OUTER HOUSE, COURT OF SESSION

[2026] CSOH 76

P461/26
P492/26
P546/26

OPINION OF LORD BRAID

In the Petitions of

(FIRST) GREATER GLASGOW HEALTH BOARD
for the court to exercise its *parens patriae jurisdiction* in respect of child A

(SECOND) GREATER GLASGOW HEALTH BOARD
for the court to exercise its *parens patriae jurisdiction* in respect of child B

(THIRD) BORDERS HEALTH BOARD
for the court to exercise its *parens patriae jurisdiction* in respect of child C

Petitioner GGHB, child A: Clair; NHS Scotland Central Legal Office
Petitioner GGHB, child B: Jardine; NHS Scotland Central Legal Office
Petitioner BHB, child C: Reid, KC; NHS Scotland Central Legal Office

20 August 2026

Introduction

[1] Within a period of about 2 weeks, three petitions were presented to this court invoking its *parens patriae* jurisdiction and inviting the court to authorise medical treatment for the child involved, the parents in each case having refused to do so. In none of the cases did the child have capacity to consent. In the two petitions at the instance of Greater Glasgow Health Board, the child's parents had refused on religious grounds to consent to the proposed treatment, including in each case blood transfusions should they be deemed

necessary by the treating medical professionals to save the child's life or to prevent serious harm, but the parents did not oppose the petitions. In the Borders Health Board case, an *interim* order was sought as a matter of urgency to vaccinate the (previously unvaccinated) child against the risk of tetanus after she had been bitten by the family dog, in circumstances where the parents had refused to give their consent, and they did oppose the interim order. In each case, (a) a curator *ad litem* was appointed by the court upon presentation of the petition, to represent the interests of the child; (b) the curator supported the petition, and (c) I granted an order permitting medical intervention (albeit not, in all cases, in precisely the terms originally sought). Since the issues raised are common to each case, and since it is important that such cases are not held and decided in secret, it is appropriate that I issue an opinion explaining the court's reasoning; and it is expedient to do that in a single opinion. This also provides an opportunity to set out the court's expectations in relation to certain procedural matters; and to comment on a recent suggestion by an academic writer that the court should not exercise its *parens patriae* jurisdiction in cases where a child's parents are alive but have refused to consent to necessary medical treatment, and that a child protection order should instead be sought.

The facts

Child A

[2] Child A is a 13-year-old boy who suffers from an aggressive form of brain cancer known as medulloblastoma. He and his parents are Jehovah's Witnesses. He has severe non-verbal autism and was assessed by the clinicians involved in his care as not having capacity to make decisions in relation to his healthcare. In accordance with their religious beliefs and an expressed degree of mistrust in Western medicine, his parents had fluctuated

in indicating whether or not they would consent to child A receiving *life-saving* (emphasis added) radiotherapy and chemotherapy; but had positively confirmed to the clinicians responsible for his care that, in particular, they did not and would not consent to the transfusion of primary blood components (more commonly known as a blood transfusion). The orders sought were authority from the court (a) that child A undergo a course of radiotherapy, followed by a course of chemotherapy, both of which were said to be necessary to provide him with the best possible chance of cure and long-term survival from his cancer; absent such treatment, he would likely die from recurrence of his cancer; and (b) that whilst undergoing both of the foregoing treatments he receive treatment by means of a blood transfusion if considered, by the clinician then responsible for child A's care, to be necessary so as to avoid serious harm including death. The risk of child A requiring a blood transfusion was high, given that the forms of primary treatment that he required were likely to result in anaemia. Should the risk materialise, the consequences could be catastrophic. A substantial loss of blood carried a risk of serious and lasting injury, and of death. Should the recognised risks and complications associated with anaemia materialise, the situation would be urgent. There would likely be insufficient time to seek a court order following the manifestation of the risks. There was no way of knowing in advance whether those recognised risks and complication would materialise and therefore no way of knowing in advance whether child A would require blood transfusion.

