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Case No: CO/5307/2004

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISON
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

23 January 2006

B e f o r e :

THE HONOURABLE MR JUSTICE SILBER

Between:

THE QUEEN ON THE APPLICATION OF SUE AXON	**Claimant**
- and -	
THE SECRETARY OF STATE FOR HEALTH	**Defendant**
THE FAMILY PLANNING ASSOCIATION	**Intervener**

Philip Havers QC and Peter Duckworth (instructed by Omerods of Croydon) for the Claimant
Philip Sales and Jason Coppel (instructed by Office of the Solicitor for the Department of Health) for the Defendant
Nathalie Lieven and David Blundell (instructed by Leigh Day and Co) for the Intervener
Hearing dates: 8-10 November 2005
(further written submissions supplied on 16 and, 21 and 24 November 2005)

HTML VERSION OF JUDGMENT

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Mr. Justice Silber:

(This Summary forms no part of the judgment)

1. This is an application by Sue Axon for declarations that (a) a doctor is under no obligation to keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually transmitted infections and abortion and must therefore not provide such advice and treatment without the parents' knowledge unless to do so would or might prejudice the child's physical or mental health so that it is in the child's best interest not to do so. The claimant's primary case is that this represents the nature and scope of the doctor's

duty of confidence in respect of all the above treatments. However, the claimant's alternative case is that, at the very least, this is his duty in respect of the provision of advice and treatment in respect of abortion and that (b) a document published by the Department of Health entitled "Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health" ("the 2004 Guidance") is unlawful.

2. In paragraphs 1-3 of the judgment, it is pointed out that this application is concerned with the position in which a young person under the age of 16 wishes to obtain advice and treatment on contraception, sexually transmitted illnesses and abortions but who cannot be persuaded to notify his or her parents or to let the medical professional inform his or her parents that their child is seeking advice or treatment on sexual matters. There is nothing in this judgment, which is intended to encourage young people to seek or to obtain advice or treatment on any sexual matters without first informing their parents and discussing matters with them. Indeed, everybody must hope that all young people will discuss these sexual matters with their parents at the earliest opportunity. After all in the overwhelming majority of cases, the best judges of a young person's welfare are his or her parents.

3. Paragraphs 4 to 8 of the judgment are devoted to explaining the claim while paragraphs 9 to 13 of the judgment explain what was decided by the majority of the House of Lords in **Gillick v West Norfolk and Wisbech Health Authority**[1986] 1 AC 112. Paragraph 13 sets out a summary of the most relevant comments. The interests of the parties in this application and the relevant statutory provisions are set out in paragraphs 15 to 18 and 19 to 21 of the judgment respectively.

4. The terms of the 2004 Guidance are set out in paragraphs 22 to 24 of the judgment and the issues are described in paragraphs 26 to 29 of the judgment. The evidence and the overseas authorities are commented upon in paragraphs 30 to 38 of the judgment,

5. Paragraphs 39 to 82 of the judgment are devoted to considering the claim that that the medical professional was under no obligation to keep confidential advice and treatment which he *proposed* to provide in respect of contraception, sexually transmitted infections and abortion and must, therefore, not provide such advice and treatment without the parent's knowledge unless to do so would or might prejudice a child's physical or mental health so that it is in the child's best interest to do so.

6. Paragraphs 83 to 91 of the judgment are devoted to the alternative claim to that set out in paragraph 5 of this summary that the claimant is entitled to a declaration in the form of that declaration but only in respect of the provision of *proposed* advice and treatment concerning abortion.

7. Paragraphs 93 to 96 of the judgment deal with the circumstances in which a medical professional can provide advice and treatment on sexual matters to a young person without parental knowledge and consent. These principles are summarised at paragraph 154 of the judgment.

8. Paragraphs 97 to 117 of the judgment are concerned with the contentions that the 2004 Guidance is unlawful.

9. Paragraphs 118 to 152 of the judgment are devoted to considering if a parent's article 8 rights are being infringed by the 2004 Guidance.

10. The conclusions of the judgment are set out in paragraphs 153 to 155 of the judgment and the circumstances in which a medical professional can provide advice and treatment on sexual matters to a young person without parental knowledge and consent are set out in paragraph 154 of the judgment. The claim has to be dismissed as the claimant is not entitled to the relief claimed, particularly in the light of the decision in **Gillick**, by which I am bound.

The Honourable Mr Justice Silber:

I. Introduction

1. Any person over the age of 16 years can give a valid consent to surgical or medical treatment (section 8(3) of the Family Law Reform Act 1969). Normally if it is proposed to provide surgical or medical treatment to a young person under the age of 16 years, the consent of that person's parent or guardian would be needed before the treatment could be given. This application is concerned with the position of a young person under the age of 16 who wishes to obtain advice and treatment on contraception, sexually transmitted illnesses and abortions but who cannot be persuaded to notify his or her parents or to let the medical professional inform his or her parents that their child is seeking advice or treatment on sexual matters. In particular, it raises the issue of how medical professionals (which is the term which I will use to describe doctors, nurses and other qualified medical staff who regularly now provide medical service on these matters) should advise and treat young people, who seek advice and treatment on sexual matters including abortions, contraception, sexual and reproductive health (which for convenience sake I will refer to collectively as "sexual matters") and who are capable of understanding the advice and its implications. In other words, this application is dealing with what everybody must regard as the very unfortunate situation in which a young person seeks or needs advice and treatment on contraception, sexually transmissible diseases or abortion but who is not prepared either to inform his or her parents or for his or her parents to be informed by the medical professional.

2. I stress that there is nothing in this judgment, which is intended to encourage young people to seek or to obtain advice or treatment on any sexual matters without first informing their parents and discussing matters with them. Indeed, everybody must hope that all young people will discuss these sexual matters with their parents at the earliest opportunity. After all, the best judges of a young person's welfare are almost invariably his or her parents.

3. As I will explain, the evidence shows that there is a realistic prospect that without being assured that the medical professionals would not inform their parents, some young people would not seek advice on sexual matters as they would not be prepared either to inform their parents themselves or to allow the medical professional to do so.

II. The Claim

4. On 29 July 2004, the Department of Health published a document, which was entitled *"Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under Sixteen on Contraception, Sexual and Reproductive Health"* ("the 2004 Guidance"). The lawfulness of the 2004 Guidance is in issue on this application.

