[2019] IEHC 691

THE HIGH COURT
WARDS OF COURT

[WOC 10234]

IN THE MATTER OF A.C., A MINOR AND A WARD OF COURT

JUDGMENT of Mr. Justice Kelly, President of the High Court delivered on the 22nd day of October, 2019

Introduction

1. This is a harrowing case. It involves a five-year-old boy A.C. (the minor) who has a diagnosis of very high risk neuroblastoma.

2. This application arises in circumstances where important treatment decisions need to be taken in his best interests in circumstances where his parents disagree on whether curative intent treatment or palliative intent management should be provided to the minor.

3. To borrow the words of Hayden J. *in Manchester University Hospital v. M*. [2019] EWHC 468 "*It is difficult to imagine a more onerous question for a court to address*" but address it I must where every effort to obtain agreement between the parents has failed.

The Parents

4. The minor's mother L.T. (the mother) and his father M.C. (the father) are not married to each other. They have two other children who are aged eight and six respectively.

5. They cohabited together with their children until May 2019. They have been cohabitants with the minor for not less than 12 consecutive months since 18th January, 2016 and thus the father satisfies the cohabitation requirement under s.2 subs. 1 and 4A of the Guardianship of Infants Act 1964 as amended. He is therefore a legal guardian of the minor.

6. The father is a plumber by trade but has not worked in that capacity for many years. Instead he has been the principal carer for all three children looking after the domestic arrangements.

7. The mother is a bank official and her earnings provide the finances for the running of the household. The mother has an alcohol addiction for which she received inpatient treatment in April 2019 and is continuing to engage with post inpatient treatment supports. She is now well and fully functioning.

8. Up to the time of her alcohol addiction manifesting itself I am satisfied that both she and the father provided very good care for all of the children. When her alcohol addiction became very serious she failed to ensure the children's safety and wellbeing thus resulting in a referral to the Child and Family Agency in March 2019. The Agency completed its assessment at the end of April 2019 and has since closed its files.

9. I am satisfied that apart from that breakdown both parents provided good care to the minor and his siblings.

10. I heard evidence from both parents and I am satisfied that they love the minor as well as his siblings and wish to do the best for them. The mother wishes the minor to have curative intent treatment whilst the father wishes him to have palliative intent management. Despite efforts on the part of the hospital authorities who brought the wardship application no consensus could be arrived at between the parents.

11. There are clearly issues in the relationship between the parents but they and their legal teams are to be commended for resisting the temptation to ventilate them in the evidence before me. They confined themselves to the issue in hand namely what is to happen to the minor.

The diagnosis

12. The minor is suffering from a neuroblastoma which is a paediatric cancer of the sympathetic nervous system namely the network of nerves that carry messages from the brain to the rest or the body. He was diagnosed with this condition in October 2018. Unfortunately, he had an inadequate response to induction chemotherapy which was carried out between 6th October and 20th December 2018. As a result, his diagnosis was reclassified as very high risk neuroblastoma.

13. High risk neuroblastoma has a five-year survival rate of approximately 50%. The survival rate for very high risk neuroblastoma is in the range of 10 – 20% five years' survival.

14. There are international contemporary protocols for treating high risk neuroblastoma. Those treatments include induction chemotherapy, surgical resection of the primary tumour, high dose chemotherapy and stem cell rescue, radiotherapy and immunotherapy.

Treatment to date

15. The diagnosis in October 2018 was confirmed when a tumour biopsy was carried out. The induction chemotherapy then took place. The minor's inadequate response to that chemotherapy gave rise to the later diagnosis of high risk neuroblastoma. As a result of this the consultant oncologist under whose care the minor is, continued to treat him with additional intensified chemotherapy in an attempt to reduce the tumour size so as to facilitate as best as possible its resection. It was not possible to achieve a complete resection because to do so the minor's left kidney would have to be removed. Accordingly, an operation to de-bulk the tumour took place. The father was reluctant to consider that surgery but ultimately agreed to it. That surgery took place on 28th June, 2019 and approximately 85% of the tumour was resected. The resected tumour contained viable anaplastic tumour cells denoting possible biological tumour aggressiveness.

