGowan v. Labour Court & Ors* [2013] IESC 21, [2013] 3 I.R. 718, that the origins of the language in Article 15 are to be found in a denial of the power of the Imperial Parliament at Westminster to legislate for Ireland after 1922. The courts, in applying and developing the common law, are not readily described as another "legislative authority" or "údarás reachtaíochta". Chief Justice Keane observed in *Iarnród Eireann v. Ireland* [1996] 3 I.R. 321 that the law in force on the passage of the Constitution included the common law and was continued in force by Article 50, which contemplated its further development. Accordingly, the term "law" in the Constitution may have different meanings depending on the context in which it is found.

141. The case of Article 42A provides a case in point. There is, we think, a clear difference between the language of Article 42A.2.1° ("as provided by law") and the language of the 3 following subsections ("provision shall be made by law"). The latter phrase seems to contemplate the future enactment of legislation, but the former phrase, and the one most relevant here, is capable of being satisfied by the existing law – it merely requires that the jurisdiction have a legal basis. That much is provided by s. 9 of the 1961 Act. It is not necessary to consider, therefore, if it is capable of being satisfied by the common law, or by the inherent jurisdiction of the court. It is, of course, the case that s. 9 merely declares and continues a jurisdiction and no more. The legislative basis for the jurisdiction to

supply the place of parents contemplated by Article 42A.2.1° could itself specify the proportionate means required, but need not do so. It is sufficient that the proportionate means are applied and have a sound basis in law.

142. It was also argued that the provisions of Article 42A.4.1° had not been brought into effect, at least insofar as the type of decision in issue in this case was concerned; that is, where it is said that a decision in relation to medical treatment prejudicially affects the welfare of a child. That appears to be correct. However, it is not clear what follows from this. If the court has a jurisdiction to supply the place of parents when the requirements of Article 42A.2.1° are present and the decision of the parents is found to prejudicially affect safety or welfare, then the court must make the decision in place of the parents. That decision must be compatible with the Constitution and the values it espouses, and Article 42A.4.1° is a part of that constitutional value structure. In any event, it is difficult to see how the court could reach its decision other than in the best interests of the child. Accordingly, we consider that the objections in relation to procedure, or the absence of legislation, are either ill-founded or do not give rise to a fundamental objection, and the court must accordingly address the central issue here in this case. We think it is best to approach this case on the basis that there is a significant area for family decision-making which the Constitution requires the State to respect and protect, and within which parents may make decisions in relation to their children with which experts, and indeed courts and judges, may well disagree. The central issue in this case is whether the decision of these parents to refuse to consent to the course of treatment proposed by the Hospital is one which lies outside the range of permissible family decision-making and so that the position of the parents must, at least in this respect, be supplied by the State: in this case, the court.

143. The Constitution requires, however, that a significant space be maintained between the views of families and particular parents and the point at which the State is obliged to intervene. If an official determination of the best interests of the child was to be the sole

determinant, then the only decision which parents could, in truth, make would be one which would receive the approval of the representatives of the State. That is not what the Constitution requires. Instead, the point at which State intervention is required is deliberately set at something which can be properly described as a "failure of duty" on the part of the parents. The label of parental failure is one which should not be lightly applied to any parent, particularly to parents where it is acknowledged that they are otherwise caring, considerate, and attentive to their children. There must be failure and, moreover, one which prejudicially affects safety or welfare. This requires something more than a determination that a child would be better off if a different decision were made. In cases where an individual decision is sought to be overridden, it is also important to consider the wider context, such as whether parental co-operation would be necessary and the likely impact on the functioning and operation of the family in the future. The observations of Denham J. that the dynamics of relationships in the family unit are sensitive and important and should be upheld if possible, as it is usually to the child's benefit to be part of the family unit, remain apposite.

144. The particular context of the decision, and the extent to which the child's rights are engaged, is also important. In the course of argument, counsel discussed some familiar features of litigation practice, such as the fact that children, like adults, who suffer serious brain injuries are routinely made wards of court if they receive an award of damages or a settlement of a claim. Where children suffer physical injuries and receive substantial compensation, the money must be paid into court and is only paid out with the approval of the court. A small statutory example of this general approach is s. 63 of the Civil Liability Act 1961, which provides for an infant plaintiff to be protected from an adverse costs award if a claim failed to beat a lodgement, but where a court had decided that it was appropriate to go to trial. Counsel for John's mother accepted that the logic of the approach she contended for would mean that these features of practice and law were

inconsistent with the Constitution. The Family and, in practical terms, the parents should be the decision-makers, and the State, in the guise of the courts, should only have a role in the decision-making in a case which met the standard of parental failure of duty, a standard which, in her submission, was also one not easily reached.

145. These examples are useful in considering this matter. They show, in our view, that the position in relation to parental decision-making in relation to children is a complex issue and cannot be reduced to a "one size fits all" formula which, moreover, increases significantly the possibility of irresponsible decisions being made in respect of children. Decisions on claims for compensation, and the use to which it may be put are not exercises of a communal collective decision-making by a family unit. There is little, if any, scope for the idiosyncratic views of a family on life and lifestyle choices. The compensation is the property of the child, and no one else. If anything, there is a potential tension between the interests of parents and those of the child. The child's own property rights (and perhaps other rights) are the sole consideration, and the duty of parents is only to secure those rights. It is doubtful indeed that it could be said that decisions in relation to the private property of a child or any other family member are matters within the authority of the Family which the State guarantees to protect, and does not fall to be analysed by reference to Article 42.5 of the Constitution as originally enacted, or Article 42A. This is subtly, but importantly, distinct from a situation where parents make decisions in relation to a child, not because they concern the child's rights but the child cannot make them for him or herself, but rather where the decision is one always for the parent to make in what they consider the interests of the child, such as educational and other choices *prima facie* within the authority of the Family. The parents are not there substituting themselves for the child – they are the primary decision-makers, and the Constitutional test for State override is applicable.