[3] It was apparent from the information provided that the conventional clinical threshold for the administration of primary blood components is a high one, and that a blood transfusion would only ever be given if it was necessary so as to avoid the risk of serious harm including death.

Child B

[4] Child B is a 3-year-old who required surgical treatment (an open pyeloplasty) for a right pelvi-ureteric junction obstruction, an anatomical blockage affecting the drainage of the right kidney. Although that surgery was initially scheduled urgently in August 2025, it was postponed following the subsequent diagnosis of sickle cell disease, which significantly complicated B's clinical management. The procedure was later rearranged for May 2026. Child B and his parents are Jehovah's witnesses. Based on their religious beliefs, his parents refused to consent to B receiving any blood products. The planned surgery, while necessary, carried risks including bleeding, respiratory complications, low oxygen levels, and the possibility of a sickle cell crisis, any of which could make a blood transfusion clinically necessary.

[5] From a haematological perspective, children with sickle cell disease are generally maintained at a haemoglobin level of at least 100 g/L, with transfusion used where necessary to achieve or restore this level. In B's case, his anaesthetist was prepared to proceed provided the level did not fall below 90g/L. Additionally, an alternative medical regimen (including hydroxycarbamide and erythropoietin) was used successfully from March 2026, resulting in B's haemoglobin level reaching 107 g/L in early May 2026, above both the recommended target and the minimum threshold of 90 g/L. While this made transfusion unlikely before surgery, clinicians agreed that it could not definitively be ruled out, particularly if complications arose.

[6] B's medical history included two significant hospital admissions (December 2025 and March 2026) involving infections and marked drops in haemoglobin (to as low as 57–58 g/L). On both occasions he recovered without transfusion, reinforcing the effectiveness of the

non-blood management strategy. His ongoing treatment regime was comprehensive and represented the maximum optimisation possible without transfusion.

[7] Regarding the surgery itself, the open approach offered a 95% success rate, compared to 60% for a less invasive alternative which was rejected due to lower efficacy and the risk of undetected bleeding. Surgical planning took account of both clinical considerations and the family's beliefs, for example by choosing an external stent (to avoid a second anaesthetic and further transfusion risk).

[8] The clinicians assessed the risk of intra-operative transfusion as very low, noting that none had been required in similar procedures over many years. Should bleeding occur, initial management would rely on non-blood volume replacement (saline and albumin), with blood reserved only for severe or uncontrolled haemorrhage. Human albumin is considered a matter of personal choice within Jehovah's Witness doctrine and is clinically used as a first-line alternative.

[9] The greater concern was post-operative complications, particularly sickle cell crisis, where transfusion may occasionally be required for conditions such as acute chest syndrome, stroke, splenic sequestration, or a significant drop in haemoglobin. In extreme cases of major bleeding, additional blood components (platelets, plasma, cryoprecipitate) may be required.

Child C

[10] Child C is a 10-year-old girl who suffered a dog bite to her right wrist, inflicted by the family dog, on 19 May 2026. The injury resulted in a visibly deformed wrist, swelling, bruising, and a 1–2 cm open wound, alongside a confirmed fracture of the distal radius. She was promptly taken to hospital by her parents, where she received pain relief, wound

cleaning, and was admitted for treatment. The clinical plan involved antibiotics, overnight admission, and surgical repair of the fracture, which was carried out successfully later that evening. Post-operatively, C recovered well, was prescribed a seven-day antibiotic course, and follow-up care was arranged. From the outset, medical staff advised C's mother that due to the risk of tetanus arising from a dog bite, C should receive immediate treatment comprising two jabs, being one tetanus-containing vaccine (REVARIX) which stimulates the body's immune system to develop longer-term immunity, and one dose of immunoglobin (IM TIG) which provides immediate, short-term protection by neutralising toxins. Together, these treatments significantly reduce the risk of tetanus. Without them, particularly in an unvaccinated patient, there is a substantially increased likelihood that the immune system will fail to prevent infection.