Curative intent treatment

16. The next phase of curative intent treatment is proposed in accordance with European protocols. It involves high dose chemotherapy and stem cell rescue. Because of the inadequate initial response to treatment the consultant oncologist proposes to further intensify the treatment with a tandem rather than a single high dose chemotherapy treatment. He has discussed this proposal with a fellow consultant oncologist at the hospital in question who completely agrees with this approach.

17. Following the necessity to institute these proceedings the view of Professor John Anderson, Honorary Consultant Paediatric Oncologist at Great Ormond Street Hospital for Children was sought. He provided a report which agreed with the approach of the Dublin consultant oncologists but suggested that certain further tests be carried out. These tests were carried out and a second report was provided by Professor Anderson just prior to the hearing before me on 16th October, 2019. He fully endorses the approach of the treating consultant in Dublin and says as follows in his report:

> *"I now in the light of the new evidence restate my opinion that with tandem transplant there is a realistic possibility of cure. I therefore continue to hold the opinion that I recommend proceeding to a tandem transplant treatment plan with careful disease re-evaluation between the two transplant components to avoid giving a second transplant conditioning procedure in the face of growing disease. Consideration should be given to a second surgical procedure after tandem transplant if he is in metastatic remission. Remission should therefore be consolidated with tumour bed radiotherapy, and immunotherapy with an anti GD2 antibody plus isotretinoin*."

18. This is the course of treatment recommended by the Dublin consultant and is fully endorsed by both his colleague and Professor Anderson.

19. It must be said however that even with treatment the minor's prognosis is predicted to be poor.

Effects of curative treatment

20. High dose chemotherapy and stem cell rescue is associated with significant treatment related morbidity and even a small mortality risk. The treating consultant, who gave evidence before me, put the mortality risk at 2-3%. The likely side effects are infection, hair loss, nausea/vomiting, mouth sores, abdominal pain, diarrhoea and a need for nutritional support either by naso-gastric tube or parenteral nutrition. Thus the treatment is very unpleasant. All of these side effects are likely. There are also possible side effects put at about 10% or less of veno occlusive disease of the liver and to a lesser extent the lung, seizures, allergic reactions, skin changes, central nervous system alterations such as behaviour changes or confusion.

21. The evidence is that curative intent treatment is likely to extend survival time. The quality of life obtained from such a course is difficult to predict and is very subjective relative to morbidity and required hospitalisation as a result of the treatment.

22. On balance, the treating consultant recommends this form of curative intent treatment. This recommendation is shared by his consultant colleague and by Professor Anderson. His recommendation is accepted by the mother but not by the father.

Other curative options

23. There are other curative options which could be tried. These have been discussed with the parents and neither of them wish the minor to avail himself of those options because they are associated with decreased survival rates.

24. The minor's father wants no further curative treatment to be given to him whilst the mother wants intensive curative intent treatment to be administered in accordance with the consultant oncologists recommendations.

Clinical discussions

25. It is not necessary for the purpose of this judgment that I should set out in detail the clinical discussions which have been had with the parents with a view to obtaining some form of consensus between them. I am satisfied that these have involved painstaking efforts being made and resulted in the father ultimately agreeing, as he did in the witness box before me, to curative treatment taking place but not until after Christmas 2019. However, the treating consultant is satisfied that to defer treatment until 2020 would be with palliative intent. The reason for this is the risk of the tumour becoming active again and being extremely difficult to control. Already the curative treatment is two months behind the recommended time because of the efforts that were made to try and persuade the parents to reach a consensus.

