CITATION:	*Fletcher (an infant by her litigation guardian Rylands) v Northern Territory of Australia* [2017] NTSC 62
PARTIES:	FLETCHER (AN INFANT BY HER LITIGATION GUARDIAN RYLANDS) v NORTHERN TERRITORY OF AUSTRALIA
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT exercising Territory jurisdiction
FILE NO:	No 7 of 2016 (21649341)
DELIVERED ON:	15 August 2017
DELIVERED AT:	Darwin
HEARING DATE:	16 November 2016
JUDGMENT OF:	Grant CJ

CATCHWORDS:

CHILD WELFARE OTHER THAN UNDER *FAMILY LAW ACT 1975* AND RELATED ACTS – LEGAL PROCEEDINGS – OTHER MATTERS

Application for orders authorising and directing the defendant to feed the plaintiff nasogastrically by force and against her will if necessary – a *Gillick* competent minor will ordinarily have the capacity to refuse medical treatment – the infant was not a *Gillick* competent minor with the capacity to refuse this particular form of medical treatment – in circumstances where a minor lacks the requisite capacity consent to medical treatment consent will ordinarily be provided by the child's parents or legal guardian – the court's

authorisation will be required for non-therapeutic procedures which carry a significant risk of making a wrong decision where the consequences of doing so would be particularly grave – involuntary nasogastric feeding in these circumstances is therapeutic in nature with no need for an order authorising that treatment – order only required by reason of the defendant's refusal to implement the treatment as recommended by eating disorder specialists – even if the infant had been a *Gillick* competent child an order authorising involuntary nasogastric feeding would have been justified – orders made authorising and directing the defendant not to unreasonably refuse nasogastric feeding.

Emergency Operations Act (NT) s 3
Supreme Court Rules (NT) r 59.06(1)

Director-General, New South Wales Department of Community Servicesv Y [1999] NSWSC 644, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, *Re GWW and CMW* (1997) 21 Fam LR 612, *Minister for Health v AS* (2004) 29 WAR 517, *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197, *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* (2004) 31 Fam LR 503, *Re C (Adult: Refusal of Medical Treatment)* [1994] 2 FCR 151, *Re Jane* (1988) 94 FLR 1, *Re M (Child: Refusal of Medical Treatment)* [2000] 52 BMLR 124, *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592, *Re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1992] 4 All ER 627, *Secretary, Department of Health and Community Services v JWB and SMB* (*Marion's case)* (1992) 175 CLR 218, *X v Sydney Children's Hospital Network* (2013) 85 NSWLR 294, referred to.

P Trowse, "Refusal of Medical Treatment – A Child's Prerogative" (2010) Vol 10 No 2 (QUTLJJ).

REPRESENTATION:

Counsel:

Plaintiff:	A Wyvill SC
Defendant:	T Anderson

Solicitors:

Plaintiff:	Povey Stirk
Defendant:	Solicitor for the Northern Territory

Judgment category classification:	B
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Fletcher (an infant by her litigation guardian Rylands) v Northern Territory of Australia [2017] NTSC 62
No 7 of 2016 (21649341)

BETWEEN:

FLETCHER (AN INFANT BY HER LITIGATION GUARDIAN RYLANDS)
Plaintiff

AND:

NORTHERN TERRITORY OF AUSTRALIA
Defendant

CORAM: GRANT CJ

REASONS FOR JUDGMENT

(Delivered 15 August 2017)

[1] By Originating Motion filed on 24 October 2016 the plaintiff sought orders "authorising" the defendant to feed the plaintiff nasogastrically, by force and against her will if necessary; and "directing" the defendant to feed the infant nasogastrically, by force and against her will if necessary, within a reasonable time after her attendance at a hospital facility owned and operated by the defendant, and upon one of the infant's parents authorising that treatment.

[2] During the course of a mention conducted on that same day pseudonym orders were made to protect the identities of the infant and her litigation guardian, and the matter was fixed for hearing on 16 November 2016.