[11] The information before the court was that the vaccination required to be done within 4 days (the minimum incubation period for tetanus). C was at particularly high risk, because she had not previously been vaccinated. C's mother refused consent, initially on the basis that she believed the risk of tetanus was low, and later expressing lack of trust in the vaccine. Despite repeated discussions and clear medical advice on 19 and 20 May 2026, both parents maintained their refusal.

[12] The medical evidence highlighted that tetanus is a rare but serious and potentially fatal infection of the nervous system. Its rarity in the United Kingdom is largely due to a long-established and highly effective vaccination programme, in place since 1961. This programme involves a six-dose schedule administered throughout childhood, providing sustained immunity. Individuals who contract tetanus in the UK are typically unvaccinated or incompletely vaccinated. Tetanus bacteria can enter the body through wounds, including dog bites, and it is not possible to predict whether infection will develop. Symptoms

generally emerge between 4 and 21 days after exposure and include jaw stiffness, muscle spasms, fever, and cardiovascular instability. Once tetanus develops, it is a serious, life-threatening condition, often requiring prolonged hospital treatment, and carries a mortality rate of approximately 10%, even with medical care.

[13] National clinical guidance supported the health board's approach. Both the UK Health Security Agency (UKHSA) and NICE recommend that individuals with tetanus-prone wounds who have not received a full course of vaccination should receive an immediate reinforcing dose, ideally within 48 hours of injury. Given that C had no prior vaccinations, her risk profile was considered high, and the recommended treatment was clear.

The procedure

[14] As noted above, in each case, the court, on making first orders, appointed a curator *ad litem* to represent the interests of the child. Orders anonymising the child and prohibiting publication of any details from which he or she might be identified were also made. It was not thought necessary in any of the cases to anonymise the Health Board making the application, which would normally only be done if to identify it might lead to identification of the child. In the case concerning child A, GGHB averred that intimation on the walls of court should not be dispensed with, on the basis that having regard to the greater emphasis on open justice since *Law Hospital NHS Trust* v *Lord Advocate* 1996 SC 301, from which the practice of non-intimation was derived, "practice was understood to have changed in that regard." Consequently, intimation was not dispensed with, and that case was duly intimated on the walls of court (or, at least, their modern virtual equivalent). In the case concerning child B, GGHB did seek dispensation with the requirement to intimate on the

walls of court, which was granted. In the case concerning child C, the same averments were made as in child A's case: however, in that case, the court's attention was drawn to RCS 14.7, which states in terms that a petition to the court in the exercise of its *parens patriae* jurisdiction shall not be intimated on the walls of the court; consequently, intimation was not dispensed with (there being no need to do so) but (unlike the child A petition) the petition was not intimated on the walls of court.

[15] As I read the Rules of Court, it is not open to the court to waive the requirements of RCS 14.7, whether or not, as GGHB averred, practice has changed since *Law Hospital.* Accordingly, *parens patriae* petitions should not be intimated on the walls of court, but there is no need to request the court to dispense with same, standing the terms of RCS 14.7. As for open justice, the petitions are now heard in open court, but the family's privacy is preserved by the sort of anonymity orders granted in these three cases. The media's attention is drawn to the existence of the petition by intimation of the interim order prohibiting publication of any details from which the child might be identified.

The law

[16] The law was recently summarised by Lady Tait in *A Scottish Health Board, Petitioner* 2026 SLT 71, as follows. 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*, above. It may do so where such treatment is in the best interests of the person: *Law Hospital*, page 316. Such authority has the same effect in law as consent provided by the person (or, in the case of a child, a parent): *Law Hospital*, page 315. 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, paragraph 35. Religious views of the child or parents are a

factor which may be taken into account but that factor does not carry pre-eminent weight: *Manchester University NHS Foundation Trust* v *Fixsler and others* [2021] 4 WLR 123, paragraph 81.