Recommendation

26. Despite the poor prognosis and the attendant potential morbidity and small risk of mortality the recommendation on balance of all the consultant oncologists who have been involved is that curative intent treatment should proceed. It is important to stress however, that if permission is given by the court for such treatment it is not a once and for all decision. The treatment will be carefully monitored and if at any stage it becomes apparent that it is ineffective or if the minor is unable to tolerate it then it will be discontinued.

27. The treating oncologist has made it clear that having regard to the poor prognosis, he would be prepared to proceed with palliative intent management only of the minor if both parents were in agreement with that approach. Thus, whilst he recommends curative treatment, palliative intent treatment would not create any ethical problem for him provided both parents agreed to it. They do not, thus this application.

Wardship

28. The treating consultant was placed in an impossible position and thus the paediatric hospital in question commenced these proceedings with a view to the directions of the court being obtained.

Proceedings

29. The minor was taken into wardship and when the matter came before me at the end of the Long Vacation I directed that separate representation be provided for the minor who up to then was not represented. Both parents have been represented as well as the hospital. I am grateful to the General Solicitor for Minors and Wards of Court who agreed to represent the minor's interest and commissioned a report from a consultant clinical psychologist who also gave evidence before me.

The Mother

30. The mother swore an affidavit and also gave evidence before me. She cohabited with the father for 13 years. She was the breadwinner for the family and after the birth of each of the children returned to work in the bank. The daily routine was that she would prepare the children for school and when she came home from work would take care of their needs and settle them for the night. That was how things worked until the minor's cancer diagnosis in October 2018.

Following the diagnosis, she took extended leave from her bank job and stayed at home and took care of him through the first year of his treatment. At the father's insistence, she says, she left the family home in June 2019 and went to reside with her parents. However, even during her absence from the home she continued to attend each day from morning to night to see to the children's needs. She says that since September of this year the father has not permitted her access to the house and she has since then been collecting the children and bringing them to her parents' home to spend time with them.

31. The relationship between herself and the father is as she describes it "*a troublesome one for many years*". But neither she nor he went into any details of this which was a commendable approach to take.

32. She acknowledges an alcohol addiction issue and following the minor's diagnosis she felt she could not cope. She checked herself into St. John of God's Hospital and went through a detoxification regime. She remained an inpatient there and has not consumed alcohol since April of this year. She continues to attend with her general practitioner.

33. She is completely committed to providing the minor with the care which he will require throughout his continuing treatment.

34. She supports the recommendation of the treating oncologist in proceeding with curative intent treatment. She said that the minor has had excellent care and both the oncologist and the hospital staff have shown enormous dedication in supporting the family. I am quite satisfied that she deeply loves the minor and has looked after him to the very best of her ability. Despite her differences with the father she readily acknowledges that he is a good father to the minor. She wants the minor to have the curative treatment as recommended. She believes that this will give her son his greatest hope of survival and wishes the treatment to commence as soon as possible as recommended by the oncologist so as to enhance that chance.

35. I am satisfied that she has had all necessary information given to her and that she understands it. She is under no illusions about the serious nature of the illness and the poor prognosis even with curative treatment. Nevertheless, she believes it worthwhile to provide the curative intent treatment.

The Father

36. I am equally satisfied that the father has been a good father to his children and the minor in particular. He is very firm in his view that he does not want curative intent treatment or at least does not want it to start until after Christmas this year. He told me that his world is a black and white one. The minor is asymptomatic at present, is going to school and appears to be well. He did not react well to chemotherapy at the early stages and he believes that chemotherapy does not work for him. He wishes him to have what may be his last Christmas without having to go through any of the curative intent treatments that are being proposed. He has also made it clear to his son that he will not subject him to further chemotherapy. I believe he feels under some form of obligation to honour that promise. I get the impression that he ascribes perhaps a greater degree of maturity to the minor than he or indeed any five-year-old could have. The fact that the minor is currently asymptomatic and appears well and to be

enjoying school would lessen any parent's inclination to commence treatment of the type involved.