[3] On 10 November 2016 the parties purported to file consent orders. The substantive terms were:-

(1) The defendant is authorised by its servants or agents to transport [the infant] to [the hospital] and to feed [the infant] nasogastrically if necessary by force and against her will.

(2) The defendant must not unreasonably refuse to feed [the infant] nasogastrically after she arrives at [the hospital] and at the request of one of her parents.

[4] Rule 59.06(1) of the *Supreme Court Rules* (NT) provides that the Order enabling the filing and entry of consent orders "does not apply if one or more of the parties to a proceeding is a person who is under a disability". That exclusion is predicated on the same general principle which requires the court's consideration and approval of any purported compromise of a claim by a person under a disability.

[5] Having regard to the provision, the parties were required to attend for hearing on 16 November 2016. The plaintiff filed written submissions in advance of the hearing. Following consideration of the plaintiff's

affidavit material and those submissions, the court gave judgment in terms consistent with the terms extracted above, and advised that it would publish reasons at a later date. These are those reasons.

The facts

[6] The facts may be briefly stated in a manner which does not undermine the purpose of the pseudonym orders.

[7] The infant had just turned 16 at the time the application was made. She had started exhibiting anorexic behaviours in mid-2015. She was formally diagnosed with *anorexia nervosa* in February 2016. By March 2016 the infant's weight had dropped to 43 kilograms and she was admitted to the Flinders Medical Centre. Her treatment plan in that institution reflected current international practice and placed emphasis on rapid weight restoration to reverse brain damage associated with malnutrition, to restore mental capacity, and to facilitate early recovery.

[8] The plan included nasogastric feeding to assist with weight restoration. That feeding modality was used to provide supplementary boli for any part of a meal purged or not eaten. The infant was discharged and returned to the Northern Territory after a two week program which restored her weight to almost 49 kilograms. Upon her return the infant stopped eating again and her weight dropped to 44 kilograms. She was admitted to the defendant's hospital and accepted nasogastric feeding

voluntarily. The infant was subsequently transferred back to the Flinders Medical Centre. Again, involuntary nasogastric feeding was employed if the infant failed to eat or complete a meal. That admission was of approximately three months' duration, during which the infant reached her target weight of 55 kilograms. That was achieved through a combination of family-based therapy and medical intervention, with assistance and input from the eating disorder team at the Westmead Hospital in Sydney. The infant was then discharged and became an outpatient at the Flinders Medical Centre.

[9] The experience in the infant's treatment was that involuntary feeding was required in particular at times of transition, including during the move to eating off the ward and the move to a flat with her family following her discharge. As part of the transition the medical centre implemented a system whereby the infant's family could return her to the centre immediately for involuntary feeding if she refused to eat.

[10] The next step in the infant's recovery was to facilitate her return home to the Northern Territory. At a conference involving specialists from the Flinders Medical Centre, Westmead Hospital and the defendant's Acting Medical Director, the defendant proposed a treatment plan under which the infant would be admitted to the defendant's hospital if she displayed signs of physiological instability, dehydration, abnormal ECG, electrolyte imbalance, or a rapid or consistent weight loss of more than one kilogram per week over several weeks. That plan

contemplated involuntary nasogastric feeding only if the infant was "at acute risk of serious medical compromise or death", in which event the hospital treating team would "consider" the provision of medical care under the *Emergency Medical Operations Act* (NT). Implicit in that plan was the misapprehension that the infant's consent was legally required for nasogastric feeding in the circumstances. The plan contemplated that the infant could either accept or decline feeding, or any other form of treatment.

[11] In the opinion of eating disorder specialists from the Flinders Medical Centre, the Westmead Hospital and Advanced Psychology Services, that plan was not optimal as it did not provide for involuntary feeding as a crucial early management strategy. In a joint report subsequently sent to the Acting Medical Director, those specialists detailed the leading evidence-based treatment for adolescent *anorexia nervosa*, and provided a history of the infant's medical history, diagnosis and treatment. That report made the points that involuntary nasogastric feeding as required was in the best interests of the infant, that the infant did not have the capacity to make decisions about nutrition in her best interests, and that the plan proposed by the Acting Medical Director was much less likely to lead to psychological recovery. Under that plan the infant would likely deteriorate rapidly and so undermine months of progress that had been achieved at the Flinders Medical Centre.