146. Here, the position is more nuanced. A significant part of the legal dispute relates to the provision of consent to treatment, without which any such treatment would be a tort and unlawful. A young child may not be mentally, and is not legally, competent to provide such consent. Parents are substitute consent providers in such a case, but in doing so, the focus is the rights of the child. This is different, therefore, from the position in relation to educational and other decisions made by parents as primary constitutional decision-makers. However, as the case law shows, issues relating to medical treatment in the broadest sense may engage the authority of the family, since they may raise ethical issues and value judgements upon which individuals and families may differ. However, they are not solely (or even primarily) decisions in the exercise of family authority; they are decisions for the child and consequently the rights of the child necessarily weigh heavily. It would be quite wrong to force all these different decisions into a single decision-making pattern of parental primacy qualified only by a high threshold of parental failure.

147. In cases of medical treatment, a primary consideration is the question of medical consensus. Where parents are inclined to follow advice which is a minority, but nevertheless respectable, view among experts in the profession, then it is unlikely that that decision could constitute a failure. Even where, as here, there is a unanimity of medical opinion, it is important to probe that opinion for its depth and conviction. Real expertise does not pretend to omniscience and, as this case itself illustrates, extensive expertise does not mean that the future can be predicted with certainty. There is a difference between diagnosis and prognosis. The firmness and conviction with which any medical opinion is held and the extent to which that opinion considers it is possible or permissible to take a different view is also relevant. Finally, particularly in important and irreversible decisions, there is a question of timing. In any given case, some people involved, particularly those with expertise in the area, may be quicker to come to the conclusion that no useful purpose would be served by further invasive or aggressive

treatment. The fact that others, and, in particular, a family, may not have arrived at that point yet would not necessarily amount to any failure on the part of the parents. Good medical practice also recognises that there is a value in the views of persons who have known a patient all his or her life and who, moreover, may be more involved with that person on a day-to-day basis even during the period when under medical care.

148. These are important and weighty considerations but, in our view, the issue cannot be treated solely as a medical issue even when sensitively and carefully evaluated by the treating clinicians. If that were so, then medical consensus would be determinative and the process of court adjudication could all too readily become reduced to elaborate hearings which lead, inevitably, to the same result and an overriding of deeply held parental views. It is unrealistic to expect parents to be able to marshal contrary medical expertise, particularly during the type of crisis that gives rise to cases such as these. But, if the Constitution guarantees some space and protection for family autonomy, then that must apply to all families whatever their resources, access to expertise, or wider capacity to process complex information and persuasively articulate their position. In considering whether a particular decision of parents amounts to a failure of duty under Article 42A.2.1°, the State (and, in practice, the courts) must attempt, therefore, to maintain space for the possibility that the difference between the parents and the medical team may be related to unspoken and perhaps unarticulated differences of approach as to the benefit and burden of the continuation of the life in question and the impact upon it of the particular treatments.

149. This case provides an example of the considerations involved. A sudden catastrophic event causing irreversible brain damage to a child is an event which all families fear and some are tragically forced to confront. Little in our previous lives can prepare us for such an emergency. A crisis such as this makes demands upon the resilience and fortitude of any family irrespective of their resources, educational attainments, or access to expertise.

The response of the family involved in this case has been both exemplary and humbling. John's mother and siblings have been with him in the Hospital from the moment he was admitted: now more than six months ago. John's father, although separated from his mother, has done his best to remain involved and has made it clear that he sees his role as being as supportive as possible to John's mother. John's mother has said simply, and impressively, that if the outcome of this is that John will require constant care and attention like a newborn baby, then that is what they will do. It is clear that, for their part, John's family will shoulder any burden that his condition imposes upon them. The fact that part of the approach of his family may be a product of strong religious faith, to an extent not commonplace today, is something which should not be discounted, still less disparaged. The care, concern, and love displayed by his family for John are exactly the values recognised by the philosophical approach embodied in Article 41 which declares the Family to be the natural primary and fundamental unit group in society possessing rights antecedent to positive law. This was explained in an eloquent passage in the judgment of Keane C.J. in *NWHB* at p. 687 of the report:-

> "What is beyond argument is that the emphatic language used by the Constitution in Article 41 reflects the Christian belief that the greatest of human virtues is love … Of the various forms which human love can take, the love of parents for their children is the purest and most protective, at least in that period of their development when they are so dependent on, and in need of, that love and protection. We believe that Article 41, although couched in the language of "rights", should not be seen as denying the truth to be derived from the experience of life itself, that parents do not pause to think of their "rights" as against the State, still less as against their children, but rather of the responsibilities which they joyfully assume for their childrens' happiness and welfare, however difficult the

discharge of those responsibilities may be in the sorrows and difficulties almost inseparable from the development of every human being."