37. The father is quite dogmatic in his approach. He has made his mind up and is not for turning. He believes that nobody is listening to him. Despite my assurance that I was and would take his views fully into account I do not believe that he accepted that.

The minor

38. The consultant child psychologist who met the minor prepared a detailed report and furnished me with oral evidence in relation to him. He is a good humoured bright and articulate five-year-old. He is asymptomatic at present. When the psychologist told him that she had come to talk to him and that she worked for the judge he announced "*I am not having chemo*" straight away. He engaged willingly with her, told her about his school experience and friends. He appeared to have a warm affectionate relationship with each of his parents. I have no doubt but that that is in fact the case.

39. He said he was very sick and had "*kid cancer*". He said "*It means you're sick*" and described the cancer as being "*all around my body*". He explained the different treatments a person can get in hospital and in particular chemotherapy. He told her the treatments did not take away his kid cancer yet and that the doctors wanted to give him more. He said that made him feel sick and that the sickness lasted for a long time. He told her emphatically that he was not going back into hospital because he does not like hospital and because it was boring. He said the nurses were nice but said "*I don't want any more chemo*". He expressed the view that he thought the cancer might get better on its own. He reported that he had chemotherapy before and that he still had "*kid cancer*".

40. He reported to her that his dad "*says no to chemo*". He confirmed that he heard his dad say this. He told her that his dad said this in front of him but he reported that his mother wants him to have chemo. His mother did not talk to him about it but his father had told him about it. He said that the doctors and his mother think that "*chemo is going to work but it isn't*". He reported taking CBD oil which was being given to him by his dad. He reported that his dad "*maked*" up his mind for him about not having "*chemo*". He reported "*dad said it would work with the CBD oil*". He agreed again that his mother thinks that he should have chemo. He reiterated that he did not want the chemo again and he thought the cancer would go away without it. He said that if the cancer did not go away he would go to another hospital but then reported that he wished to stay in his current one. On questioning he indicated that if the "*kid cancer*" did not go away itself and he got very sick he might then go for "*chemo*" but instantly changed his mind to say he would not go for treatment even then and expressed the view that it would probably get better by itself. He did not appear to acknowledge the possibility of becoming very ill without treatment and expressed no awareness in relation to possible mortality. His concept of the future if he does not have further chemotherapy was a very benign one in that he described a strong expectation of being well, attending school and being able to take CBD oil as a treatment instead of more difficult or invasive treatments.

41. I should say at this stage that the oncologist subsequently gave evidence to me concerning CBD oil. I am satisfied that it has no curative properties insofar as neuroblastoma is concerned.

42. The view of the psychologist was whilst the minor has a greater knowledge about hospitals and medical treatments and particularly about chemotherapy than a typical five-year-old he has very limited knowledge about the progress of his own illness. He showed little knowledge of the reasons that further chemotherapy had been advised. He was clearly unaware of the possibility or likelihood of his becoming very ill without treatment and expressed no awareness of the possibility of mortality from his cancer. She points out that children of five years of age do not have an understanding of death as irreversible. She said that he does not have the cognitive capacity to consider relative risk or weigh up the risks and benefits of any course of action. The minor does not feel ill at present and so his concept of his cancer and its impact on his body is somewhat abstract and thus it is even harder for him to consider the potential benefits of further treatment. He had a general understanding that he can hold views which are different from his parents. However, the views of a five-year-old will inevitably be subject to being influenced by the views of trusted adults. The parents have opposing views. He reported aligning himself with his father's expressed views about refusing further chemotherapy and taking CBD oil daily. She was of opinion that he is not simply taking on his father's views but rather his father's views are a strong support to his own expressed wish to avoid sickness and discomfort and hospital stays. His main wishes are to avoid sickness and discomfort and to continue with his normal life of attending school and playing. He is unwilling to have further treatment with chemotherapy because of its significant attendant sickness and hospital stays. He is influenced by his understanding that refusing further chemotherapy or having treatment with CBD oil instead which he sees as an alternative will not have negative consequences for his ability to pursue a normal life.