5. The main issue raised on this application is whether and in what circumstances a health professional can provide advice and treatment on sexual matters to young people without their parents first being notified after the young person concerned has refused either to inform his or her parents themselves or to allow the medical professional to do so. The Secretary of State for Health ("the Secretary of State") maintains that a medical professional can provide such advice and treatment on sexual matters for young people under the age of sixteen years without the knowledge or consent of their parents provided that certain important and stringent conditions laid down by the House of Lords had been complied with. That is also the stance of the intervener on this application, which is the Family Planning Association ("Fpa"), which together with the Secretary of State submits that the 2004 Guidance is lawful.

6. Ms Susan Axon ("the claimant") contends that the 2004 Guidance is unlawful and that the medical professional:-

   "is under no obligation to keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually transmitted infections and abortion and the health

professional must, therefore, not provide such advice and treatment without the parent's knowledge unless to do so might prejudice the child's physical or mental health so that it is in the child's best interest not to do so. The Claimant's primary case is that this represents the position in respect of all the above treatments but at the very least, is his duty in respect of the provision of advice and treatment in respect of abortion"

7. This application raises a tension between two important principles of which the first is that a competent young person under sixteen years of age (who is able to understand all aspects of any advice, including its consequences) is an autonomous person, who first should be allowed to make decisions about his or her own health and second is entitled to confidentiality about such decisions even vis-à-vis his or her parents. The second principle is that a parent of a young person has a responsibility for that young person's health and moral welfare with the consequence that he or she should be informed if a medical professional is considering providing advice and treatment on sexual matters to that young person so that the parent could then advise and assist the young person. There is also a significant public policy dimension because there is evidence that without the guarantee of confidentiality, some of these young people might not seek advice or treatment from medical professionals on sexual matters with potentially disturbing consequences.

8. On this application, the claimant seeks the following relief:

   "*1. A declaration that the 2004 Guidance is unlawful in that it:*

   (1) misrepresents the decision of the House of Lords in Gillick whilst purporting to clarify it;

   (2) makes doctors and other health professionals the sole arbiters of what is in the best interests of a child;

   (3) makes informing parents the exception rather than the rule;

   (4) excludes parents from important decision-making about the life and welfare of their child;

   (5) fails in any event to discharge the State's positive obligation to give practical and effective protection to the Claimant's rights under article 8(1).

   2. A declaration that, other than in circumstances where disclosure would be likely to damage the child's physical or mental health-

   (1) doctors and other health professionals have a duty to consult the parents of a young person under 16 before providing advice and/or treatment in respect of contraception, sexually transmitted infections or abortions;

   (2) parents have a right to be informed about the proposed provision of advice and/or treatment in respect of contraception, sexually transmitted infections or abortions".

III. The Decision in Gillick v West Norfolk and Wisbech Health Authority [1986] 1 AC 112.

9. The starting point for the submissions of all parties has been the decision of the House of Lords in **Gillick v West Norfolk and Wisbech Area Health Authority** [1986] 1 AC 112 ("Gillick") in which a central issue for determination was whether a doctor could ever, in any circumstance, lawfully give contraceptive advice or treatment to a girl under the age of sixteen years of age without the consent of the girl's parents. The majority of the Appellate Committee, comprising of Lord Fraser of Tullybelton, Lord Scarman and Lord Bridge of Harwich, held that a doctor could give such advice and treatment to a girl under the age of sixteen if she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment and provided that certain conditions were satisfied. The claimant in that case had contended that the relevant previous Guidance issued by the Secretary of State

("the Pre-Gillick Guidance") was unlawful but the majority of the Appellate Committee reversed a previous decision of the Court of Appeal, which had upheld the claimant's complaint.

10. Lord Fraser explained at page 174B-D in a speech with which Lord Scarman and Lord Bridge expressly agreed that:

    "There may well be other cases where the doctor feels that because the girl is under the influence of her sexual partner or for some other reason there is no realistic prospect of her abstaining from intercourse. If that is right it points strongly to the desirability of her doctor being entitled in some cases, in the girl's best interest, to give her contraceptive advice and treatment if necessary without the consent or even the knowledge of her parents. The only practicable course is to entrust the doctor with a discretion to act in accordance with his view of what is best in the interests of the girl who is his patient. He should, of course, always seek to persuade her to tell her parents that she is seeking contraceptive advice, and the nature of the advice that she receives. At least he should seek to persuade her to agree to the doctor's informing the parents. But there may well be cases, and I think there will be some cases, where the girl refuses either to tell her parents herself or to permit the doctor to do so and in such cases, the doctor will, in my opinion, be justified in proceeding without the parent's consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or allow him to inform that parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

    That result ought not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would be failing to discharge his professional responsibilities, and I would expect him to be disciplined by his own professional body accordingly. The medical profession have in modern times come to be entrusted with very wide discretionary powers going beyond the strict limits of clinical judgment and there is nothing strange about entrusting them with this further responsibility which they alone are in a position to discharge satisfactorily".

11. I will refer to the matters numbered as (1)-(5) in Lord Fraser's speech as "Lord Fraser's Guidelines". The validity and relevance of these guidelines are not challenged by Mr Philip Havers QC for the Claimant, or by Mr Philip Sales for the Secretary of State or by Miss Nathalie Lieven for fpa. Indeed all counsel rely on them and the speeches of the majority in the House of Lords to support their submissions.

12. Lord Scarman stated that he agreed with Lord Fraser's speech, which means that he must have agreed with Lord Fraser's Guidelines but he also said at page 189A-E that:

    "It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances…... When applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long- term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. And it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refuses, not to prescribe

contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent".