150. Any approach to the question of whether a particular parental decision should be supplanted by the State must give full value and effect to the genuine, heartfelt, and honest response of the family here, even if it runs counter to the entirety of the medical consensus. One aspect of this case that troubles us, therefore, is the difficulty it has created for John's family over and above the dreadful circumstances which have brought them to this point. There is no doubt that the treatment that John has received in the Hospital has been exemplary. But John's family have had to deal with the bewildering medical procedures and specialisations which they had never encountered before and attempt to digest and comprehend sometimes complex medical terms and advice. Similarly, once it became clear that legal issues were involved, the manner in which the matter has been addressed has been impressive: both the speed with which it has been addressed and the care and attention it has received in the High Court. Detailed expert evidence has been assembled, and carefully and conscientiously delivered and, in turn, tested by cross-examination. Comprehensive arguments have been assembled and advanced. Thereafter, an appeal to this court has been advanced in a very short timescale. Nevertheless, if the outcome of what, objectively viewed, may be seen as exemplary medical and legal procedures is that John's family, or any other family, might feel that their deeply held experiences and views have been overridden by impenetrable medical and legal language and procedures – leading to an inevitable and predictably adverse outcome – then that would be to fall short of what the Constitution promises to families facing critical decisions.

E. Discussion

151. Turning, then, to the facts of this case, it is useful to distinguish between the situation presented to the court in August and September when the initial application was brought – at that point, John's dystonia was uncontrolled and extremely severe – which necessitated an urgent application to the High Court, and the circumstances which presented themselves to that court in September and to this court in the light of the further evidence that has come to be adduced.

152. We have sought to understand and appreciate the position of John's parents and give full weight to it. We have, however, reluctantly come to the clear conclusion that John's parents' decision to refuse their assent to any care plan that contemplates, in the event of a dystonic or other medical crisis, the administration of whatever level of medication is required to alleviate suffering, unless invasive therapies and treatments are also made available for the purpose of resuscitation, was a decision which could not be said to be in John's best interests. We must further conclude, therefore, that it is a decision which was prejudicial to his welfare since it was a decision that, if implemented, would be likely on the evidence to cause him extreme and avoidable pain and suffering. It is also clear, on the evidence, that any intervention in John's case will, even if successful in the short term, return him to a weakened state of health, with depleted cardiorespiratory reserves and the likelihood of a further crisis in the relatively near future.

153. It is obviously the duty of parents to seek to ward off such avoidable suffering for their children and, accordingly, we must conclude that, notwithstanding the exemplary care and love shown by parents faced with a dreadful crisis, their decision in this single regard can properly be described as constituting a failure of duty. We endorse everything said by Hogan J. in *Re Baby AB* and Birmingham J. (as he then was) in *Re Baby B* (Unreported, High Court, Birmingham J., December 28th, 2007) in turn about the language of failure. It is useful insomuch as it expresses a high hurdle against State intervention, but unhappy

since it might suggest inadequacy or, worse, culpability on the part of parents who are otherwise devoted and conscientious. However, it should be made clear that there can now be no question of any moral failing or culpability in reaching such a conclusion. Instead, the question is to be judged solely by the consequences of any decision for the safety or, as here, the welfare, of the child. On that basis, if the welfare of the child requires the possibility of strong pain-relieving treatment, then a refusal to consent to such treatment must, at least *prima facie*, be a failure of the duty on the part of the parents to promote and protect the welfare of the child.

154. It is also important to distinguish between the orders sought and the different legal contexts in which they arise. In particular, there is a significant distinction between the order sought at para. 4(i), providing for the positive administration of pain-relieving treatment, and those sought at para. 4(ix), permitting the withholding of invasive and aggressive life-sustaining treatments.

155. The application here, taken as a whole, involves John's future medical treatment. In simple terms, a critical impasse has been reached because the Hospital (supported by all relevant medical opinion) considers that aggressive life-sustaining measures, such as CPR, and other invasive and aggressive treatments which would take a significant toll on the patient, are not justified in this case. In cases where these measures are employed, they are justified by the view that the burden they undoubtedly impose upon the patient is outweighed by the benefits to the patient in extending life. Here, however, they are likely to trigger further dystonia, leading to a cycle of further crises requiring further invasive measures, ultimately depleting John's cardiac and pulmonary resources. While the event giving rise to the possibility of such invasive and aggressive measures may occur in a number of ways, given John's condition, the situation is made more acute by John's extreme dystonia and the difficulty of controlling it. The type of treatment indicated which would address the severe pain caused by the dystonia may include

measures such as sedation and anaesthesia. This treatment, however, risks suppressing his pulmonary function so that John might stop breathing and might die, unless admitted to ICU and subjected to ventilation and resuscitation. The Hospital wishes not to engage in this cycle of treatment, but rather to treat John by palliative care addressed to his symptoms, and relieving his pain.

156. John's family and, in particular, his mother, supported by John's father, do not wish this course to be taken insofar as it implies that other interventions would not be carried out, but wish every step to be taken that would keep John alive. It is commonplace to speak of a family "consenting" to a treatment plan and it is normally highly desirable that the broad course of treatment is agreed with the patient and/or his or her family. That is not just for the benefit of the doctor or, indeed, the patient, but is also much in the interest of the family members themselves since, otherwise, the grief caused by the death of a loved one can be compounded by a lack of acceptance, and feelings of conflict and guilt. However, as a matter of law, consent of the patient, or substitute consent provided by a family, is not a legal pre-requisite of all treatment decisions and, in particular, a decision not to institute aggressive life-sustaining measures. As the *Guide to Professional Conduct,* referred to at para. 84 above, makes clear, while doctors will usually give treatment intended to prolong a patient's life, there is no obligation to start or continue treatment if the doctors judge the treatment might cause more harm than benefit, or is likely to cause the patient pain, distress, and discomfort that will outweigh the benefits it may bring.