43. If curative treatment is directed she does not believe that that would have a serious impact on his relationship with his father despite the father's promise to him that no such treatment would be given.

The law

44. Under Article 42A of the Constitution the State recognises and affirms the natural and imprescriptible rights of all children and is required as far as practicable, by its laws to protect and vindicate those rights.

45. Article 42A(ii) provides that in exceptional cases, where the parents, regardless of their marital status, fail in their duty towards their children to such extent that the safety or welfare of any of their children is likely to be prejudicially affected, the State as guardian of the common good, shall, by proportionate means as provided by law, endeavour to supply the place of the parents, but all of this with due regard for the natural and imprescriptible rights of the child.

46. Article 42A(iv) provides that provision shall be made by law that in the resolution of all proceedings concerning *inter alia* the adoption, guardianship or custody of or access to any child the best interests of the child shall be the paramount consideration.

47. Article 42A(iv)2 provides:

> *"Provision shall be made by law for securing, as far as practicable, that in all proceedings referred to in subsection 1 of this section in respect of any child who is*

capable of forming his or her own views, the views of the child shall be ascertained and given due weight having regard to the age and maturity of the child"

48. It was because of the provisions of Article 42A(iv)2 that I specifically directed the views of the child be obtained and legal representation afforded to him.

49. The constitutional requirement that the interests of the child shall be the paramount consideration chimes perfectly with the approach of the court in its wardship jurisdiction. The best interests of wards is the criterion applied by the court. That is so whether the wards are adults or minors. It is the best interests test which I apply on this application. That is also the test which is prescribed under the Guardianship of Infants Act 1964 as amended. Section 31(1) of that Act as amended provides:

> *"In determining for the purposes of this Act what is in the best interests of a child, the court shall have regard to all of the factors or circumstances that it regards as relevant to the child concerned and his or her family."*

Subsection (2) then sets out the factors and circumstances referred to in subs (1) and includes eleven such circumstances.

50. Minors are taken into wardship because they lack the legal capacity to make decisions pertinent to their own welfare. The mere fact that they lack such capacity, however -

> *"… does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy…*" (per Hamilton C.J. in *Re A Ward of Court (No. 2)* [1996] 2 I.R. 79 at p.126).

That judge went on to say:

> *"The ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity."*

51. In that same case Hamilton C.J. said:

> *"The nature of the right to life and its importance imposes a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances".*

52. There exists "*a constitutional presumption that the wards life be protected*" (per Denham J. in the same case at p.167).

53. Those observations, as I pointed out in *In the Matter of J.M. a Ward of Court* [2018] 1 I.R. 688 were made in the context of rights derived from the Constitution. But the position is no different at common law as is clear from the views expressed by Baker J. in *Re M* [2011] EWHC where he said:-

"The first principle is the right to life. As Lord Goff observed nearly twenty years ago in Airedale NHS Trust v. Bland [1993] A.C. 789 at p. 863:-

'The fundamental principle is the principle of the sanctity of human life. Munby J. in R. (Burke) v. General Medical Council [2005] QB424 spoke of the "very strong presumption in favour of taking all steps which will prolong life.'"

54. As I pointed out in *Re J.M.*

"There is a very strong presumption in favour of taking all steps which will prolong life. But in exercising its jurisdiction the court is not precluded in principle from finding that in the circumstances of a particular case it is in the wards 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 wards 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 wards best interests. Neither is there any absolute duty on a doctor to provide, or on occasion to consent to, medical treatment in order to prolong life at all costs and without regard to other matters concerning the patient's best interests."

55. In the 1996 decision Hamilton C.J. said:-

"In the exercise of this jurisdiction the courts prime and paramount consideration must be the best interests of the ward. The views of the committee and the family of the ward, although they should be heeded and careful consideration given thereto, cannot and should not prevail over the courts view of the wards best interest."