13. Lord Bridge agreed with the speeches of both Lord Fraser and Lord Scarman although there are differences between them but Lord Bridge did not give any further guidance on the central issue in this case. I will return to consider different aspects of all the speeches in due course but it is significant that the majority approached the issue by considering parental rights in general terms before then turning to the specific matter raised on the appeal. The following important points emerge from the speeches of the majority of the Appellate Committee, which are that:

(i).*"Nor has our law ever treated the child as other than a person with capacities and rights recognised by law*" per Lord Scarman at page 184B

(ii) *"….parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child and towards other children in the family*" per Lord Fraser at page 170D-E. Similarly, Lord Scarman said *"parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child*"(page 184B) and *"parental right or power of control of the person and the property of his child exists primarily to enable the parent to discharge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and to make his own decisions*"(page 185E)*;*

(iii) "*even up till a young person's 18th birthday, the parental right] is a dwindling right which the courts will hesitate to enforce against the wishes of the child and the more so the older he is*" per Lord Denning MR in **Hewer v Bryant** [1970] 1 QB 357, 369. In **Gillick**, Lord Fraser at page 172 H explained that he "*agreed with every word of that and especially with the description of the father's authority as a dwindling right*" while Lord Scarman at page 186D said that these comments of Lord Denning *"captured the spirit and principle of the law";*

(iv) *"I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law*" per Lord Scarman at page 188H -189A;

(v) Lord Scarman then explained what he meant by *"sufficient understanding of what is involved to give a consent valid in law"* when he said with emphasis added at page 189 C-D that *"when applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is* ***much*** *to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given; she must also have a sufficient maturity to* ***understand what is involved****. There are* ***moral and family questions****, especially her relationship with her parents; long term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment*";

(vi) Lord Scarman then stated with emphasis added at page 189E that "*it further follows that ordinarily the proper course will be for [the doctor, as the pre-Gillick] guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental* ***knowledge and consent***";

(vii) Lord Fraser said at page 173 D that *"once the rule of the parent's absolute authority over minor children is abandoned, the solution to the problem in this appeal can no longer be found*

by referring to rigid parental rights at any particular age. The solution depends upon a judgment on what is best for the welfare of the particular child". He then said with emphasis added at page 174 D *"…I think there will be some cases, where the girl refuses either to tell the parents herself or to permit the doctor to do so and in such cases, the doctor will, in my opinion, be justified in proceeding without the parent's* ***consent or even knowledge*** *provided he is satisfied on the following matters [namely Lord Fraser's Guidelines, which are set out at paragraph 12 above]";*

(viii) The Guidelines set out by Lord Fraser were, as he stated at page 174 E *"not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would be failing to discharge his professional responsibilities, and I would accordingly expect him to be disciplined by his own professional body accordingly*";

(ix) It is noteworthy that both Lord Fraser and Lord Scarman sanctioned the provision of advice and treatment to young persons on sexual matters not only without **parental consent** but also without **parental knowledge**

14. As I have explained, the majority of the Appellate Committee in **Gillick** upheld as valid the pre-Gillick Guidance issued by the, then, Department of Health and Social Security but there is a fundamental dispute between the parties about whether the 2004 Guidance is compatible first with Lord Fraser's Guidelines, second with what was said in **Gillick**, and third with article 8(1) of the European Convention on Human Rights ("the ECHR"). The Secretary of State and the fpa contend that it is compatible and lawful while the claimant submits that not only is it incompatible but that it is also unlawful. It is now necessary to explain the interests of the parties to this application.

IV. The Parties

15. The Claimant is a divorced single parent with five children, the younger two of whom were daughters aged twelve and fifteen when these proceedings were commenced in 2004.

16. Twenty years ago, she underwent an abortion and she still regrets it. She hopes that neither of her daughters would have to undergo such an experience without their mother, the claimant, being present and being able to give guidance. The claimant considers that the 2004 Guidance undermines her role as a parent, as this role entails her being involved in helping her daughters during their early teenage years making wise decisions on matters such as contraception and, if necessary, abortion.

17. In her view, the prospect of her daughters receiving contraception or having an abortion without even her knowledge is horrifying because she cannot understand how it could be in the best interests of her daughters to undergo an abortion without the claimant as her mother having been consulted in order that she could then help them through the trauma of an abortion and provide them with an effective after care.

18. The predecessor of the Secretary of State issued the 2004 Guidance and thus she is the defendant. Fpa describes itself as the United Kingdom's leading sexual health charity, which works to improve sexual health reproductive rights among all people in the United Kingdom. Lightman J gave fpa permission not only to make written representations but also to make oral submission, which they have done. I have been greatly assisted by the wide-ranging and excellent written and oral submissions of all counsel for which I am very grateful.

V. The Statutory Provisions

19. Section 1 of the Children Act 1989 ("the 1989 Act") provides that in respect of the welfare of a child

"*(1) When a court determines any question with respect to-*

(a) the upbringing of a child; or

(b) the administration of a child's property or the application of any income arising from it, the child's welfare shall be the court's paramount consideration".

20. The parental responsibility for children is set out in section 2 of the 1989 Act, which insofar as is material provides that

    "(1) where a child's father and mother were married to each other at the time of his birth, they shall each have parental responsibility for the child…..

    (9) A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf".

21. Parental responsibility is defined in section 3 of the 1989 Act as follows:

    "*(1) In this Act "parental responsibility" means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property".*

VI. The Terms of the 2004 Guidance

22. The 2004 Guidance explains the duty of confidentiality owed by the medical professional in this way with footnotes omitted:

    "The duty of confidentiality owed to a person under 16, in any setting, is the same as that owed to any other person. This is enshrined in professional codes.

    All services providing advice and treatment on contraception, sexual and reproductive health should produce an explicit confidentiality policy which reflects this guidance and makes clear that young people under 16 have the same right to confidentiality as adults.

    Confidentiality policies should be prominently advertised, in partnership with health, education, youth and community services. Designated staff should be trained to answer questions. Local arrangements should provide for people whose first language is not English or who have communication difficulties.

    Employers have a duty to ensure that all staff maintain confidentiality, including the patient's registration and attendance at a service. They should also organise effective training, which will help fulfil information governance requirements.

    Deliberate breaches of confidentiality, other than as described below, should be serious disciplinary matters. Anyone discovering such breaches of confidentiality, however minor, including an inadvertent act, should directly inform a senior member of staff (e.g. the Caldicott Guardian) who should take appropriate action.

    The duty of confidentiality is not, however, absolute. Where a health professional believes that there is risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols, as outlined in Working Together to Safeguard Children. In these circumstances, the over-riding objective must be to safeguard the young person. If considering any disclosure of information to other agencies, including the police, staff should weigh up against the young person's right to privacy the degree of current or likely harm, what any such disclosure is intended to achieve and what the potential benefits are to the young person's well-being.

Any disclosure should be justifiable according to the particular facts of the case and legal advice should be sought in cases of doubt. Except in the most exceptional of circumstances, disclosure should only take place after consulting the young person and offering to support a voluntary disclosure".