157. In circumstances involving the withholding of treatment, in accordance with the Guidelines, the legal issue is *not* whether the patient or the patient's family consents to the course proposed by the doctors, but rather whether it is lawful for the doctors to do so; i.e., whether the judgement is one to which they can properly come. For those reasons, we would, and with respect, not agree with the portion of the judgment of Baroness Hale

of Richmond in *Aintree University Hospital* quoted by Kelly P. in *JM*, and set out at para. 80 above, to the effect that it becomes lawful to withhold life-sustaining treatment if a court considers that it is not in the patient's interests to give the treatment, and will not give its consent. While, in most cases, it will not matter how the issue is phrased, it appears to us that if it is appropriate to withhold treatment, then the court's consent – or lack of it – does not alter the legal position. If it is lawful to withhold the treatment, then the court's positive consent to that treatment would not require it to be administered, or make its withholding unlawful. The legal issue, therefore, in respect of withholding of life-sustaining treatment, is: whether it is lawful in all the circumstances of the case; whether the patient is an adult or a child; and, whether the patient or family consent or not. In practical terms, however, it would normally be the case that the hospital and treating doctors would want to bring a patient and family to the same position so that they could be said to "consent" to the course of treatment, and, in cases where that was not possible, it is prudent to seek confirmation, if necessary, from a court that it is permissible to do so.

158. The administration of positive treatment, however, does normally require consent other than in cases of emergency, or where no one is in a position to give it. Consent can normally be general and it is not normally required to seek consent to each and every medicine or change of drug or therapy. However, if a competent patient withholds or refuses consent, either general or specific, to positive treatment involving the patient, then it cannot normally be carried out.

159. The fact that the medical team involved have their own ethical decision to make in respect of the withholding of life-sustaining treatment is part of the reason why the reliance placed by counsel for the parents on the passage from the judgment of Denham J. in *NWHB*, set out above at para. 55, is misplaced. There, Denham J. observed that a parental decision to refuse to accept the advice of some medical experts to provide acute medical

treatment, and instead to elect for palliative care only, could be within the range of permissible parental decisions. It was suggested that this case was merely the converse of that situation. However, that is not so. In that example, parents were accepting the advice of *some* medical experts and rejecting that of others. Here, all the medical opinion and evidence is to the same effect. But, in any event, the two situations are not symmetrical. Parents (or patients) in this situation cannot dictate the form of care which is provided. Any influence they have is negative: by withholding consent to certain treatment where such consent is necessary; and/or by raising, either expressly or by implication, the possibility of a threat of action. But for parents to ensure that a child receives certain treatment which they consider desirable, there must be doctors willing to provide it. That is why treatment decisions are best made by discussion and agreement between the parents and the clinicians. No one wishes to address this issue by reference solely to what can be required or not as a matter of law. It follows that if the course the parents propose involved doctors taking action which they consider inadvisable, and perhaps even irresponsible, then that, in itself, would be an indicator that the parental decision may be outside the bounds of permissible family decision-making.

160. The fact that the treatment to be afforded is not a matter solely for the decision of the patient or parents was reflected in the decision in *Re a Ward of Court* where, while the High Court determined that it would be lawful to withhold the nutrition and hydration being provided to the ward by artificial means, the court nevertheless refused to make any order directed towards the institution then caring for the ward, because such a course of action would be against the ethical principles of the institution.

161. The question in this case is not, therefore, a broad question as to the appropriateness of the treatment to be afforded to John, or his parents' attitude to it. That treatment is not something which is wholly within the power of John's parents, or the court if it were to seek to supply the place of his parents. Nor is it a global question of whether the parents'

approach to John's treatment amounts to a failure of duty. Nor is it even the more specific question of whether, in resisting a move to palliative care because she believes or hopes that John can recover to a point at which she will continue to care for him, or should at least be given the chance to so, John's mother can be said to have failed in her duty. In fact, it is easy to understand her approach and, at one level, to sympathise with her.

162. The issue in this case is, however, firstly, whether the Hospital may lawfully withhold aggressive life-sustaining measures in the event that John suffers a crisis in which his life can only be sustained by admission to ICU. To decide that such a move to palliative care and refraining from more aggressive life-sustaining measures is lawful does not involve any consideration of the parents' attitude; still less does it require any finding of parental failure. In the event, however, that the Hospital would be acting lawfully in so deciding, and acting on that decision, then the precise question that arises is whether, in that event, if John suffered a severe dystonic crisis, the decision of the parents not to consent to pain-relieving treatment, including anaesthesia and sedation – because it might result in a suppression of respiratory function giving rise to the type of possible crisis that might lead to his death without aggressive life-sustaining measures – is a decision within a range of permissible parental decision-making, or, on the contrary, whether it is a decision prejudicial to John's welfare such that the court may override it and provide the necessary consent?

