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SUPREME COURT OF SOUTH AUSTRALIA

(Civil: Application)

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CHILDREN, YOUTH & WOMEN'S HEALTH SERVICES INC v YJL, MHL AND TL (BY HIS NEXT FRIEND)

[2010] SASC 175

Reasons for Decision of The Honourable Justice White

4 June 2010

FAMILY LAW AND CHILD WELFARE - CHILD WELFARE UNDER STATE LEGISLATION - CHILDREN IN NEED OF PROTECTION - PROCEEDINGS RELATING TO CARE AND PROTECTION - POWERS RELATING TO MEDICAL TREATMENT

Application under parens patriae jurisdiction by Women's and Children's Hospital for authority to administer transfusions of blood products to a child - parents of child object on religious grounds - consideration of parens patriae jurisdiction - whether in best interests of the child to authorise transfusions.

Held: authority granted.

Family Law Act 1975 (Cth) Part VII; *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth) s 4(1); *Commonwealth Powers (Family Law) Act 1986* (SA) s 3; *Childrens Protection Act 1993* (SA) Pt 5 Div 2, s 6; *Consent to Treatment and Palliative Care Act 1995* (SA) s 13, referred to.

Chignola v Chignola (1974) 9 SASR 470; *Fountain v Alexander* (1982) 150 CLR 615; *The Queen v Gyngall* [1893] 2 QB 232; *Wellesley v Wellesley* [1828] 2 Bligh NS 124; *Carseldine v Director of Department of Children's Services* (1974) 133 CLR 345; *Johnson v Director General of Social Welfare (Victoria)* (1976) 135 CLR 92; *Secretary of Department of Health & Commmunity Services v JWB (Marion's Case)* (1992) 175 CLR 218; *Re O'Hara* [1900] 2 IR 232; *In Re X (a minor)* [1975] Fam 47; *AMS v AIF* (1999) CLR 160; *Rolands v Rolands* (1983) 9 Fam LR 320; *Re Paul* [2008] NSWSC 960; *Re Bernard* [2009] NSWSC 11; *Director General of the Department of Community Services v BB* [1999] NSWSC 1169; *Re Jules* [2008] NSWSC 1193, considered.

Plaintiff: CHILDREN, YOUTH & WOMEN'S HEALTH SERVICES INC Counsel: MR M HINTON QC S-G - Solicitor: CROWN SOLICITOR
First Defendant: YJL Counsel: MR K GLUCHE - Solicitor: WEBSTERS LAWYERS
Second Defendant: MHL Counsel: MR K GLUCHE - Solicitor: WEBSTERS LAWYERS
Third Defendant: TL Counsel: MR R CROSER - Solicitor: MR R CROSER

Hearing Date/s: 04/06/2010

File No/s: SCCIV-10-717

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CHILDREN, YOUTH & WOMEN'S HEALTH SERVICES INC v YJL, MHL AND TL (BY HIS NEXT FRIEND)
[2010] SASC 175

Civil
WHITE J

1 The Women's and Children's Hospital (WCH) wishes to be able to administer transfusions of blood products to a child but his parents object on the basis of their sincerely held religious convictions, to treatment of that kind. Accordingly the WCH has applied for orders from this Court, the effect of which would be to permit it to administer transfusions without the child's parents' consent to that procedure.

2 Because the circumstances in which transfusions may be required may occur very soon, I directed, on the application of the WCH, and without opposition from counsel representing the parents and the child, that the matter be dealt with as a matter of urgency.

3 TL is now aged 10 years. In late April this year he was referred to the WCH with a lump on his left leg. Investigations revealed the presence of an osteosarcoma at the lower end of the left femur. An osteosarcoma is a malignant tumour which is highly aggressive and highly malignant. It requires aggressive treatment.

4 Dr Revesz, a consultant haematologist/oncologist, is the doctor with the primary responsibility for the care of TL at the WCH. He is being assisted by Dr Hansford, a senior trainee in children's oncology at the WCH. Each of Drs Revesz and Hansford has made an affidavit which I received in connection with the plaintiff's application and, in addition, the plaintiff called Dr Revesz to give oral evidence. I accept that each of Drs Revesz and Hansford has appropriate expertise in relation to the treatment of TL's osteosarcoma. I accept their evidence and opinions about TL's treatment. I have used their evidence in making the findings which follow.