23. The 2004 Guidance then proceeds to deal with the "Duty of Care" owed by doctors and health professionals stating that:

    "Doctors and other health professionals also have a duty of care, regardless of patient age.

    A doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

    1. She/he understands the advice provided and its implications.

    2. Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

    However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above.

    The personal beliefs of a practitioner should not prejudice the care offered to a young person. Any health professional who is not prepared to offer a confidential contraceptive service to young people must make alternative arrangements for them to be seen, as a matter of urgency, by another professional. These arrangements should be prominently advertised".

24. The practice to be adopted by medical professionals is explained in the 2004 guidance under the heading "Good Practice in providing Contraception and Sexual Health to Young People under 16" as follows:

    "It is considered good practice for doctors and other health professionals to consider the following issues when providing advice or treatment to young people under 16 on contraception, sexual and reproductive health.

    If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing:

    - The emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections.

    - Whether the relationship is mutually agreed and whether there may be coercion or abuse.

    - The benefits of informing their GP and the case for discussion with a parent or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.

    - Any additional counselling or support needs.

    Additionally, it is considered good practice for doctors and other health professionals to follow criteria outlined by Lord Fraser in 1985, in the House of Lord's ruling in the case of **Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security**. *These are commonly known as the Fraser Guidelines:*

    - the young person understands the health professional's advice;

- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;

- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;

- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health are both likely to suffer;

- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent".

25. It will be appreciated that what are described as "the Fraser guidelines" in the 2004 Guidance are attempts to paraphrase Lord Fraser's guidelines which are quoted in paragraph 10 above and I will have to consider if they do summarise them properly and accurately in section XII below.

VII. The Issues

26. Before setting out the issues, it is appropriate to mention that it is common ground that:

    (i) a young person under the age of 16 has the legal *capacity* to give valid consent to advice and treatment relating to contraception as well as sexual and reproductive health, including abortion;

    (ii) a medical professional, who gives such advice and treatment to a young person without his or her parent's consent, does not incur criminal liability;

    (iii) there are no statutory provisions, other than those set out in paragraphs 19 to 21 above, which are relevant to the issue of whether a parent has to be notified before a young person receives such advice or treatment;

    (iv) as the issue on this application is the legality of the 2004 Guidance, it is not relevant that the present application is for judicial review rather than an ordinary Queen's Bench action, which was the procedure adopted in **Gillick** and

    (v) the claimant has standing to bring her claim.

27. The major submission of Mr Havers is that the duty owed by a medical professional to a young person should be in the following terms

    "The doctor is under no obligation to keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually transmitted infections and abortion and must therefore not provide such advice and treatment without the parents' knowledge unless to do so would or might prejudice the child's physical or mental health so that it is in the child's best interest not to do so.

    The claimant's primary case is that this represents the nature and scope of the doctor's duty of confidence in respect of all the above treatments. However, the claimant's alternative case is that, at the very least, this is his duty in respect of the provision of advice and treatment in respect of abortion.

    Note: Before notifying the parents of the proposed advice and or treatment the doctor will, no doubt, wish to try to persuade the child whether to notify his/her parents himself/herself or to agree to the doctor doing so".

28. This submission, if accepted would in the view of the Secretary of State radically change the duties of medical professionals and the submission has three aspects to it each of which deserves very serious consideration. I should explain at this stage that the alternative claim of Mr. Havers in respect of limiting the duty of medical professionals for proposed abortion advice and treatment is in my view stronger than the alternative claim for limiting the duty for proposed treatment and advice on contraception and sexually transmitted illnesses because as he submits , unlike treatment for contraception and sexually transmitted illnesses, abortion first involves an invasive and irreversible procedure; second has potentially serious risks and side effects and third raises difficult moral issues. I will therefore consider it separately because if Mr. Havers is unsuccessful in establishing his proposed limitation for proposed treatment for contraception and sexually transmitted illnesses, he then has additional arguments for establishing the limitation for proposed treatment and advice for abortion. The first issue with which I will deal relates to the confidentiality of the *proposed* advice and treatment for contraception and sexually transmitted illnesses while the second relates to confidentiality of the *proposed* advice and treatment for abortion. The third aspect relates to the *actual* provision of treatment and advice for all sexual matters without parental knowledge. Similar and overlapping but not identical considerations apply to these three different issues as they all have to be considered on the assumption that the young person refuses to inform their parents or to allow the medical professional to do so. I will deal with the three situations separately in sections IX, X and XI below

29. It is convenient to deal with the submissions made by Mr Havers under the following heads, namely his contentions that;

(A) the claimant is entitled to the first part of the declaration in the terms set out in paragraph 27 above, (namely that the medical professional was under no obligation to keep confidential advice and treatment which he *proposed* to provide in respect of contraception and sexually transmitted infections and must , therefore , not provide such advice and treatment without the parent's knowledge unless to do so would or might prejudice a child's physical or mental health so that it is in the child's best interest to do so (" The limitation on the young person's right to confidentiality in relation to proposed advice and treatment on contraception and sexually transmissible diseases issue") which is dealt with in paragraphs 39 to 82 in section IX below;

(B) (as the alternative to A above) the claimant is entitled to a declaration in the form of paragraph (a) above but only in respect of the provision of proposed advice and treatment concerning abortion ("The limitation on the young person's right to confidentiality in relation to proposed advice and treatment on abortion issue"), which is dealt within paragraphs 83 to91 in section X below;

(C) the claimant is entitled to a declaration that a medical professional is not entitled to provide *actual* advice and treatment on contraception, sexually transmitted infections and abortion without the parents' knowledge unless to do so would or might prejudice the young person's physical or mental health so that it is in the young persons' best interests not to do so ("The provision of actual advice and treatment on sexual matters issue") which is dealt with in paragraphs 92 to 96 in section XI below;

(D) the 2004 Guidance is unlawful ("The guidance unlawfulness issue") which is dealt with in paragraphs 97 to 117 in section XII below and

(E) the 2004 Guidance fails to discharge the State's positive obligation to give practical and effective protection to the claimant's rights under article 8 of the ECHR (" The Article 8 issue") which is dealt with in paragraphs 118 to 152 in section XIII below.