163. As matters stood when the evidence was given to the High Court in September, there can be little doubt that the Hospital and treating doctors were entitled to take the view that it was inappropriate to deploy aggressive and invasive life-sustaining measures in John's case, and that the Hospital would be acting lawfully in acting on that decision. This is because a hospital is entitled to take the view that the burden of the treatment outweighs any possible benefit to John. That is not merely because the treatments involved are themselves very burdensome, but also because they necessarily risk triggering a further

dystonic crisis, giving rise to the necessity of further invasive life-sustaining treatments, resulting in a depletion of John's cardiac and respiratory reserves and a progressive decline in his health.

164. If this is so, then it must follow that a decision not to consent to pain-relieving measures in the nature of sedation and anaesthesia in the event of severe dystonic crisis, or other critical medical crisis, cannot be said to be in John's interests, will prejudicially affect his welfare, and thus falls outside the range of permissible family decision-making. We must have regard to the unanimity of medical evidence presented to the court, not just representing the views of the entire treating team and covering different areas of expertise, but also, and perhaps even more impressively, the Hospital, as part of its procedures, had itself sought independent opinion from outside the treating team and the Hospital itself, which is to the same effect. The court procedure involved the appointment of a guardian *ad litem* who discharged the duty with conspicuous diligence and, in doing so, retained a further independent expert, who provided a detailed report and evidence to the court which also agreed with the approach of the Hospital and the independent consultant. That evidence was clear, consistent, and convincing, and did not suggest that a contrary view was feasible or plausible. The evidence was not contradicted or challenged by any contrary evidence. It is clear that if such pain-relieving treatment is withheld, any dystonic attack that John will suffer will cause extreme but avoidable pain and suffering. It is obviously the duty of parents to seek to ward off such avoidable suffering from their children, as was stated by Ó Dálaigh C.J. in *Ryan v. The Attorney General* [1965] I.R. 294, 350, and by Walsh J. in *G v. An Bord Uachtála* [1980] I.R. 32, 68, quoted by Keane C.J. in *NWHB* at p. 692. Perhaps of most importance is, however, that the reason why John's parents are not willing to consent to this treatment – namely, that they wish the Hospital to provide all life-sustaining treatments in the event that John has a crisis event – is one which is not capable of achievement. If the present position is maintained, then

the refusal of consent will result in avoidable pain and suffering for John. If, moreover, the Hospital was to change its position in respect of any such crisis brought on by the administration of pain-relieving treatment to relieve acute dystonia, then, on the evidence, this would only lead to a repeating cycle of dystonia treatment crises, and aggressive life-sustaining measures triggering, or leading to, further dystonia.

IV – Contingent Nature of Orders Sought

165. The next question is whether the order appealed against should have been made in the High Court in the light of the changed circumstances and, in any event, whether the order should now be upheld. First, and most obviously, it was apparent in October that John's dystonia was no longer uncontrollable or, at least, uncontrolled. The risk of a severe dystonic attack and, indeed, a crisis precipitated by a number of such attacks was, at a minimum, less immediate. It was accepted that it was these features which had precipitated the original application to court. Second, it was argued that John's physical condition had improved somewhat and there was some limited evidence of minimal responsiveness. Counsel for John's mother correctly drew the court's attention to these features and, furthermore, to the fact that these developments, while not ultimately altering the end point of the medical evidence, nevertheless had an effect on the strength and certitude with which that evidence was expressed. At one level, this could be said to reinforce the confidence the court might have in the witnesses since it shows a degree of flexibility in the light of changing circumstances. However, it is clear that the situation has changed and, with it, the legal issue.

166. These developments raise the question of whether, in the light of the changed circumstances, it could still be said that the decision to refuse consent to treatment was still one outside the range of any permissible autonomous family decision-making. But, the development of the evidence also raised a more basic objection as to whether, in the

light of these developments, it was necessary to make any such determination at all at this stage. This is, perhaps, the most difficult issue in this appeal.

167. We have given considerable thought to the question of whether it was necessary and appropriate to make the order sought in the light of the developing evidence and, more particularly, whether it is appropriate to uphold that order now. The focus of this case has moved from a situation which urgently presented itself as appearing to require an immediate order, to one in which, of necessity, the relief sought is more contingent and where the Hospital now seeks the orders on the basis of a situation which, it is anticipated, could occur at some time in the future. There is an inherent difficulty in anticipating in advance how John's condition may develop and, perhaps, deteriorate, and the response of the doctors and family in that situation. But, at a more fundamental level, it can be said that the court should not anticipate the decision of a family in developing and complex circumstances, particularly when to do so would have the effect of labelling the parental conduct, in advance, a failure of parental duty and would, moreover, have the effect of removing all decision-making power from the family.

168. These considerations are weighty and might be decisive in another case without the history that this one has. However, we have come to the conclusion that the court cannot and, in any event, should not avoid coming to a conclusion on the issue. Counsel for the respondent Hospital drew our attention to the discussion contained in a decision of the Court of Appeal of England and Wales in *Portsmouth Hospitals NHS Trust v. Wyatt & Anor* [2005] EWCA Civ 1181, [2005] 1 W.L.R. 3995. The High Court in that case had made a declaration that, in circumstances which were anticipated but not then present, it would be lawful to withdraw life-sustaining treatment from a baby girl. The order was made subject to a review after six months. It was argued on appeal that the order should not have been made on this contingent basis. The Court of Appeal referred to the decision of the ECtHR in *Glass v. UK* (Application No. 61827/00) [2004] 1 F.L.R. 1019 dealing

with similar circumstances. In that situation, the ECtHR criticised the course taken not by reason of the particular decision, but rather because the opportunity had not been availed of to make an earlier application to court which would have provided sufficient time to permit all the arguments in respect of human rights to be properly ventilated. Even so, the Court of Appeal considered that the arguments in the particular case were finely balanced. It pointed out that, while there was considerable benefit in having a treatment plan which could be implemented without the need for a further application to court, there was an unavoidable tension between the concept of a declaration intended normally to state what is lawful in given circumstances and a situation sufficiently fluid to render it likely if the circumstances may change and call into question the lawfulness of the conduct. However, the court concluded that the High Court had been correct to make the order sought subject, however, to review. The court placed particular weight on two arguments advanced on behalf of the hospital set out at p. 4027 as follows:-

