OUTER HOUSE, COURT OF SESSION

[2025] CSOH 121

P1201/25

OPINION OF LADY TAIT

In the Petition of

A SCOTTISH HEALTH BOARD

Petitioner

for

the court to exercise its *parens patriae* jurisdiction to authorise medical treatment of Child A

Petitioner: Reid KC, McEwan, advocate; NHS Scotland Central Legal Office
Curator *ad litem*: Innes KC

4 December 2025

Introduction

[1] This petition concerns a 14-year-old child who imminently will undergo a medical procedure. The child is a Jehovah's Witness. In accordance with her religious beliefs, she has confirmed to the clinicians responsible for her care that she does not (and will not) consent to the transfusion of primary blood components (more commonly known as a blood transfusion) even in the event of a life-threatening emergency. She has been assessed by her clinicians as having capacity to make that decision.

[2] The petitioner is the health board which has responsibility for the provision of health care to those living in the child's area. It seeks authority from this court to give the child a blood transfusion at any time up until 14 days after the medical procedure if considered to

be necessary so as to avoid serious harm, including but not limited to death, by the clinician then responsible for her care. That is because blood loss is inevitable in the particular medical procedure and there is an increased risk of a blood transfusion being required.

[3] On 18 November 2025, the Lord Ordinary (Uist) made an interim order permitting such a transfusion. He appointed Mrs Innes KC as curator *ad litem.*

[4] No answers have been lodged.

[5] Following a hearing on 4 December 2025 and with the benefit of the curator's report, I granted authority for the child to receive a transfusion of any and all blood products at any time up until 14 days after the medical procedure if considered to be necessary so as to avoid serious harm, including but not limited to death, by the clinician then responsible for her care. As there is no reported consideration of the particular issues which arise in this petition, I was invited to provide a written decision.

The legal framework

Court authorisation of medical treatment

[6] The Court of Session can authorise treatment for a person (including a child) who does not have capacity and who cannot consent to medical treatment: *Law Hospital NHS Trust* v *Lord Advocate* 1996 SC 301. It may do so where such treatment is in the best interests of the person: *Law Hospital* at p 316. Such authority has the same effect in law as consent provided by the person or a parent in the case of a child: *Law Hospital* at p 315. Applications in which authorisation of treatment is sought should be made by way of a petition to the *parens patriae* jurisdiction of the court: *Law Hospital* at p 309. *Law Hospital* is submitted to be the only reported decision from the Scottish courts which gives substantive consideration to

the legal basis for the authorisation of medical treatment. There is a more developed body of case law from the courts of England and Wales as follows.

[7] In respect of an adult who has capacity, a clinician cannot provide treatment that is in the patient's best interests if it is contrary to the patient's wishes: *R (Burke)* v *General Medical Council* [2006] QB 273 at paragraph 30. A patient who has legal capacity can decline treatment for reasons which others consider irrational or for no reasons at all; it is the patient's decision: *Burke* at paragraph 50. This reflects a patient's autonomy and the right to self-determination which underpins the patient/clinician relationship: *Montgomery* v *Lanarkshire Health Board* 2015 SC (UKSC) 63 at paragraph 81.

[8] As a starting point, there is a strong presumption that it is in a person's best interests to stay alive: *Aintree University Hospitals NHS Trust* v *James* [2014] AC 591 at paragraph 35.

[9] When considering the best interests of a patient who lacks capacity or of a child, the religious views of the patient or their parents are a factor which may be taken into account but it is not a factor that carries pre-eminent weight: *Manchester University NHS Foundation Trust* v *Fixslter and others* [2021] 4 WLR 123 at paragraph 81.

Capacity of a young person

[10] The Age of Legal Capacity (Scotland) Act 1991 ("the 1991 Act") provides that, as a general rule, a person under the age of 16 shall not have legal capacity: section 1(1). Exceptions are made to that general rule: section 2. Those exceptions include section 2(4):

> "A person under the age of 16 shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

[11] Capacity to consent to treatment necessarily includes capacity to withhold consent. Accordingly, understanding the nature and possible consequences of a procedure or treatment includes understanding the nature and possible consequences of not having a procedure or treatment.

[12] In respect of a person under the age of 16, irrespective of their capacity to give (or withhold) consent to a medical procedure or treatment, the court can exercise its *parens patriae* jurisdiction in the best interests of the child. Like any decision made in relation to a child, the primary consideration is their best interests (objectively assessed) but due weight must be given to any views of the child, including any religious views. The older and more mature the child is, the greater the weight which should be given to those views. Those views are never, however, determinative. The ultimate issue is the best interests of the child.

[13] In the present case, the child has been assessed as having capacity. There is no reported decision from the Scottish courts considering the position in respect of a person under 16 who has legal capacity in terms of section 2(4) of the 1991 Act. The petitioner referred to the decision of the Court of Appeal in *E* v *Northern Care Alliance NHS Trust* [2022] Fam 130, at paragraphs 44 - 60. In determining whether to authorise medical treatment contrary to the views of a child who has legal capacity in respect of that decision, the court should undertake a three-stage assessment: *E* at paragraph 45. First, it must establish the facts. In particular, it must establish the risk of an event occurring (its probability) or the risk to the person from that event occurring (its consequences). Secondly, it must consider whether an immediate decision is necessary. That is informed by an assessment of how realistic it would be to expect a fair and timely decision to be given if a future possible crisis does arise. Finally, it must carry out a welfare assessment. This is an objective assessment

of what is in the best interests of the child. In particular, it requires the balancing of two transcendent factors: the preservation of life and personal autonomy: *E* at paragraph 53.