[12] The evidence from the infant's treating psychiatrist received during the course of the proceedings was to the effect that it was in the best interests of both the infant and her family to return to the Northern Territory. During the course of the infant's treatment at the Flinders Medical Centre she was noted to suffer from a particularly severe form of *anorexia*. That condition was properly characterised as a mental illness, which had the result of impairing the infant's judgement to the point that she did not have the capacity to make decisions about nutrition in a manner that was in her best interests. An incident of her condition was that she would not eat unless a failure to eat was met with nasogastric feeding, against her will if necessary.

[13] It was the psychiatrist's opinion that the availability of that measure had been the key to the infant's positive progress over her five-month admission to the Flinders Medical Centre. It was essential that the nasogastric feeding take place quickly in the event that there was a failure to eat. Should the infant relocate to the Northern Territory, any delay involved in transferring her interstate for that purpose would be detrimental to her progress. If the infant failed to eat without remedy, the potential consequences of that prolonged malnutrition would include premature death, infertility, osteoporosis, and cardiac and brain dysfunction.

[14] The evidence received from the infant's treating paediatrician was also to the effect that the option of involuntary nasogastric feeding was

crucial to containing the infant's symptoms and ensuring eating occurred as it should. That evidence reiterated the warning that adequate nutrition was essential to prevent the same complications spoken of by the treating psychiatrist.

[15] The paediatrician's opinion went on to observe that all medical staff and most paediatric nurses have been trained to insert nasogastric tubes. The requirement to treat patients against their will arises from time to time in practice, and all medical students and many nurses have been trained in the application of physical restraint in such cases. Appropriate guidelines have been promulgated in relation to both nasogastric feeding and patient restraint. Those observations were clearly directed to addressing any suggestion that involuntary nasogastric feeding could not be undertaken safely at the defendant's hospital.

[16] Despite the representations and opinions of the eating disorder specialists from the Flinders Medical Centre and the Westmead Hospital, the defendant's Acting Medical Director refused to adopt a plan which involved involuntary nasogastric feeding as an early intervention strategy. In adopting that position, the Acting Medical Director suggested that the infant was capable of making her own decisions regarding her healthcare. That asserted autonomy apparently included determining whether or not to eat despite the fact that the

infant was suffering from a severe form of *anorexia nervosa*. It was in the face of that attitude that these proceedings were brought.

Consideration

[17] As the orders sought and ultimately made contemplate the involuntary treatment of the infant, the starting point for any consideration of the issues is the common law principle that a minor with the requisite insight, maturity and competence may consent to therapeutic procedures.

[18] The common law position in England relating to a minor's competency to consent to treatment was established by the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*.[1] That case determined that minors may authorise medical treatment when they are old enough and mature enough to decide for themselves, provided they are capable of understanding what is proposed and expressing their own wishes. This concept has since commonly been referred to as that of the "Mature Minor" or "*Gillick* competent child".

[19] In *Secretary, Department of Health and Community Services v JWB and SMB* (*Marion's case*), the High Court affirmed the operation of the *Gillick* principle in Australia in the following terms:[2]

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1 [1986] AC 112.

2 *Secretary, Department of Health and Community Services v JWB and SMB* (*Marion's case)* (1992) 175 CLR 218 at 234 per Mason CJ, Dawson, Toohey and Gaudron JJ.

> A minor is, according to this principle, capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. This approach, though lacking the certainty of a fixed age rule, accords with experience and psychology. It should be followed in this country as part of the common law.

[20] The level of intelligence and understanding required is a question of fact. Judgement about a minor's competence involves a consideration of such matters as the ability to understand the issues and circumstances; the maturity and degree of autonomy; the age of the minor; the complexity and nature of the issue involved; and the nature and effect of any medical condition with which the minor presents.