> "(4) The existence of a court order did not dictate what clinicians should do and did not absolve them of their duty to act in the best interests of a child. It merely provided a clear legal framework within which the clinicians could act to deliver their obligations to their patient. However in this case the clinicians would like to make it clear that if [the child] had an unpredictable deterioration (ie not the respiratory deterioration that [had] been predicted by them and the experts to be most likely) then they would seek advice rather than simply try to rely on the current judgment. They would thus seek to reassure the court that they are keeping an open mind on her best interests. (5) Until the court has ordered otherwise, the clinicians must follow the instructions of the parents. In practical terms in this case if there were not a court order the clinicians would be obliged to resuscitate [the child] whilst the hearing was being sought and proceeding. That would, to a very large extent, render the hearing unnecessary and mean that the doctors would be

obliged to follow the parents' wishes and thus act in a way they considered to be against the patient's best interests."

169. These considerations also apply in this case. But, there is, if anything, a stronger case for this court proceeding to consider the correctness of the order made here. First, although this case has been progressed with admirable speed – including a leapfrog appeal from the High Court to this court – more than four months have elapsed since the proceedings were initiated. If this court were simply to set aside the order of the High Court on the grounds that it was now premature, it is likely that the same or some similar process would have to be undertaken at some point in the future, but now in circumstances of even greater crisis and urgency. In such a case, it is also not unreasonable to think that the courts, obliged to address the weighty issues involved under pressure of time, would bemoan the loss of opportunity for preparation, presentation, and a more comprehensive consideration of the issues. Furthermore, to decide this case on the basis that it was premature to rule on it would not remove the necessity for any future hearing. It would merely postpone it and, as already observed, ensure that it would proceed both in circumstances and on a timescale that were even less suitable. Furthermore, if the decision of this court was that an order cannot be made on any contingent basis, but rather would require an actual crisis, then the decision of the court would not provide clarity or guidance for any future court since it would not address the merits of the substance of Irvine P.'s decision. But, most critically, we think it is clear that the situation here has now reached the point, unfortunately, where it is clear that a care plan of some limited degree is necessary. The point has been reached where the parents have refused consent to the pain-relieving treatment proposed. They have maintained that position through two hearings in the High Court and the appeal to this court. It is not unreasonable to assume, therefore, that their position would be the same if the dystonia were to become active again. The question should, therefore, be addressed as to whether the parents' decision to

refuse the pain-relieving treatment in those circumstances is one which can or should be overridden. Furthermore, while clinicians may normally have a significant area for discretion on the question of withholding aggressive life-sustaining measures in an end-of-life situation – and while consent is not strictly required in such circumstances – that discretion is severely constrained once the possibility is raised that such a course of treatment would be a breach of the criminal law. In the circumstances, it is not unreasonable, and is perhaps unavoidable, that the Hospital and doctors would seek to have the legality of any proposed course conclusively determined.

170. Viewed from this perspective, we have come to the conclusion that the order of the High Court was, in principle, correct and that the changed circumstances since late September, while having a real impact on the issues, may be addressed by a variation of the order rather than setting aside the order altogether. In that regard, the flexibility and relative informality of the wardship procedure may indeed prove to be an advantage rather than a hindrance. We have come to this conclusion because once it is accepted that there is a sufficient basis to anticipate the possibility of the dystonia re-emerging – or, indeed, some other crisis – then the result must be the same and for the same reasons. If it is made clear that the orders sought are permissive rather than mandatory, and would only operate in circumstances where a crisis was presented, then the legal situation is effectively the same as that which applied when it appeared that a crisis was present and the application was made to the court. The main and most legitimate objection to the form of the order made is that it was contingent. For the reasons set out above, we consider that it is, however, appropriate to make an order on that contingent basis. The development in the evidence was principally directed towards the likelihood of that contingency occurring. But, if the contingency did not occur, and John's dystonia was controlled and his physical condition stabilised or improved, then the orders made would not have any practical effect. It is, nevertheless, a legitimate concern that orders are now being sought in relation to an

evolving situation and it is both appropriate and, in our view, necessary to address that so far as possible in the nature of the orders sought.

V – Conclusion

171. We would vary the orders made in the High Court. In particular, in lieu of the wide order in terms of para. 4(i) in the notice of motion, we would substitute an order consenting on behalf of the ward to the administration of such medication, sedation or anaesthesia to the ward by subcutaneous, buccal or enteral routes for the primary goal of treating the severe breakthrough of terminal neurological symptoms even though the doses required to alleviate the ward's suffering may have a secondary or terminating effect on his respiratory function.