5 Without treatment the prognosis for osteosarcoma is poor, being likely to result in a painful death within a matter of weeks or months. Fortunately, osteosarcoma can be treated. The internationally recognised course of treatment is a form of chemotherapy associated with surgical removal of the tumour. This form of treatment results in survival in approximately 60 to 70 per cent of cases. Doctors Revesz and Hansford have recommended this course of treatment for TL and he has embarked on it. Dr Revesz describes it as the current "gold standard of care".

6 The evidence does not indicate that there is any other form of treatment which has realistic prospects of success. Dr Revesz described the alternatives as

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untested and he does not recommend them. In his cross-examination Dr Revesz said that he considered the administration of chemotherapy as the only way to save the patient in a case like the present.

7 The recommended regime of treatment involves intensive chemotherapy for a period of 10 weeks, followed by surgery to remove the tumour. TL will then undergo further chemotherapy, the length of which will depend upon the particular path of treatment which is adopted in his case, but will, at the least, be a further 29 weeks.

8 During the initial 10 weeks of chemotherapy TL will be given, in accordance with the recommended regime, a combination of drugs. It is not necessary for me to describe the purpose or effect of those drugs in any detail, beyond noting that they have an important effect in disrupting cell division and the inhibiting cell growth.

9 However, chemotherapy has a number of side effects. Amongst other things it is likely to depress various elements in TL's blood, including his red blood cell (haemoglobin), white cell and platelet levels to a dangerous degree. His body is capable of remedying that situation naturally but it may take several weeks to do so, during which time it would be dangerous to apply further chemotherapy. Not administering the chemotherapy during such a period would mean that the osteosarcoma could not be treated in the aggressive way which is required.

10 The precise effect of a delay in the administration of chemotherapy is not known, but it is generally accepted that delays do compromise, in a significant way, the prospects of a successful outcome.

11 The recommended way of addressing the depressed level of the various elements in the patient's blood is to provide transfusions of blood products before or during the chemotherapy. Doing this has many advantages, the principal one of which is permitting the ongoing timely delivery of chemotherapy, but transfusions can also reduce the risk of other serious, and perhaps fatal, complications such as bleeding and septicaemia.

12 If TL is given chemotherapy at a time when his haemoglobin levels are low, he runs the risk of serious complications, including possibly death. In addition, the evidence indicates that allowing TL to have a low haemoglobin count for a long period of time, although not immediately life threatening, may have serious long-term effects. Dr Revesz said that it is likely to predispose his heart to serious complications in early adulthood, probably between the ages of 20 and 30.

13 TL commenced chemotherapy on 10 May this year. He had sessions of chemotherapy on 10 and 11 May, and again on 31 May and 1 June. So far he has not required any transfusions. However, Dr Revesz said, and I accept, that TL will almost definitely require transfusions of blood products during the

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chemotherapy regime at some stage. In addition, he considers it almost inevitable that TL will require transfusion of blood or of blood products during the anticipated surgery. I note in this regard Dr Revesz's experience that all children in his care, who have suffered from the same or similar conditions, have required a form of blood transfusion at some stage in the course of their treatment.

14 In his affidavit Dr Revesz estimated a 25 per cent chance of TL requiring a blood transfusion before he can have the next planned administration of chemotherapy on Monday, 7 June 2010. However, in his cross-examination Dr Revesz accepted that the prospects were less than that, having regard to TL's current haemoglobin levels. Even if transfusions are not required on 7 June, I am satisfied that it is very probable that they will be required at several stages of TL's ongoing treatment.

15 There are alternatives to the use of blood products; one of which is Granulocyte Colony Stimulating Factor, a product which is used for the stimulation of white blood cells. However, it has no effect on the production of red blood cells. Accordingly, it is not a complete alternative.

16 Another alternative is a substance called Erythropoietin or EPO. The use of EPO is subject to a number of unknowns. I accept Dr Revesz's evidence that use of EPO is controversial and also that there is evidence that it increases the risk of mortality. That increased risk is a statistically significant risk. Both Drs Revesz and Hansford have recommended against the use of EPO.

17 TL's parents are keen to try EPO as an alternative to the use of blood products, but I am satisfied that there would be a level of experimentation in doing so, and that the use of EPO would materially increase the risk of TL's death.

18 A comparison of the anticipated benefits of the chemotherapy and of the transfusions which are incidental to it, on the one hand, and the risks from that course of action, on the other, is an important consideration on an application of the present kind. Dr Revesz acknowledged that there are some risks in blood transfusions. These include the risk of infection, risks arising from the manner in which the blood transfusions are administered and, in some cases, risks of the patients developing allergies. However, the degree of risk of these kinds of complications being realised is quite small. The risk of transfusion transmitted infection is extremely rare in Australia.