He also said:-

"In addition, in this jurisdiction the court must have regard to the constitutional rights of the ward and defend and vindicate these rights."

56. Denham J. in the course of her judgment in the 1996 case (*In Re a Ward of Court (No. 2)* [1996] 2 I.R. 79) listed 14 matters in an inclusive list which ought to be taken into consideration looking at the totality of a wards situation. They are:

1) The ward's current condition.

2) The current medical treatment and care of the ward.

3) The degree of bodily invasion of the ward the medical treatment required.

4) The legal and constitutional process to be carried through in order that medical treatment be given and received.

5) *The ward's life history, including whether there has been adequate time to achieve an accurate diagnosis.*

6) *The prognosis on medical treatment.*

7) *Any previous views that were expressed by the ward that are relevant, and proved as a matter of fact on the balance of probabilities.*

8) *The family's view.*

9) *The medical opinions.*

10) *The view of any relevant carer.*

11) *The ward's constitutional right to:- (a) life, (b) privacy, (c) bodily integrity, (d) autonomy, (e) dignity in life, (f) dignity in death.*

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

13) *The constitutional requirement that life be protected for the common good. The case commences with the constitutional presumption that the ward's life be protected.*

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

57. Kearns. P. in *Re S.R. A Ward of Court* [2012] 1 I.R. 305 set out a shorter non-exhaustive list of considerations and concluded 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."*

58. Some weeks ago MacDonald J. in the English High Court in the case of *Raqeeb v. Barts NHS Foundation Trust* [2019] EWHC 2531 set out key principles in this regard. He said:-

> *"(i).The paramount consideration is the best interests of the child. The role of the court when exercising its jurisdiction is to take over the parent's duty to give or withhold consent in the best interests of the child. It is the role and duty of the court to do so and to exercise its own independent and objective judgment.*

(ii) The question for the court is whether, in the 'best interests' of the child/patient, a particular decision as to medical treatment should be taken. The term 'best interests' is used in its widest sense, to include every kind of consideration capable of bearing on the decision, this will include, but is not limited to, medical, emotional, sensory and instinctive considerations. The test is not a mathematical one, the court must do the best it can to balance all of the conflicting considerations in a particular case with a view to determining where the final balance lies. Within this context the wise words of Hedley J. in Portsmouth NHS Trust v. Wyatt [2005] 1 FLR 21 should be recalled.

'This case evokes some of the fundamental principles that undergird our humanity. They are not to be found in Acts of parliament or decisions of the courts but in the deep recesses of the common psyche of humanity whether they be attributed to humanity being created in the image of God or whether it simply a self-defining ethic of a generally acknowledged humanism.'

(iii) Each case is fact specific and will turn entirely on the facts of the particular case.

(iv) In reaching its decision the court is not bound to follow the clinical assessment of the doctors but must form its own view as to the child's best interests.

(v) The starting point is to consider the matter from the assumed point of view of the patient. The court must ask itself what the patients attitude to treatment is or would be likely to be. Within this context the views of the child must be considered and be given appropriate weight in light of the child's age and understanding.

(vi) There is a strong presumption in favour of taking all steps to preserve life because the individual human instinct to survive is strong and must be presumed to be strong in the patient. The presumption however is not irrebuttable. It may be outweighed if the pleasures and the quality of life are sufficiently small and the pain and suffering and other burdens are sufficiently great. Within this context as I noted in RE Y [2015] EWHC 1920, the right to life under Article 2 of the ECHR imposes a positive obligation to provide life sustaining treatment, but that that obligation does not extend to providing such treatment if that treatment would be futile in nature and where responsible medical opinion is of the view that the treatment would not be in the best interests of the patient concerned.