172. We would, however, not make any order consenting to, or make any declaration in relation to, the treatments covered at paras. 4(ii) to 4(viii) of the notice of motion because, at this point, there is no evidence and no reason to believe that the parents would not, themselves, consent to such treatments if the situation arose. The order sought at para. 4(ii) appears directed to permitting respiratory suctioning treatment but in fact contemplates withholding that treatment in some circumstances and, accordingly, is best addressed under that general heading. It does not seem appropriate to override parental authority and the parental/familial decision-making function in regard to the matters addressed in the absence of an indication that it is necessary to do so. If, however, the parents were to evince any unwillingness to consent to any of these procedures if they were medically indicated to be in the interests of the ward, an immediate application could be made to the President of the High Court.

173. We would also make the declaration sought at para. 4(ix) that the Hospital would not be acting unlawfully if the clinical director considered it to be in the best health and welfare interests of the ward, and if it was considered appropriate to do so, to withhold life-

prolonging treatments or supports that are not considered to be in the best medical or welfare interests of the ward including:

- The administration of high flow oxygen, continuous positive airway pressure or biphasic positive airway pressure support;
- Rescue breaths delivered via bag or mask resuscitation;
- Intubation for the purpose of invasive mechanical ventilation;
- Mechanical ventilation;
- Inotropes for blood pressure instability;
- Cardiac compression for insufficient cardiac output or medical or electric cardioversion for cardiac arrhythmia
- Invasive access including intraosseous and central venous access devices, or peripheral intravenous access;
- Intravenous fluid replacement; and
- The readmission of the ward to an intensive care unit.

174. We consider that it is appropriate, however, to maintain the possibility and primacy of parental decision-making in this case and, accordingly, the consent given and declarations made above are subject to the proviso that they would only become effective if, in each instance, the prior consent of John's parents had been sought and refused. The consent given and declarations made should also be limited in time and will, accordingly, be subject to review in three months from today's date with liberty to apply to the High Court in the meantime in the event of any unforeseen circumstance and the Hospital must re-enter the matter before the President for the purpose of such review.

175. It is important to make clear that the consent given and declarations made are also limited in that no general order is made to permit the clinical director to carry out such medical and nursing ancillary treatment as he or she considers, in the exercise of their clinical judgement, to be appropriate. As things stand, and given the contingent and anticipatory

nature of the order sought, it is not, in our view, appropriate to make an order in such general terms. It is also important to emphasise that the limited consent and declarations made are permissive and not mandatory. They allow a certain course of conduct but do not require it. It is to be anticipated that John's condition will be kept under review, and decisions in relation to treatment will be made in the light of the particular facts then appearing. It may be that, in all the circumstances, the treating doctors may decide to provide some treatment identified at subpara. (ix) or to do so for some period of time. The effect, therefore, of the decision is to remove a veto over a course of conduct that may be required in circumstances that may arise, though they have not yet arisen.

176. It is implicit in the foregoing that we would also respectfully differ from the President as to the precise test to be applied in coming to this conclusion. We agree that it is not a question of the court or other decision-maker imposing their own views. Thus, a judge may have strong personal views on the issues involved, but those are not relevant. While any views a ward may have expressed and any consideration as to what a ward would decide may be relevant to the decision, we do not think that the decision is to be made by seeking to imagine what John in this case might want if capable of understanding his condition. Indeed, that exercise is, of necessity, somewhat artificial and unrealistic. In our view, the test is to consider what a loving and considerate parent would do once apprised of all the relevant information. Such a parent would take into account the views of the child, if expressed, and the character of the child, and would make a decision as to the best interests of the child in that context. It is important that, while an assessment of the benefits and burdens of a treatment are relevant to the decision, that does not involve the court making judgments as to the quality of the life being lived by the patient. Where it is sought, whether by a decision in wardship or by exercise of the inherent jurisdiction or by making a general declaration, to override a contrary parental decision in relation to a child, then it is necessary to go further and be satisfied by clear and convincing evidence

that the decision of the parents is one which prejudicially affects the health and welfare of the child to such an extent that the decision of the parents can properly be described as a failure of parental duty to the child in question. We agree that, insomuch as the decision is one made under the wardship jurisdiction, it is not a question of an onus or standard of proof, but rather of the court being satisfied. Because we have considered that that test has been satisfied in this case, we have not found it necessary to consider whether any different standard is required by reference to any test of compelling reasons or of vindicating the rights of the child and, if so, whether such a test can now be derived from the Constitution as it now stands. We take some comfort the fact that these limited orders do not mean that the hopes expressed by John's mother that more time will be permitted to allow for the stabilising of treatment of John's dystonia, and the possibility of further improvement in his condition, are necessarily rejected. The orders only arise in the event that John experiences a severe dystonic crisis that is not capable of being treated other than by the measure proposed at para. 4(i). Furthermore, the orders permit – but do not require – all the measures outlined to be adopted. It is to be expected that the treatment decisions would be made in the light of the particular circumstances applying. If, as John's mother believes, his dystonia is now stable and his condition improves, and he defies medical opinion, as she hopes, then the necessity to act upon the consent given and declaration made will not arise.

177. Cases involving the withholding of medical treatment contrary to the wishes of a family of a child involve decisions of enormous importance for everyone involved, and often combine the maximum of factual and legal difficulty with a minimum of time for consideration of the decision. It may be useful, therefore, to summarise the principles which we consider are applicable, and which have led to our conclusion in this case:

(i) A child has rights under the Constitution both individually as a person, and collectively as a member of a family.