19 I am satisfied that, considered from a clinical perspective, the benefits of TL having transfusions greatly outweigh the risks. Those benefits arise, as I say, from the alleviation of the depletion of elements in his blood which TL is almost certain to experience as a result of continued chemotherapy.

20 TL's parents, who are the first and second defendants to this action, are Jehovah's Witnesses. The receipt of transfusions of blood or of blood products is

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contrary to their religious convictions. Because of those convictions they have refused to consent to the WCH giving any blood transfusions to TL. TL himself is opposed to receiving blood transfusions.

21 I heard oral evidence from TL's father. I accept his evidence as being honest and reliable. I also accept that when giving his evidence TL's father was also communicating to the Court the views of his wife. TL's mother did not herself give evidence but she has the same conscientious objection to the use of transfusions.

22 Some things are quite clear from the evidence. TL's parents are very loving and caring, and have his best interests very much at heart. They are genuinely seeking a good outcome for TL. For them, a good outcome is an outcome which is good, both clinically and spiritually.

23 TL's parents are people of deep faith and strong conviction. Their opposition to TL having blood transfusions is not an arbitrary, or ill-considered, choice on their part. It is based in their faith and in their understanding of the scriptures, as explained by that faith. It is not necessary for me to discuss the scriptural basis for their beliefs: it is sufficient to say that I am well satisfied that their beliefs are honestly and conscientiously held.

24 TL's father said, in effect, that the receipt of blood transfusions by TL would be a serious affront to their emotional, spiritual and moral well-being. He and his wife consider that if TL is given blood, it will, in addition to the immediate emotional upset, have continuing adverse emotional and spiritual consequences, possibly for the rest of their lives. They fear that those consequences will manifest themselves in TL's psychological health, and in turn in his physical health. They are concerned about the overall impact upon the family relationships.

25 The evidence of TL's father also indicates that, that whatever be the outcome of this application, he and his wife will go on loving him and providing the same care and support for him as they have in the past.

26 Mr Croser read a statement which he obtained from TL yesterday afternoon in relation to the present application. While I recognise the limitations of such a statement as a substitute for evidence, it does appear to confirm Dr Revesz's opinion that TL is a bright articulate child with quite good insights into his own thinking and beliefs. TL too is a member of the Jehovah's Witness faith; he is learning the tenets of that faith; and adopting those tenets as he matures. It is that faith which provides the basis for his own opposition to receiving blood transfusions.

27 I am satisfied that TL has some understanding, albeit an incomplete understanding, of the nature of his condition. As already noted he has some insights into that condition, and into the way in which he himself thinks about it. TL understands that he is being treated with chemotherapy and understands that

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as part of that treatment the doctors have recommended blood transfusions. He does not wish to have those blood transfusions partly because of the effect which he perceives they will have on him, and partly because of his reluctance, in his words, "to make use of the part of the body of another person". TL says that he does not wish to die but nevertheless does not wish to take the blood which may be part of the treatment required to save him. TL wishes to behave in a way which conforms with the requirements of his God, as he perceives them to be. He fears being uncomfortable for the rest of his life if he is required to undergo the transfusion. Nevertheless, TL believes that his God will continue to love him even if this Court makes an order authorising the administration of transfusions.

28 It is appropriate, in my opinion, for the Court to have regard to TL's own expressions of his attitude to the receipt of blood transfusions, even though he is only 10 years old. I consider his expressed attitude to be a very relevant factor, although it is not the decisive consideration. As will be seen the authorities indicate that the overriding consideration is TL's best interests, however he perceives those interests at the present time.

29 In seeking an order permitting it to carry out blood transfusions and, in effect, orders requiring TL's parents to permit such treatment to be administered to him, the WCH invokes the inherent *parens patriae* jurisdiction of this Court. In the alternative, the WCH invokes the jurisdiction vested in the Family Court of Australia by the *Family Law Act 1975* (Cth),[1] which is cross-vested to this Court, at least in respect of the welfare of children, by the *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth).[2]

30 The *parens patriae* jurisdiction is a longstanding jurisdiction of this Court which can be exercised to protect the person and property of those citizens of this State who are unable to look after themselves. It is a jurisdiction which has existed for many centuries going back to the Court of Chancery in England.[3] As Mason J in *Fountain v Alexander* described it:

> The origin of the wardship jurisdiction was the Sovereign's feudal obligations as *parens patriae* to protect the person and property of his subjects, particularly those unable to look after themselves, such as infants.[4]