(vii) The views and opinions of both the doctors and the parents must be considered. The views of the parents may have particular value in circumstances where they know well their own child. However, the court must also be mindful that the views of the parents may, understandably, be coloured by emotion or sentiment. There is no requirement for the court to evaluate the reasonableness of the person's case before it embarks upon deciding what is in the best interests …..

(viii) *The court must consider the nature of the medical treatment in question, what it involves and its prospects of success, including the likely outcome for the patient of that treatment.*

(ix) *Regard must be paid to the rights of the child in particular her right to life under Article 2 and her right to respect for private and family life under Article 8. Regard must also be paid to the parents' rights, in particular their right to respect for private and family life under Article 8. ….*

(x) *There will be cases where it is not in the best interests of the child to subject him or her to treatment that will cause increased suffering and produce no commensurate benefit, given the fullest possible weight to the child's and mankind's desire to survive."*

59. Bearing in mind the legal principles which I have set out and which I now apply I turn to my decision.

Decision

60. Having considered all of the evidence and the submissions I have come to the conclusion that it is in the best interests of the minor that curative intent treatment should be proceeded with. I have come to that conclusion for a number of reasons.

1. There is a strong legal presumption in favour of taking all steps to preserve life. It is not irrebuttable. But in this case there is a unanimous view of all relevant medical experts who have been consulted that, on balance, curative intent treatment should proceed. There is no medical evidence to suggests otherwise.

2. The curative intent treatment which is suggested is to be carried out in accordance with well-established protocols which apply at an international level. It will last, if carried out in full, for one year. It is mainstream treatment and not experimental.

3. Whilst the survival rate is as low as 10-20% in the words of Professor Anderson "*there is a realistic possibility of cure*". Not to have the curative treatment means that there is no realistic possibility of cure.

4. The mother strongly supports the curative intent treatment and its immediate commencement. She does so in the hope of prolonging the minor's life and a cure being obtained. Whilst clearly being emotionally involved and loving her child, she took a balanced and rational approach. She could understand the importance of the minor having an enjoyable Christmas but not at the price of losing future Christmases.

5. Whilst it is perfectly possible to understand the father's views and to sympathise with him, I believe he has been rather more affected by emotion and sentiment than by reason. The black and white world which he inhabits means that he has a very fixed view on the matter and wishes to give his child a possible last Christmas that the child can completely enjoy. That presupposes, however, that the tumour

does not become active. His use of CBD oil and his belief in it is not based on any medical evidence which supports it having any curative effect on a neuroblastoma. He believes the minor will not benefit from further chemotherapy and is not prepared to try it. I do not think he is correct in that approach.

6. Insofar as the five-year-old himself is concerned, whilst I quite understand his thinking, I believe it is influenced by his father's approach to "*no more chemo*". In any event I do not believe that he has either the maturity or insight to understand his position.

7. A decision to commence curative treatment immediately is not final. As the treatment proceeds it will be carefully monitored and reviewed and if it should transpire that it is being ineffective or that the minor is unable to tolerate it, it will cease.

8. The first element of the treatment is of one month's duration. If that starts now it will be finished by the end of November and thus it is unlikely that there will be any treatment involved over the Christmas period. Thus, one would hope that he would have an enjoyable Christmas as the parent's wish. This may address his father's particularly strong wish about Christmas. One hopes that with treatment that it will not be his last Christmas but that he will proceed to have others to enjoy in years to come.

61. In these circumstances, the determination which I make is that the minor should proceed to have the curative intent treatment as recommended by the consultant oncologist and that it should commence as soon as possible so as to minimise the risks of the tumour becoming active again.

62. I conclude by wishing the minor well. I hope that he will achieve a cure as do all concerned with his welfare. A 10-20% chance of cure even with the undoubted horrible side effects of the treatment is to be preferred to the virtual certainty of death.

63. I wish to pay tribute to the care and attention given to the minor and his family by the hospital and in particular to thank the treating oncologist for his commitment to them.

64. I also thank the General Solicitor and all of the legal teams for their assistance in this difficult case.