VIII. The Evidence and the Overseas Authorities

30. It is appropriate to mention at this stage that there were many witness statements produced by the parties in this case and together with the exhibits, they filled eight large ring-binder files. The material in those files has been only of limited use to me because first on many issues,

there is limited statistical evidence. Second, much of the evidence comes from countries, such as the United States, in which the attitude to sexual matters and abortion is different from that in this country. Third, there is a dispute between certain of the experts which cannot be resolved satisfactorily without cross-examination. Finally, as I will explain, many of the issues which have to be determined on this application are questions of law on which the views of experts do not assist. Nevertheless, I have found some of the expert evidence to be helpful especially on the issue of the importance of confidentiality to many young people when they need advice and guidance on sexual matters.

31. At my request, counsel helpfully carried out a search to ascertain if there were any relevant Commonwealth or American cases on the issues raised in this application but they have not found any Commonwealth authority, which would be of assistance on the issues arising in this case.

32. Mr Havers seeks to rely on some American cases and principally on the decision of United States Supreme Court in **Planned Parenthood of South East Pennsylvania v Casey** 505 U.S. 833 (1992), which confirms that states may- but are not required to-impose requirements of parental notification and/or consent before an abortion may be provided to a minor, provided that there is a mechanism in the form of a "*judicial bypass*", which would enable a minor to obtain treatment without her parents' knowledge or consent.

33. I am grateful to counsel for their researches but having read **Casey** and the other American cases relied upon by Mr Havers, I have concluded that none of them are relevant to the issues before this court for three reasons, which were advocated by Mr Sales, of which the first is that, in the American cases, the issue of whether or not it is legitimate for States to impose parental notification or consent restrictions upon the availability of abortion is intimately bound up with the question of the extent to which women may have any prima facie right to seek an abortion at all. Hence the debate in **Casey** and the difference between the majority and minority views in the Supreme Court, centred upon the major issue of whether **Roe v Wade** (the authority which recognises the right to abortion) should be overruled. The majority comprising of five judges upheld it while the minority comprising of four judges held that it should be overruled. The same issue does not arise in this country, where the right to an abortion is clearly established in certain prescribed circumstances.

34. **Casey** and authorities like it are therefore concerned with what is described as the State's *"interest in the potentiality of human life*" (see for example page 837 of **Casey** at sub-paragraph (e)). That interest arises under the American Constitution and it reflects the cultural values of their society. There is no equivalent interest in the United Kingdom. Under the ECHR, the unborn are not covered by the right to life in article 2 (see, for example, **Vo v France** (2005) 40 EHRR 12). Therefore, the balance which must be struck under article 8 of the ECHR is between the rights of young people and the interests of their parents, and there is no third, potentially overriding, state interest in preserving unborn life. It would be an error to seek to apply American authorities to an English and European law context, which have been shaped by this different interest.

35. There are other relevant differences between the United States legal system and our legal system including the absence of first a judgment equivalent to **Gillick** recognising in competent minors a right to consent to medical treatment, and second a statute equivalent to the Family Law Reform Act 1968, conferring a general right to consent upon young people aged 16 or over as I explained in paragraph 1 above. In the United States, anyone under 18 is a minor and may be required to notify parents about, or seek their consent to, abortion. Accordingly, the principle of autonomy is far less well-developed in the United States in the case of young people than it is under our domestic law or under the ECHR.

36. Another very important consideration is that the domestic courts in Human Rights Act cases have often warned against the dangers of incorporating jurisprudence from other jurisdictions which arises under Charters of Rights, which are very different to the ECHR. The United States Constitution, which sets out absolute rights, leaves the courts to imply limitations on them while article 8 of ECHR is a good example of a totally different approach. Thus for

example, the High Court has rejected submissions based on Supreme Court freedom of expression cases where there is a challenge to restrictions on tobacco advertising based on EC and ECHR grounds. I respectfully agree with what McCombe J stated in **R (BAT) v Secretary of State for Health** [2004] EWHC 2493 (Admin), which was that:

"From these [US Supreme Court] cases, Mr Pannick submitted that care has to be exercised so as not to impede communication between manufacturers and adult consumers of a lawful product. I think, however, that Mr Sales was right to invite attention to certain features of the US law and the cases which must limit their relevance to the present case. First, the first amendment to the US Constitution is expressed in broad terms and does not have a "justification" provision such as article 10(2) of our Convention…. With the very greatest of respect to that distinguished court, it was dealing with the United States Constitution rather than our Convention. While it is instructive, in general terms, to see how another respected jurisdiction has dealt with a related but confined problem, the balance between State legislation and federal legislation in the United States is a subject of renowned complexity. Decisions on such matters can have limited effect on our consideration of the balance to be struck in considering a restriction of a limited Convention right and the measure of a discretion to be afforded to Parliament and ministers under our own rather different constitutional system"

37. A second reason why the American cases do not assist in this case is that the social and moral values of American society are very different from those which are prevalent in the United Kingdom. There is sensitivity and a controversy regarding the availability of abortion which does not exist on a comparable scale in this country.

38. Finally, the American cases are concerned with the availability of abortion and this raises the particular considerations which I have outlined. They do not support a general exception to the principle of confidentiality in the case of medical advice provided to young people, which is what the claimant seeks in this case. Nor can they be extended to the issue of an exception to the medical professional's duty of confidentiality, which is clamed in these proceedings.

IX. The limitation on the young person's right to confidentiality in relation to proposed advice and treatment on contraception and sexually transmissible diseases issue.

(i) The Issues

39. Mr Havers contends that the duty of confidence owed to the young person by a medical professional is limited vis-à-vis the young person's parents and he formulated the limitation using the word "doctor" to describe a medical professional in his claim for a declaration that:

"the doctor is under no obligation to keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually transmitted infections and abortion…. unless to do so would or might prejudice the child's physical or mental health so that it is in the child's best interest not to do so.

The claimant's primary case is that this represents the nature and scope of the doctor's duty of confidence in respect of all the above treatments. However, the claimant's alternative case is that, at the very least, this is his duty in respect of the provision of advice and treatment in respect of abortion.

Note: Before notifying the parents of the proposed advice and or treatment the doctor will, no doubt, wish to try to persuade the child whether to notify his/her parents himself/herself or to agree to the doctor doing so".

40. Mr Sales for the Secretary of State supported by Miss Lieven contends that the medical professional owes a duty of confidence to a young person and this duty cannot be overridden in the way Mr Havers suggests or in any similar way, especially where the medical professional is satisfied first that the young person understands the advice in the way in which

Lord Scarman indicated as appears at paragraph 13 (v) above and second that the best interests of the young person require that the advice or treatment be given.