Lord Esher MR in *The Queen v Gyngall* described it as follows:

> But there was another and an absolutely different and distinguishable jurisdiction, which has been exercised by the Court of Chancery from time immemorial. That was not a jurisdiction to determine rights as between a parent and a stranger, or as between a parent and a child. It was a paternal jurisdiction, a judicially administrative jurisdiction, in virtue of which the Chancery Court was put to act on behalf of the Crown, as being the

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1 *Family Law Act 1975* (Cth) Part VII.
2 *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth) s 4(1).
3 *Chignola v Chignola* (1974) 9 SASR 479 at 480.
4 (1982) 150 CLR 615 at 633.

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guardian of all infants, in the place of a parent, and as if it were the parent of the child, thus superseding the natural guardianship of the parent.[5]

31 By virtue of section 17(2) of the *Supreme Court Act 1935* (SA) the Supreme Court is vested with the like jurisdiction as was formerly vested in, or capable of being exercised by, *inter alia*, the Court of Chancery.

32 The welfare of the child is the Court's first and paramount consideration and the Court must make its own independent judgment on any question which involves the interests of the child. While proper respect is paid to the views of the parents or of the child in question, when there is a conflict it is for the Court to decide what should occur. As Lord Esher MR described it:

> The Court is placed in a position by reason of the prerogative of the Crown as a supreme parent of children, and must exercise that jurisdiction in the manner in which a wise, affectionate, and careful parent would act for the welfare of the child. The natural parent in the particular case may be affectionate, and may be intending to act for the child's good, but unwise, and may not be doing what a wise, affectionate, and careful parent would do.[6]

33 Nevertheless, it is appropriate for the Court to act with caution. In this respect I refer to what was said by Fitzgibbons LJ in *Re O'Hara*:

> In exercising the jurisdiction to control or to ignore the parental right the Court must act cautiously. Not as if it were a private person acting with regard to its own child but acting so that the welfare of the child requires that the parental right should be suspended or superseded.[7]

34 This jurisdiction supports such orders relating to custody, care and control, protection of property, health problems, religious upbringing, and protection against harmful associations. These examples are by no means exhaustive and the jurisdiction of the Court extends "as far as is necessary for protection and education" of children.[8] There are several authorities indicating the *paren patriae* jurisdiction may be exercised to supplant parental decisions so as to authorise transfusions to be given to a child.[9] I am satisfied that the *parens patriae* jurisdiction is available to be exercised in the present case, and accordingly that it is unnecessary to rely upon the Family Court jurisdiction to which I referred earlier.

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5 [1893] 2 QB 232 at 239. See also at 247 per Kay LJ; *Wellesley v Wellesley* [1828] 2 Bligh NS 124 at 135-6; 4 ER 1078 at 1083; *Carseldine v Director of Department of Children's Services* (1974) 133 CLR 345 at 350-1; *Johnson v Director General of Social Welfare (Victoria)* (1976) 135 CLR 92 at 99; *Secretary of Department of Health & Community Services v JWB (Marion's Case)* (1992) 175 CLR 218 at 258-9.

6 *The Queen v Gyngall* [1893] 2 QB 232, 241-2.

7 [1900] 2 IR 232 at 240.

8 *Wellesley v Wellesley* [1828] 2 Bligh NS 124 at 136; 4 ER 1078 at 1083; *In Re X (a minor)* [1975] Fam 47 at 57; *AMS v AIF* (1999) 199 CLR 160 at 189.

9 See *Rolands v Rolands* (1983) 9 Fam LR 320; *Re Paul* [2008] NSWSC 960; *Re Bernard* [2009] NSWSC 11; *Director General of the Department of Community Services v BB* [1999] NSWSC 1169.

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35 I am further satisfied that the Court's *parens patriae* jurisdiction is not displaced by statute. In order to displace the Court's supervisory jurisdiction with respect to guardians and the welfare of children, Parliament must do so in unambiguous language.[10] It was not submitted by any party that the Court's *parens patriae* jurisdiction was displaced by statute.

36 By virtue of s 3 of the *Commonwealth Powers (Family Law) Act 1986* (SA), legislative power regarding, *inter alia*, the custody and guardianship of, and access to children, was referred to the Commonwealth Parliament. However, the exercise of powers with respect to the welfare of children was not referred in its entirety, and there was nothing in the referral which indicates any intention to affect this Court's inherent jurisdiction with respect to the welfare of children.[11] Consequently I do not consider the provisions of the *Family Law Act 1975* (Cth) oust this Court's *parens patriae* jurisdiction.