[21] Although the issue under consideration in *Gillick* involved whether a doctor could lawfully prescribe contraception for a girl under 16 without her parents' consent, the operation of the principle is not confined to "medical treatment" narrowly defined. Rather, the principle is directed to the broader question of parental rights and a minor's capacity to make informed (or competent) decisions in relation to a range of matters.[3]

[22] Even before *Gillick* was decided the common law had, in a limited category of cases, recognised that the views and wishes of a child over

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3 By way of example, the principle also has application to the steps that may be taken to ensure that a child resides in a particular place. Under the common law, a parent cannot compel the return of a mature child who leaves home. The matter is generally governed by the principles laid down in *Gillick*, such that a court will not intervene to compel a child to return home if it is established that he or she has sufficient intelligence and understanding to make his or her own decision as to where to live.

a certain age demanded some consideration. These cases, known as the "age of discretion" cases, involved proceedings in which a parent or guardian sought a writ of *habeas corpus* to secure the return of a child who had left home without consent. The courts would refuse an order if the child had attained the age of discretion, which came to be regarded as 14 years for boys and 16 for girls, and the child did not wish to return. The principle underlying this refusal was that a child who had attained this age had sufficient understanding to make his or her own decisions.

[23] These concepts reflect the operation of broader principles in our legal system dictating the circumstances in which a person below the age of majority may nevertheless make determinations with legal consequences. Those principles operate in relation to such matters as criminal responsibility, the valid entry into contracts for those goods and services necessary to the maintenance of lifestyle, and the capacity to form beneficial contracts of employment.

[24] The common law principles continue to have application in those Australian jurisdictions which have not specifically legislated in relation to the issue of minors' consent to medical treatment, including the Northern Territory.[4] That leads necessarily to the questions arising

4 The matter has been the subject of legislative intervention in some Australian jurisdictions. In New South Wales, the *Minors (Property and Contracts) Act* 1970 prescribes that: a child aged 14 years or over may consent to his or her medical treatment, and the consent of the child will be effective in terms of defending an action for assault or battery relating to the treatment; and the parents of children under the age of 16 may validly consent to their child's medical treatment. In South Australia, the *Consent to*

in this case concerning whether a minor may refuse medical treatment; the circumstances in which the capacity of a minor in that respect will be subject to qualification (by, for example, parental consent or curial authorisation); and the circumstances in which authorisation of a medical procedure by a court will be required. A number of general propositions may be accepted in that respect.

[25] The first general proposition is that a *Gillick* competent minor will ordinarily have the capacity to refuse medical treatment, just as he or she will have the capacity to consent to medical treatment.

[26] The second general proposition is that where a minor lacks the requisite capacity, consent to medical treatment will ordinarily be provided by the child's parents or legal guardian.[5] Equally, the parents or guardian will have authority to refuse medical treatment on behalf of the minor.

Medical Treatment and Palliative Care Act 1995 prescribes that: an individual of 16 years of age or over can consent or refuse consent to medical treatment "as validly and effectively as an adult"; and in relation to children under the age of 16, when two medical practitioners believe and state in writing that certain treatment is in the best interests of the child and the child is "capable of understanding the nature, consequences and risks" involved, that child can validly consent to their own treatment. On the other hand, legislation in some Australian jurisdictions makes it an offence to administer a tattoo to a minor, and legislation has been enacted in Queensland prohibiting certain cosmetic surgery procedures being performed on minors, irrespective of capacity or consent.

5 The common law recognises an exception under which consent is not required in the case of emergency treatment: see, for example, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 189. The matter is dealt with by statute in the Northern Territory providing that a medical practitioner may perform an operation on a patient (including an infant) without consent where the patient is in danger of dying or of suffering a serious permanent disability and the performance of an operation on the patient is desirable in order to prevent that death or disability: *Emergency Medical Operations Act* (NT), s 3.

[27] The third general proposition is that the consent of the parents or guardian will be insufficient in relation to certain types of procedures. The central finding in *Marion's case* was that the authorisation of a superior court was necessary for the non-therapeutic sterilisation of a mentally handicapped minor; and that the parent alone cannot consent. This finding represents a qualification to the general rule that an incompetent minor's parent or guardian has power to consent to medical treatment of the child.