(ii). The Claimant's Case

41. As the then President of the Family Division explained in **Venables v News Group Newspapers Limited** ([2001] Fam 430, 469),

"103…*children, like adults, are entitled to confidentiality in respect of certain areas or information…medical records are the obvious example"*

42. Similarly in **Re C (A Minor Wardship: Medical Treatment) (No 2)** [1990] Fam 39**,** the Court of Appeal indicated that an obligation of confidentiality was owed to a baby by those who had been caring for her (at 48G per Sir John Donaldson MR, at 52C per Balcombe LJ and at 55C per Nicholls LJ). The General Medical Council and the British Medical Association ("BMA") have consistently stressed the duty of confidentiality owed by doctors to competent young people. The claimant asserts that there is and should be a parental right to be notified because it is in every child's interests for his or her parents to be notified and Mr Havers describes this submission as "modest" while Mr Sales and Miss Lieven regard it as a fundamental change, which would appear to me to be the case in the light of the authorities to which I have referred and to the evidence, which shows that there is a generally held view within the BMA and other professional bodies that a duty of confidentiality is owed by a medical professional to a young person.

43. In determining whether Mr Havers is correct in so limiting the medical professional's duty of confidence, it is appropriate to consider the position relating to proposed advice and treatment on contraception and sexually transmitted disease before considering as a separate and discreet exercise the position in relation to proposed advice and treatment in relation to abortion. The reason is that any decision for a girl relating to abortion is, as Mr Havers correctly contends, likely to be more difficult and more demanding than decisions on, for example, treatment for sexually transmitted diseases and contraception because an abortion is an intrusive surgical intervention which cannot be reversed. There are also other distinguishing reasons, which I will explain in paragraph 83 below.

44. Mr Havers points out there are important features of the relationship between parents and their children, which support his submission that there has to be a limited duty of confidence owed by the medical professional to the young person in relation to that young person's parents. He stresses that a parent, rather than any third party, is responsible for the welfare of the young person under the age of 16 and so he contends that it follows that a parent is the best person for guiding and advising a young person of that age. Mr Havers also says that it is significant that parents have a duty to protect their children and to guide them on issues of education, social matters and health as well as having an interest in providing welfare for their children. He attaches weight to the significant public interest in promoting family life and that means that the courts should not sanction secrecy on any aspect of their children's lives, which is as important as sexual matters.

45. Mr Havers submits that the medical professional (unlike a parent) does not owe the same duties to a young person and if the medical professional is not relieved of the obligation to keep confidential from the young person's parents the proposed advice and treatment in respect of contraception and sexually transmitted diseases, this would undermine or destroy the important role that parents can and should play in advising and in helping their child. Mr Havers stresses that secrecy is destructive of family life and also that it is important for parents to be able to advise their children as to how to deal with the important issues of contraception, sexually transmitted infections and abortion. His case is that in order to fulfil their parental obligations to their children, parents must be sufficiently informed because if, as is contended to be the position by Mr Sales, there was a full and unlimited duty of confidentiality owed by a doctor to a young person, it would not then be possible for the young person's parents to fulfil this important obligation to advise and to help the child on matters as important as sexual matters. I have already set out in paragraphs 18 to 20 above the

obligation owed by a parent to a child in the 1989 Act on which the claimant also relies. I was instinctively attracted and continue to be attracted by these factors, which have been relied on by Mr Havers and which I will call "the family factors" but nevertheless they have to be considered and appraised against the background first of **Gillick** and other legal authority, second of the evidence in this case, third of the crucial fact that a young person does not want his or her parents to be informed, fourth of the risk that the young person will not seek or obtain advice on sexual matters together and fifth of the consequences of that risk. I stress that this issue is only relevant where a young person in the particular case with which we are concerned now does not want his or her parents to be informed.

46. Mr Havers contends that his submission for a limitation on the duty of confidentiality owed by a medical professional to a young person is consistent with the "broad general principle" explained by Lord Goff in **Attorney General v Guardian Newspapers [No2]**[1990] 1 AC 109,281B-C when he said:

"that a duty of confidence arises when confidential information comes to knowledge of a person(the confidant) in circumstances where he has notice, or has held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others…. The existence of this broad general principle reflects the fact that there is such a public interest in the maintenance of confidences, that the law will provide remedies for their protection".

Lord Goff raised three limiting principles of which the only one relevant to the present application is the third one, which he stated at page 282E was :

"that although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure…It is this limiting principle which may require a court to carry out a balancing operation in maintaining confidence against a countervailing public interest favouring disclosure"

47. It is Mr Havers' submission that the "public interest" of having the duty of confidence owed by a doctor to a young person limited in relation to the young person's parents in the way he advocates is so important as to outweigh any private interest of the young person. He relies on the family factors as being of paramount importance because of the benefits that parental guidance gives to the child. Mr Havers seeks to fortify his submission by relying on "the conscionability route", namely that *"the basis of the obligation to respect confidences… lies in the notion of an obligation of conscience arising from the circumstances in or through which information was communicated or obtained"* which was expressed by the Federal Court of Australia in **Smith Kline and French Laboratories** (**Australia) Ltd v Secretary to the Department of Community Services and Health** [1991] 99 ALR 679, 692 and which was quoted with apparent approval by Simon Brown LJ (as he then was) in **R v Department of Health ex parte Source Informatics Ltd** ([2001] QB 423 at 436).

(ii) The Secretary of State's Case

48. Mr Sales with Miss Lieven's support submits that no limitations should be placed on the duty of confidence owed by the medical professional to the young person in the way Mr Havers advocates because any such limitation cannot be justified by the decision in **Gillick** or by public policy considerations, which are underpinned by the evidence in this case to which I will have to return later in this judgment.

(iii) Conclusions

49. I readily accept the potency of the family factor considerations advocated by Mr Havers but for reasons which I will now seek to explain, I am unable to agree that there should be any exception to the duty of confidence along the lines advocated by Mr Havers. In reaching that

conclusion, I should record that it has not been suggested that the duty in respect of confidentiality should be different in the case of proposed contraceptive advice and treatment from that in respect of proposed advice and treatment for sexually transmissible disease and in my view there is no reason why they should be treated differently. I reach the decision that I cannot accept Mr Havers` formulation of the duty of confidence owed by medical professionals for a number of reasons, some of which are overlapping and which I will now set out in no particular order of importance.