37 Under the *Childrens Protection Act 1993* (SA), the Youth Court may make a "care and protection order" if satisfied that a child is at risk.[12] Section 6(2)(aa) provides that, for the purposes of that Act, a child is at risk if "there is a significant risk that the child will suffer serious harm to his or her physical, psychological or emotional wellbeing against which he or she should have, but does not have, proper protection". The Solicitor-General submitted, correctly in my opinion, that these provisions too, fall short of ousting the Supreme Court's *parens patriae* jurisdiction.

38 Finally, I note that the *Consent to Treatment and Palliative Care Act 1995* (SA). Section 13 provides that a medical practitioner may lawfully administer medical treatment if, *inter alia*, that medical practitioner is of the opinion that the treatment is necessary to meet an *imminent* risk to life or health. I accept the Solicitor-General's submission that that section is intended to apply to a situation where the treatment is reactive rather than preventative or facilitative, a situation which is analogous to that faced by the NSW Supreme Court in *Director General of the Department of Community Services v BB*.[13] Accordingly, this power does not appear to be available in the present case, and it should not be concluded that the application to this Court by the WCH in relation to TL is unnecessary.

39 I now turn to consider the exercise of the *parens patriae* jurisdiction as it relates to the circumstances of the present case. The decisions of Santow J and Brereton J in *Director General of the Department of Community Services v BB*[14] and *Re Jules*[15] respectively provide useful assistance as to the proper approach.

40 I should say that I am satisfied that neither Dr Revesz nor Dr Hansford, is proceeding without regard to the beliefs of TL or of his parents. On the contrary,

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[10] *Johnson v Director-General of Social Welfare (Victoria)* (1976) 135 CLR 92 at 96-7; 99.
[11] *AMS v AIF* (1999) 199 CLR 160 at 244.
[12] *Childrens Protection Act 1993* (SA) Part 5 Division 2.
[13] [1999] NSWSC 1169 at [22].
[14] [1999] NSWSC 1169.
[15] [2008] NSWSC 1193.

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the evidence shows that they have so far endeavoured to accommodate those religious beliefs in the treatment which they are administering to TL. I accept that they too are concerned that TL should achieve a good clinical, emotional and psychological outcome.

41 This Court, too, should be concerned with TL's spiritual welfare as much as it is with his physical welfare. I respect the concerns which both TL and his parents have in that respect. In some respects this case is unusual because TL is at an age at which he can speak for himself, and he has done so in an articulate way. However, I think it appropriate for me to take into account that TL is still only 10 years old, and, necessarily, has not yet reached a stage of full maturity. The evaluation of the statement which Mr Croser read and the weight which I can attach to it should take that factor into account.

42 While I respect the religious beliefs of TL and his parents, and the strength of their faith and convictions, I am satisfied that it is in TL's best interests to receive blood transfusions as and when required as part of his treatment. My conclusion is based upon the evidence which I recited earlier as to the risks of a very grave outcome for TL if the WCH is not permitted to continue with the regime of recommended treatment, which regime requires from time to time transfusions of blood or of blood products.

43 In coming to that conclusion I have taken account of the expressions of intent of Drs Revesz and Hansford that they will keep the number of transfusions to the minimum necessary, and further that they will administer transfusions only when TL's haemoglobin levels fall to 60 grams per litre, or lower, rather than adopting the usual threshold of 70 grams per litre.

44 I am satisfied, while exercising the degree of caution which is appropriate in cases of this kind, that it is appropriate to make the orders sought. I indicate further that I am satisfied that it is not appropriate to wait until it is known that TL does in fact require a transfusion, and that it is preferable to make the orders today. Deferring making the orders would be productive of delay and would not, I think, be conducive to calm and un-pressured decision-making. I also accept the Solicitor-General's submission that it is desirable to let everyone know where they stand as soon as practicable.

45 I proceed on the basis that it is not necessary to make an order declaring TL a ward of the Court. The evidence indicates that an order to that effect is unnecessary. As I have said TL's parents are loving and caring and wish to act in his best interests. They have indicated that they will act in conformity with this Court's order. It is appropriate accordingly for this Court to frame an order in a way which minimises the disruption to their guardianship of TL.

46 I will make orders authorising the WCH to give transfusions of blood or of blood products to TL, and requiring TL's parents to comply with reasonable directions concerning the WCH's treatment of him.

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