(ii) In most cases, the parents of a child under 16 years of age may agree on his or her behalf to a course of treatment proposed, or to the withholding of treatment, and may provide positive consent to the administration of treatment where that is necessary to permit the treatment to be carried out.

(iii) The Constitution recognises the benefits to a child of being a member of a family. The dynamics of relationships are sensitive and important and should be upheld where possible, as a child benefits, in multiple ways, from being a member of a family.

(iv) In cases of disagreements between doctors and parents as to medical treatment, it may be necessary to distinguish between consent to treatment and the withholding of treatment.

(v) In the case of the provision of consent to treatment, parents may be acting both as family members and parents, and as substitute consent providers. In such circumstances, the rights of the child have particular weight.

(vi) The withholding of treatment to a child does not necessarily require parental consent to be lawful if it based on a properly made decision as to the best medical interests of the child and it would be contrary to medical ethics to provide the treatment. However, it may be prudent in cases of dispute to seek a determination from a court that such a proposed course is not unlawful. In practice, the question of consenting to some treatment or withholding other treatment will often be interlinked and treated as a general issue of medical treatment, and if the wardship jurisdiction is invoked, the issue can be determined in a single set of proceedings.

(vii) In the absence of a specific statutory procedure to resolve disputes as to the future treatment of a child, wardship jurisdiction may be used to determine if the court, in performance of the State's duty under Article 42A, should supply

the place of the parents and provide, in the particular circumstances, consent to treatment.

(viii) The commencement of wardship proceedings may permit, at an early stage and before the making of a formal order taking a child into wardship, the making of protective orders, if necessary, and the procurement of independent evidence, if thought desirable by the court. A child should not be admitted to wardship without full hearing and argument. In cases where the objective of the procedure is to permit the consideration of the question of whether the court should supply the place of parents in relation to the consent to medical treatment, the test for admission to wardship and the test for consent to treatment is not merely the best interests of the child, but rather whether the constitutional test has been satisfied: that is, that a decision of the parents, or the absence of a decision, is a failure of duty towards the child to such an extent that the safety or welfare of the child is likely to be prejudicially affected. It will, therefore, be convenient to deal with the decision to admit to wardship and the decision as to whether to supply the place of parents at the same time, and at the end of the proceedings.

(ix) Making a decision to override a parental decision, particularly a decision of conscientious, committed parents, is not merely a matter of a court's view of the medical evidence. The court should consider the nature and significance of the procedure involved, the extent to which the opinion of treating doctors is unanimous, is shared by independent experts, and the depth and conviction with which it is held. The court should, at all times, consider the possibility that the decision is one within the permissible range of family decisions.

(x) The procedure is not a *lis inter partes*, but is rather an inquiry. It is not, therefore, a case for a standard or onus of proof. However, the court should

only make the order sought when there is clear and convincing evidence establishing that the constitutional test is met, and where an opportunity has been afforded to test that evidence.

(xi) The decision does not involve the court making any judgement on the quality of life of a child. The test is not what decision the judge would themselves make in the situation, and a judge should be careful to avoid imposing the judge's own, perhaps strongly held, views on the situation. Nor should the court hypothesise as to what the child in question might wish to do if that child had all the knowledge available, and the maturity to consider it. Instead, the test to be applied is that the court should decide what it considers that loving and considerate parents of this child would do if apprised of all the facts and evidence, and aware of the character, personality, and history of the child.

(xii) If it is established by clear and convincing evidence that the decision of the parents is one which prejudicially affects the safety or welfare of a child, then exceptionality is not a separate requirement before the court may supply the place of parents.

(xiii) Article 42A requires that the means by which the place of the parents is supplied by the State should be proportionate. Accordingly, wardship orders should be limited to the relevant decision as to those aspects of medical treatment where there is reason to believe that parental approval will not be provided.

(xiv) Even where a child is admitted to wardship, and the consent is provided for treatment, it may be appropriate to provide that such consent only becomes operative if, having been given the opportunity to do so, parents refuse their own consent.

(xv) Particularly in cases which do not involve a single emergency decision, but rather a consent to a care plan, it will normally be appropriate to provide for review within a relatively short period and, if necessary, further reviews at regular intervals.

178. Finally, we would like to acknowledge the considerable assistance given to the court, first of all, by the parties including the guardian *ad litem* in the assembling of evidence and its presentation to the court. All the documentation and legal submissions were prepared and presented to the court notwithstanding the great pressure of time. The arguments have been comprehensively advanced and have been of considerable assistance to the court in coming to its conclusion. In that regard, we should say that we appreciate the value of submissions made by the parties notified by the court – in this case, the Attorney General and IHREC – in relation to the general legal issues. We recognise that those parties may wish to focus on the general issues of law arising and to maintain some distance from the particular dispute. While recognising the benefits of a dispassionate stance, and the dangers of apparent partisanship, it is, nevertheless, a fundamental feature of the common law system that legal issues arise only because it is necessary to determine them in order to decide the particular controversy. Indeed, the merits of any general proposition of law are best assessed in their application to concrete circumstances and the resolution they would achieve. For our part, therefore, we would encourage intervening parties to go further in explaining how the approach they assert would likely resolve the particular case.

179. In this case, we would vary the order made by the High Court, as set out above. As so varied, we would, however, affirm the decision of the High Court and dismiss the appeal.