50. First, a similar limitation to that advocated by Mr Havers was *implicitly* rejected by the majority of the Appellate Committee in **Gillick,** who had to determine among other matters whether there was a limitation on the doctor's duty of confidence.

51. The case for the claimant mother in **Gillick** was put in a number of different ways, all of which were ultimately and carefully aimed at establishing an obligation on the part of a doctor to obtain the consent of a young person's parents before giving contraceptive advice to a young person. Mr Gerald Wright QC on behalf of the claimant mother had submitted at page 157D-G that

"*Parents have the legal responsibility for the physical and moral care and upbringing of their children....The law supports that responsibility by granting and enforcing a power or right of control which extends to all major decisions concerning the welfare of the child in question...'Major decisions' extend to and include a decision as to contraceptive treatment. A doctor has no right or power to make his own independent decision as to contraceptive treatment what ever the wishes of the female child in question. His duty is to advise and assist the parent or person in loco parentis, or the court, in carrying out that party's duty to care for the child in question*".

52. Mr David Poole QC (as he then was), who was also counsel for the claimant mother in that case, also submitted to the Appellate Committee at page 161H-162J that:

"Where a child is living with the parents, a doctor who communicates with a parent who is responsible for the child would not be in breach of confidence. At common law, the doctor would in such case be free to make disclosure to the parents. When faced with a child patient, the doctor's duty of confidentiality would be adjusted to take in the child's lack of capacity to consent and the parental responsibility".

53. These submissions show that it was the case of the claimant mother in **Gillick** that the doctor was obliged to notify a parent before giving advice or treatment on contraception. There are some differences between, on the one hand, the formulation of Mr Poole by which the doctor *"would not be in breach of confidence*" if he disclosed matters to a parent and, on the other hand, Mr Havers` formulation, which states that *"the doctor is under no obligation to keep confidential"* matters disclosed by the young person. In addition, unlike Mr Poole's limitation, Mr Havers` formulation has a proviso but it is noteworthy that both formulations constitute major exceptions to the duty of confidence owed to the young person by his or her medical adviser. If the submissions of Mr Wright and Mr Poole had been accepted, it would have meant that Mrs Gillick would have been entitled to have been informed of any request by her child for contraceptive advice or treatment, and so the claimant would have succeeded on her appeal. But as I have explained that is not what occurred although as Mr Havers correctly says, the arguments on behalf of Mrs Gillick set out in the previous two paragraphs were not *expressly rejected* or commented upon by the majority of the Appellate Committee.

54. The submissions of Mr Wright and of Mr Poole were *impliedly* rejected by the majority of the Appellate Committee in **Gillick**. The Appellate Committee was considering an appeal against the order of the Court of Appeal which had, inter alia, made the second declaration sought by Mrs Gillick, which was against the Area Health Authority to the effect that *"no doctor or other health professional employed by [the Area Health Authority] either in the Family Planning Service or otherwise might give any contraceptive and/or abortion advice and/or treatment to any child of the plaintiff below the age of 16 without the prior knowledge and consent of the child's parent or guardian*" but with the addition of the words *"save in cases of emergency or*

with leave of the court" (per Parker LJ ibid at page 138F-G and Fox LJ at page 146D). In essence, this required the doctor to ensure that the parents of the young child were notified before advice or medical treatment was given on contraception. The majority of the Appellate Committee allowed the appeal against that second declaration made by the Court of Appeal with Lord Fraser describing it as *"erroneous*" (page 176A) and with Lord Scarman regarding it as "*erroneous in law"* (page 191E) while Lord Bridge agreed with both Lord Fraser and Lord Scarman.

55. In my view, the decision of the majority of the Appellate Committee in **Gillick** shows that they had *impliedly* rejected the submission that a medical professional was obliged to inform the young person's parents or to ensure that they were informed about proposed advice on contraception that would be given to the child.

56. My second reason, which overlaps to a substantial degree with the first reason, is that the *reasoning* of the majority of the Appellate Committee in **Gillick** is inconsistent with the limitation on the duty of confidence owed by the medical professional of the kind submitted by Mr Havers. As I have explained in paragraph 13 above, the reasoning of the majority was that the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed, with the result that the doctor was entitled in cases in which it was appropriate to do so, to provide advice and treatment to a young person on sexual matters without parental knowledge subject to the conditions, which I have described in paragraph 13 above.

57. Thus, the majority concluded that the refusal of the competent young person to *notify* his or her parents of contraceptive treatment did not mean that the treatment could not be given as it was permissible for the doctor to give it provided that certain conditions were satisfied. Indeed, as I have explained, Lord Fraser with emphasis added said at page 174C:

    "there may well be cases, and I think there will be some cases, where the girl refuses either to tell the parents herself or to permit the doctor to do so and in such cases, the doctor will, in my opinion, be justified in proceeding without the parent's consent or even ***knowledge*** *provided [that Lord Fraser's guidelines are adhered to]".*

58. This approach with which Lords Scarman and Bridge agreed also shows that the submissions of Mr Wright QC and Mr Poole QC to which I referred in paragraphs 51 and 52 above, were not accepted. Lord Scarman (with whom Lord Bridge agreed) explained with emphasis added at page 189 E in **Gillick:**

    "that ordinarily the proper course would be for [the doctor], as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refused, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental ***knowledge*** *and consent" .*

59. The salient feature of the majority's approach in **Gillick** was that in certain circumstances, the medical professional need not *notify* the young person's parents before giving contraceptive advice or treatment. This conclusion is inconsistent with Mr Havers' formulation of the limitation on the duty of confidence, which means that in cases not covered by his proviso, the parents had to be notified and could then take such steps as they thought appropriate. Indeed, if the submissions of Mr Wright and Mr Poole had been accepted in **Gillick**, there would have been no need for anything to be said other than that parents would have had to have been told that their daughter was being given advice and treatment in respect of contraception.

60. A third reason, which overlaps with the first two reasons, why I cannot accept Mr Havers' contention is that if the medical professional was entitled or obliged to tell a parent sexual matters that the young person had told the doctor in confidence in the circumstances suggested by Mr Havers, then it would follow that **Gillick** was wrongly decided.