[17] Insofar as the capacity of a child is concerned, the Age of Legal Capacity (Scotland) Act 1991 provides, by section 1(1), that, as a general rule, a person under the age of 16 shall not have legal capacity. Section 2 provides for exceptions to that general rule, including, at 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."

As already noted, none of the children involved in these cases had capacity to consent, none of them falling within the section 2(4) exception.

[18] The UNCRC (Incorporation) (Scotland) Act 2024 incorporated the United Nations Convention on the Rights of the Child into Scots law, for certain purposes. Insofar as material for present purposes, section 6 of that Act makes it unlawful for a court to act, or fail to act, in connection with a "relevant function" in a way which is incompatible with the UNCRC requirements. A "relevant function" includes one which is conferred by an Act of the Scottish Parliament, or by a rule of law not created by an enactment. The UNCRC requirements include (Article 3) that in all actions concerning children, the best interests of the child shall be a primary consideration; and (Article 6) that every child has the inherent right to life, Article 6(2) providing that "States Parties shall ensure to the maximum extent possible the survival and development of the child." In addition, in terms of Article 5, States must respect the rights and responsibilities of parents to provide guidance and direction to

their child; and Article 18 provides that both parents share responsibility for bringing up their child and must always consider what is best for the child.

[19] In the present cases, the court was applying a rule of law, and as such had to act compatibly with the UNCRC requirements.

[20] An issue which Lady Tait did not address is whether the child must be an orphan for the *parens patriae* jurisdiction to apply. For my part, while that is a sufficient reason for the court to step in and give parental consent where that is required, I see no reason either in logic, or in law, why it should also be a necessary one. Where the welfare of the child demands that parental consent be given to a particular medical procedure which is necessary to avoid death of, or serious harm to, the child, and parental consent is not available, then it matters not whether the reason for that non-availability is that no parent is alive, or (for whatever reason) alive but unable to give consent (for example, if they cannot be found), or simply refusing to give consent on religious, moral or life-choice grounds. The situation is in substance no different from that where one parent refuses consent, but the other gives consent: the court is, in effect, acting as a third parent in such circumstances. If the court does do that, of course, it must recognise that any authorisation in relation to a child is an exception to parental autonomy; it is an interference by an organ of the state in family life and any authorisation which is given must be a proportionate response to a material risk. This underlines that when considering whether to exercise its *parens patria* jurisdiction, the court must carry out a balancing exercise, at the heart of which lies the welfare of the child, but where other considerations including the parents' wishes and religious beliefs, and indeed their right to parental autonomy, must also be taken into account.

[21] For completeness, since it was raised by the curator in two of the cases, Part 5 of the Children's Hearing (Scotland) Act 2011 permits a local authority or other person to apply to the sherif for a child protection order. Such an order may authorise the carrying out of an assessment of the child's health or development, if and only if the order authorises the removal of the child to a place of safety and the prevention of the child's removal from that place: section 37(2) and (4). It may *also* (emphasis added) include any other authorisation necessary to safeguard or promote the welfare of the child: section 37(3). The sheriff may make a CPO only if satisfied that there are reasonable grounds to suspect or believe (depending on whether the applicant is a local authority or other person) that (reading short) the child is likely to be, or has been, neglected or treated in such a way as is likely to cause significant harm: section 39. Applications for a CPO are dealt with in chambers; there is no requirement to intimate them to the parents, although that is sometimes done; and serve as an entry route into the children's hearing system. A curator *ad litem* would never be appointed, although a safeguarder is often appointed by the children's hearing (which enters the process some days after a child protection order has been made).