[28] By its reference to “therapeutic” and “non-therapeutic” procedures the Court was drawing a distinction between sterilisation which is a by-product of surgery appropriately carried out to treat some malfunction or disease, and sterilisation for the purpose of preventing hormonal flux, pregnancy and menstruation with its psychological and behavioural consequences (as in the case there under consideration).

[29] The former category of procedure was one falling within the ordinary power of parental consent. The latter category of procedure required court authorisation because of the significant risk of making a wrong decision in relation to the child's present or future capacity to consent or about the child's best interests, and because the consequences of a wrong decision would be particularly grave.

[30] Although the distinction between therapeutic and non-therapeutic procedures has understandably been criticised for artificiality,

uncertainty and imprecision,[6] it does not follow that such a test is of no value in determining which procedures properly require consent from a court invested with the *parens patriae* jurisdiction. Where a procedure has as a principal or major aim a non-therapeutic purpose, and the prospective patient is incapable of giving consent by reason of age or intellectual disability, the court's consent should be obtained. Having regard to the decision in *Marion's case*, that requirement operates only in relation to non-therapeutic procedures which carry a significant risk of making a wrong decision where the consequences of doing so would be particularly grave.[7]

[31] The fourth general proposition is that there are circumstances in which the principle of adolescent autonomy does not give a minor the right to refuse treatment that is in his or her best interests. The *parens patriae* jurisdiction may be exercised to authorise medical treatment where it has been refused by both a child and his or her parents.[8] So, for example, in *Re W (A Minor) (Medical Treatment: Courts Jurisdiction)*[9] the English Court of Appeal dealt with a case involving an otherwise

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6 See, for example, *Re Jane* (1988) 94 FLR 1. It may also be accepted that the procedure proposed in *Marion's case* might as a definitional matter be characterised as "therapeutic" rather than "non-therapeutic" given its purpose of preventing, or perhaps ameliorating, psychological and behavioural consequences.

7 Other examples would include gender reassignment, organ donation procedures, and bone marrow transplants. See, for example, P Trowse, "Refusal of Medical Treatment – A Child's Prerogative" (2010) Vol 10 No 2 (QUTLJJ), making reference to *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* (2004) 31 Fam LR 503; *Re GWW and CMW* (1997) 21 Fam LR 612.

8 *Director-General, New South Wales Department of Community Services v Y* [1999] NSWSC 644.

9 [1992] 4 All ER 627.

competent 16-year-old girl who was seriously ill with *anorexia nervosa* but refused treatment. The Court of Appeal left undisturbed a finding by the court below that the parents had power to authorise the child's transfer to a specialist unit in order to be force-fed.

[32] That finding would seem to have been justified on the ground that a superior court may intervene where an infant refuses medical treatment in circumstances which would probably result in death or severe permanent injury. In the course of reasons Lord Donaldson observed that one of the symptoms of *anorexia nervosa* is a desire by the sufferer to be in control and refusal of medical treatment is an obvious way of demonstrating this.[10] The power has been said to subsist regardless whether or not the child is *Gillick* competent.[11]

[33] The same approach has been adopted by some Australian courts. So, for example, the New South Wales Supreme Court has made orders for the detention and involuntary treatment in hospital of a 15-year-old suffering from *anorexia nervosa*.[12] Those orders were made notwithstanding that the treatment was also contrary to the wishes of the child's parents, who had been encouraging her to refuse treatment.

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10 *Re W (A Minor)* (*Medical Treatment: Courts Jurisdiction)* [1992] 4 All ER 627 at 631.

11 *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 at 602 (the administration of anti-psychotic drugs against the will of the child); *Re M (Child: Refusal of Medical Treatment)* [2000] 52 BMLR 124 (the authorisation of a heart transplant that had been refused by the child).