Circumstances of present case

[14] The clinicians involved in the child's care are satisfied that the child has an appropriate understanding of the nature, risks and possible consequences of her decision to decline primary blood components. As noted above, they are satisfied that she has capacity to make that decision.

[15] What is commonly known as a blood transfusion is the transfusion of primary blood components. Primary blood components are red blood cells, fresh frozen plasma, platelets and white cells. The child has refused consent to receiving such products. That refusal is consistent with her religious beliefs. There are other components taken from donated blood which can be administered. Those are products containing a minor blood fraction. They include cryoprecipitate, albumin, intravenous immunoglobulin, anti-D immunoglobulin and other immunoglobulins. The child has consented to receive such products. That choice is permitted in accordance with her religious beliefs.

[16] Blood loss is an inevitable part of the medical procedure which the child will undergo but a blood transfusion is very rare. A major haemorrhage can occur unpredictably. The need for a blood transfusion during or in consequence of the procedure is a rare but recognised risk and complication. While the risk remains in absolute terms small, should it materialise, the consequences can be catastrophic. Should the child require a transfusion as a result of blood loss during the procedure, failing to give her such a transfusion could result in her death or significant and irrevocable injury. Such injuries can include brain damage as a consequence of organs being deprived of oxygen. Adopting the

language of *E* above, the probability of sustaining blood loss necessitating a blood transfusion is very low but the consequences of requiring but not receiving a blood transfusion are severe.

[17] The conventional clinical threshold for the administration of primary blood components is a high one. There are other options (including proactive steps which have been taken to lower the already small risk) which are available before a blood transfusion becomes necessary. A blood transfusion is only administered if the clinicians deem it necessary so as to avoid significant harm (including death). Accordingly, were the order made, a blood transfusion would only be given if it were necessary to avoid such harm.

Curator's report

[18] The curator formed the impression that the child is a mature, confident and articulate young person. She has thoroughly researched material relevant to her refusal to consent to receive a transfusion and the other processes to which she has consented. She has been assisted in her understanding of the present legal process by her religious community. She understands why the petitioner has taken court action and accepts that if a court order is made then a transfusion can be given. However, she is very clear that she expects her wishes to be respected insofar as they can be and that a transfusion should be a last resort.

[19] The child can have confidence in her medical team who have taken a person-centred approach. They are both determined to uphold her wishes if they can but also to protect her in a life-threatening situation or one which would be seriously detrimental to her health. Despite the application to the court, the team has communicated extremely effectively with her so that she feels supported and reassured.

[20] From a best interests' perspective, the curator considers that the risk of death or serious harm to the child outweighs her clearly expressed and considered views not to accept a transfusion. She notes the child's acceptance that the court is likely to take the same view and she will accept that as long as her wish that a transfusion is a last resort is upheld and respected.

Discussion

[21] The novel issue which arises in the present petition is how the court should exercise its protective jurisdiction (*parens patriae*) in respect of a person under 16 who has legal capacity in terms of section 2(4) of the Age of Legal Capacity (Scotland) Act 1991.

[22] I am invited to approach matters in terms of the three-stage decision making process set out by the Court of Appeal in *E* above. *E* concerned two cases in which minors had capacity to decide whether to consent to or refuse medical treatment. The court was asked to exercise its protective inherent jurisdiction to declare that it would be lawful to administer blood to each minor in the course of an operation (where the minor conscientiously rejected blood transfusion as an article of faith) to prevent serious injury or death if a crisis arose.

[23] Senior counsel for the petitioner submitted that there is no principled reason why the Scottish approach should differ from that adopted by the Court of Appeal in *E.* That approach is rooted in the best interests of the child. The law of Scotland also gives primacy to those interests (both at common law and, where exercising a "relevant function", pursuant to United Nations Rights of the Child Incorporation (Scotland) Act 2024 ("the 2024 Act")). No separate issue arises under the 2024 Act. The child's best interests are the central consideration and she has had an opportunity to participate in, and express a view on, these proceedings.

[24] In exercising its *parens patriae* jurisdiction, I agree that this court engages in the same task as was undertaken by the Court of Appeal in *E* and that the English court's three-stage approach provides a helpful framework. I adopt that approach.

[25] In the circumstances set out above, it is clear that whilst the probability of a blood transfusion being required is small, the consequences of it being required but not given are severe. A substantial loss of blood carries a risk of serious and lasting injury and also a risk of death.

[26] Were the recognised risk to materialise, the situation would be urgent. There would likely be insufficient time to seek a court order following the manifestation of the risk. There is no way of knowing in advance whether the recognised risk will materialise. Further, it is plainly preferrable that the team caring for the child has certainty on the matter before the medical procedure starts. In these particular facts and circumstances, it is appropriate for the court to determine the matter in advance.

[27] Finally, I am satisfied that an objective assessment of the best interests of the child, giving appropriate weight to her views and particularly her religious views, comes down in favour of granting the order sought. As noted, the conventional clinical threshold for the administration of primary blood components is high. There are other available options before a blood transfusion would become necessary. A proactive approach in managing the child's care has been adopted to lower the already small risk. A blood transfusion will be administered only if deemed necessary to avoid significant harm (including death).

[28] It is clear that the clinicians are respectful of the child's wishes and other alternatives would be exhausted before transfusion. The clinicians have demonstrated a professional, sensitive and patient-centred approach which has assisted the child. They are determined to uphold the child's wishes if they can but also to protect her in a life-threatening situation or

one which would be seriously detrimental to her health. The child has confidence that her clinicians will respect her wishes within the boundaries of the law and that a blood transfusion would be a last resort. The child has also been assisted by the balanced information shared by her religious community as to why the present petition was brought before the court.