Decisions

[22] In the cases involving children A and B, application of the foregoing principles readily led to the granting of orders permitting medical intervention (although, largely thanks to the report of the curator in each case, in narrower terms than originally sought). There was no real need to resort to the UNCRC requirements, which were in any event consistent with Scots law. In each case, stated bluntly, there was a risk of the child dying if the orders were not granted: it would be unsatisfactory if the Court of Session were not entitled to make an order in such circumstances on the basis that another form of procedure,

in a lower court, might have been more appropriate. As I said recently in a different context, the procedural cart must not drive the welfare horse. Child A needed life-saving treatment. B, while not in such a drastic position, also urgently required surgery which potentially would lead to his requiring blood products as a matter of urgency. In B's case, in particular, the clinicians managing his care had already gone above and beyond to avoid the need for blood products and I was satisfied that they would continue to make such efforts, and administer blood products only as a last resort. In both cases, the orders granted were in the narrowest possible terms, and were proportionate. So far as possible, the orders had to account for the possibility that blood transfusion might be required at a number of different stages of the medical process, in a variety of different emergency scenarios. In neither case did the parents object, and there was at least a hint that they expected the court to grant the consent to enable the procedures to take place, in order that their child would not die.

[23] C's case was less straightforward, inasmuch as her parents actively opposed the making of any order and disputed the medical science underlying the request. It is worth recording at the outset that in the petition as presented to the court, the Health Board initially sought, in addition to an order permitting initial treatment, an order permitting two further doses of REVAXIS at intervals of one month. However, the curator elicited from the treating clinician that those further doses were "not technically related to this acute episode"; that their purpose was to bring C into the routine childhood vaccination schedule for long-term protection; and that he had "mostly assumed" that the court would not authorise the follow-on doses, which meant that without them, C would essentially go back to no immunity and be back at square one. As the curator pointed out, that would be to use the *parens patriae* jurisdiction to bring an unimmunised child into the routine childhood vaccination schedule against the wishes of her parents in circumstances where there was no

acute medical event making that necessary, which would go considerably beyond the proper compass of an exception to parental autonomy, and which there was no authority to support. Those comments appeared to me to be well made. The *parens patriae* jurisdiction enables the court to intervene only in urgent situations, rather than to impose measures which the medical profession considers to be in the best interests of children against the wishes of the parents. However, no formal decision was required, because when the petition called for an interim hearing, senior counsel for the Health Board informed me that the Board was no longer seeking an order in those terms (and would not have initially sought one, had counsel been aware of the views expressed by the clinician), but was now simply seeking an interim order to administer the two doses of vaccination which were required to address the immediate short-term risk of C contracting tetanus.

[24] As to whether an interim order should be granted, C's parents addressed me both orally, and by adopting a written statement which they had lodged. In summary, they said that they choose to live in a way that prioritises simplicity, nature and mindful choices about what is put into their bodies. Wherever possible, they prefer to explore natural remedies and support the body in a holistic way. They believed the incident was low-risk, because their dog had not been eating piles of dirt or manure (where tetanus bacteria thrive); tetanus bacteria cannot live inside a dog's mouth; the wound would have been flushed out by the body's natural defence mechanisms; iodine, which was used to clean the wound superficially, would have killed the bacteria; and there was a possibility that C had developed immunity due to her lifestyle. Further, the vaccination may itself cause harm to C. There was little research on the negative effect of vaccinations, both short-term and long-term; still less research on what happens when a healthy unvaccinated person received multiple vaccines at the same time. They did not think that the risk was as great as the

doctors were saying. They also submitted that the decision felt rushed, and that they would like more time to look into the matter more fully.

[25] Dealing with that last point first, the urgency of the situation did not permit more time to be given to the parents. The medical evidence before the court was that a vaccination ought to be given within 4 days of the bite; by the time of the interim hearing, 3 days had already elapsed, and the hearing had already been postponed by a day, in order that intimation of the motion could be given to the parents, so that they had the opportunity to be heard; an opportunity which they took and, although not legal represented, they were able to present their views reasonably and articulately.