12 *Director-General, New South Wales Department of Community Services v Y* [1999] NSWSC 644 at [100]-[103]. See also *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 at [20], [24]; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197 at [25].

The exercise of the jurisdiction was predicated on the fact that the child's long-term health and survival were seriously at risk, and was not dependent upon a finding of incompetence.

[34] A similar disposition was made by the Supreme Court of Western Australia in relation to the authorisation of a blood transfusion for a *Gillick* competent child who had refused the treatment.[13] The minor in that case was a highly intelligent, mature and well-informed 15-year-old suffering from leukaemia. The court authorised the procedure despite the fact that the minor had expressly refused a blood transfusion on the basis of his religious beliefs.

[35] For reasons that will become apparent, it is unnecessary for the purposes of this case to determine whether the operative principle is that the *parens patriae* jurisdiction may be exercised in relation to *Gillick* competent children, or that a finding of *Gillick* competence only affords the child the same powers to refuse consent to medical treatment as his or her parents would otherwise have had.[14]

Application

[36] In the application of those general propositions, a number of conclusions may be drawn in relation to this matter.

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13 *Minister for Health v AS* [2004] WASC 286; 29 WAR 517 at [20]-[23]. See also *X v Sydney Children's Hospital Network* (2013) 85 NSWLR 294.

14 See discussion in P Trowse, "Refusal of Medical Treatment – A Child's Prerogative" (2010) Vol 10 No 2 (QUTLJJ).

[37] The first conclusion is that having regard to the nature of her medical condition the infant was not, on the balance of probabilities, a *Gillick* competent minor with the capacity to refuse this particular form of treatment. It has been recognised that a compulsive disorder may affect competency.[15] Disorders of that nature give rise to difficulties with thought processing, and changes in values. In particular, competence to refuse treatment may be compromised in people with *anorexia nervosa*.

[38] During the course of the infant's treatment at the Flinders Medical Centre she was noted to suffer from a particularly severe form of *anorexia*. That condition was properly characterised as a mental illness which had the result of impairing the infant's judgement to the point that she did not have the capacity to make decisions about nutrition in a manner that was in her best interests. To the extent that the Acting Medical Director had some different view of the matter, no basis for that view was proffered during the course of these proceedings.

[39] The second conclusion which may be drawn is that it would ordinarily have been open to the infant's parents to provide consent to the infant's medical treatment. If it is accepted that involuntary nasogastric feeding in these circumstances is therapeutic in nature (which is

15 *Re C (Adult: Refusal of Medical Treatment)* [1994] 2 FCR 151.

discussed further below), there was no need for an order of a court authorising that treatment in the exercise of the *parens patriae* jurisdiction. This is presumably why the medical practitioners at the Flinders Medical Centre considered it open to adopt that treatment modality without curial authorisation.

[40] It was open to the medical practitioners at the defendant's hospital to adopt the same course. To the extent that the defendant's servants and agents might possibly have considered themselves precluded from doing so by the operation of the *Emergency Medical Operations Act* except in the most acute circumstances, that was to misunderstand the legal position.

[41] The third conclusion which may be drawn, running on from the second, is that the purpose of involuntary nasogastric feeding in this situation was clearly therapeutic. Moreover, the decision to implement involuntary feeding did not carry a significant risk of grave consequences. On the other hand, on the evidence that presented, a decision not to employ involuntary nasogastric feeding as part of the infant's treatment carried a significant risk of retarding her recovery and giving rise to a range of adverse physiological and psychological consequences. Again, for that reason the court's authorisation was not required before that treatment could be implemented. The application to this court only became necessary upon the defendant's refusal to implement the treatment plan that had been in place for the preceding

six months and that had been recommended by the eating disorder specialists from the Flinders Medical Centre and the Westmead Hospital.

[42] The fourth conclusion which may be drawn is that even if the infant in this case had been a *Gillick* competent child, an order authorising involuntary nasogastric feeding would have been justified on the ground that to abide by the infant's refusal to eat would, on the medical evidence to hand, give rise to an unacceptable risk of permanent injury.

[43] It was for these reasons that the orders were made.