[26] As to whether an order should be made, this was a much more finely balanced decision than in the case of children A and B. In deciding whether the order was justified, I considered two questions. First, what was the risk of C developing tetanus if not given the injections; and second, what harm would she suffer if she did develop that disease. In broad terms, intervention by the court was likely to be justified where, even though there was a small risk of something happening, there would be a high risk of serious harm if the risk did eventuate. The parents' objections to the injections were in the main directed to the first of these questions. They had argued that the risk of tetanus was low because of the various factors they had identified, and pointed to the absence of statistical information on the incidence of tetanus where an unimmunised person has been bitten by a dog. That is so, but at least part of that was likely to be down to the fact that the majority of the population is immunised, which C was not. As against all of that, the court had the medical evidence before it, which was that where a person has suffered a dog bite such as the one that C suffered, there is *a* risk that tetanus will develop; and further that tetanus can be caused by a single spore. As regards the assertion that C may have developed a natural immunity, there

was no scientific evidence supporting that assertion. The ultimate problem was, as C's mother herself stated, that it was impossible to know for certain whether C would develop tetanus or not. That being so, I proceeded on the basis of the medical information before me, which was that there was a greater than negligible risk that she may do so if not treated.

[27] Turning to the second question, that of harm, here there was little room for doubt. The probability was high that if C did develop tetanus, she would suffer serious harm, which could cause her considerable pain and likely inpatient hospital care. Even aside from the risk of death – which at 1 in 10 was considerably higher than negligible – such a consequence for her health would not be in her best interests. In short, there was a greater than negligible (but impossible to quantify) risk of tetanus, which if it came to pass would cause C harm ranging from serious illness to death. That being so, I reached the view that there was a material risk to C's health such that some intervention by the court was justified.

[28] The final question to address was what that intervention should be; in particular whether the court should authorise both the REVAXIS vaccination and the immunoglobin one; or only the immunoglobin one, otherwise referred to as IM TIG. This was also a balancing exercise. On the one hand, the parents had argued that there was a risk in providing any vaccination; and that there could be an adverse and harmful effect on C. On the other hand, the Health Board submitted that if only the IM TIG were given, that would not adequately eliminate the risk of C contracting tetanus, and that the standard guidance was that both should be given. While neither the court nor the medical profession could ever say that anything was 100% safe, the overwhelming weight of the available evidence was that C was highly unlikely to suffer serious adverse effects from the two vaccinations which it was proposed to give her; and that the very small risk of minor side effects is outweighed by the much more serious harm she would suffer should she develop tetanus.

[29] I therefore concluded that it was in C's interests to receive both the REVARIX and the IM TIG, and that she should receive them that day, such an order being both proportionate and necessary. I therefore granted authority for those to be administered, and ordained her parents to take her to hospital for that purpose (which I understand they duly did). The petition was subsequently served but since no further orders were sought, and the purpose of the petition had been achieved, it was later dismissed.

Postscript

[30] Finally, I should say a few words about child protection orders. I express no opinion on whether or not there might be circumstances where a child protection order might be sought so as to permit medical intervention in respect of a child whose parents had refused to consent thereto. Should a child protection order be sought in such circumstances, it will be for the sheriff to decide on whether or not an order is justified, and if so, what measures it should, and competently, include. However, I would say that it did not strike me in relation to any of the three cases that I was considering that a child protection order ought to have been sought, or was likely to have been granted if an application had been presented. In all cases, there were no social work concerns about the parents. All were loving parents who were acting in accordance with what they perceived to be their child's best interests. It would appear counter-intuitive to order that they be removed from their parents' care, even for a short period, in order that consent might be given to a medical procedure. Further, it is not at all obvious to me that the statutory mechanism for the making of a child protection order provides for the same safeguards as are utilised by the court when a *parens patriae* petition is presented. The sheriff does not have the luxury of the power to seek a curator's report, nor are applications for such orders heard in public. The urgency of the situation

may be such that by the time the children's hearing became involved, it may already be too late.