61. The basis of the **Gillick** decision was that a doctor's duty was vis-à-vis the girl's parents was initially to "*seek to persuade the girl to bring her parents into consultation*" (per Lord Scarman at page 189E) and "*always seek to persuade [the girl] to tell her parents that she is seeking contraceptive advice, and the nature of the advice she receives*" (per Lord Fraser at page 174E). If those attempts failed, then the majority decision in **Gillick** allowed the medical professionals to provide contraceptive advice and treatment subject to certain important conditions being complied with. Mr Havers` formulation of the limitation on the duty of confidentiality would mean that the majority in **Gillick** were wrong as, subject to the proviso, the medical professional would have been entitled to pass on information on sexual matters to the parent of the child patient. I have already explained in paragraph 54 above that the majority in Gillick rejected the claim to the second declaration and that this is inconsistent with Mr Havers' contentions. If Mr Havers' contentions on this issue were to be accepted, it would seem that the claimant would have succeeded by the back door after the defeat for similar submissions suffered at the front door in the House of Lords in **Gillick** .

62. Fourth, the very basis and nature of the information which a doctor or a medical professional receives relating to the sexual and reproductive health of any patient of whatever age deserves the highest degree of confidentiality and this factor undermines the existence of a limitation on the duty of disclosure as advocated by Mr Havers. As Sir Roger Toulson writing extra-judicially and Mr C M Phipps explain, " *the doctor stands in a confidential relationship to every patient of whatever age but the purpose of the relationship is the welfare of the patient"* (**Confidentiality** (1996) page 153); in my view, that purpose must not be forgotten or under-estimated.

63. Baroness Hale of Richmond also stated in **Campbell v MGN Ltd** [2004] 2 AC 457 at 499 [145] that.

    "it has always been accepted that information about a person's health and treatment for ill health is both private and confidential. This stems not only from the confidentiality of the doctor- patient relationship but from the nature of the information itself. As the European Court of Human Rights put it in Z v Finland (1997) 25EHRR 371,405-406, paragraph 95;

    `Respecting the confidentiality of health data is a vital principle in the legal system of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community`

64. It is appropriate to bear in mind that the ECHR attaches great value to the rights of children as I will explain in paragraphs 144 to 146 below. Furthermore the ratification by the United Kingdom of the United Nations Convention on the Rights of the Child ("UNC") in November 1989 was significant as showing a desire to give children greater rights. The ECHR and the UNC show why the duty of confidence owed by a medical professional to a competent young person is a high one and which therefore should not be overridden except for a very powerful reason. In my view, although family factors are significant and cogent, they should not override the duty of confidentiality owed to the child. It must not be forgotten that this duty was described in **Z v Finland** (supra) as *"a vital principle in the legal system of all Contracting Parties to the Convention".*

65. Mr Havers points out that the claimant in that case was not a child but that is not a distinction of decisive or any great importance especially where the child is sufficiently mature to be able to understand the consequences of his or her decision. I am fortified in reaching to that conclusion by the fact that in **Yousef v Netherlands** (2003) 36 EHRR 20, the European Court of Human Rights explained with emphasis added that in *"judicial decisions where the rights under article 8 of parents and of a child are at stake, the child's rights* **must** *be the paramount*

consideration"[73]. By parity of reasoning, I consider that the child's claim to confidentiality should not be overridden in the way, which Mr Havers advocates.

66. A fifth reason why I cannot accept Mr Havers' contention (that there should be a limitation on the medical professional's duty to a young person so as to permit the medical professional to pass on information to the young person's parents) is that such a limitation could only be justified if the medical professional's duty of confidence is in the word of Lord Goff ,which I quoted in paragraph 46 above *" outweighed by some other countervailing public interest which favours disclosure"* but, as I will explain, the proposed limitation cannot satisfy that requirement. Indeed as I have already pointed out in paragraph 46 above, Lord Goff has explained the justification of confidence as being with emphasis added that "*the existence of this broad general principle reflects the fact that there is such a **public** interest in the maintenance of confidences, that the law will provide remedies for their protection*". A matter of importance in determining what the public interest requires in relation to the existence and nature of any limitation of any duty owed by a medical professional to a young person must inevitably be to predict the consequence of any such limitation. In this connection, it is very significant that there will be a group of young people, who do not want their parents to be notified of what they might discuss with a medical professional for a wide variety of reasons, which might include hostility to their parents, a wish for privacy or even plain embarrassment. As I will explain shortly, the evidence before me shows that the lack of confidentiality would probably or might well deter young people from seeking advice and treatment on contraception, sexually transmitted diseases and abortion, and this would have undesirable and troubled consequences. Such evidence to which I will turn shortly in the next few paragraphs below satisfies me in respect of the information obtained by medical professionals that in Lord Goff's words "*that there is such a public interest in the maintenance of confidences, that the law will provide remedies for their protection*" in the law as it now stands without the change proposed by Mr Havers and which is not "*outweighed by some other countervailing public interest which favours disclosure*" . I will now summarise this evidence which underpins that conclusion.

67. It is common ground that there is evidence in this case which demonstrates that when medical professionals were not precluded from passing on information to the young person's parents, this led to a reduced use by young people of medical professionals for advice and treatment on contraceptive and abortion services. As Dr Fiona Adshead, the Deputy Chief Medical officer in the Health and Social Standard Group of the Department of Health, points out in her witness statement that in addition to this evidence, the anecdotal evidence obtained by the Department shows that "*reluctance to access contraceptive advice increases the risk of pregnancy, of abortion at a later stage of pregnancy, and of sexually transmitted infection".* This is also borne out by some statistical evidence.

68. It will be recollected that in December 1984, the Court of Appeal held in **Gillick** that any doctor, who gave contraceptive treatment to a girl under sixteen without the consent of her parent or guardian, would be infringing the inalienable and legally enforceable right of parents relating to the custody and upbringing of their children, which save in an emergency could not be overridden otherwise than by leave of the court in an emergency. As a result of this decision, the Department of Health issued guidance, which suspended the pre-Gillick guidance and made explicit that, save in emergencies, doctors and other health professionals should not prescribe contraceptives or provide advice or treatment for abortion to a young person under 16 without parental consent or a court order. As I have explained, the Court of Appeal decision was reversed by the House of Lords in October 1985 but significantly in the period between the decision of the Court of Appeal in **Gillick** and that of the House of Lords during which medical professionals were required to pass on information to children's parents, the number of young women aged under 16 who sought advice on contraception fell from 1.7 per resident thousand to 1.2 per resident thousand, which was a striking and disturbing reduction of just under one-third. In addition, the rates of attendance at places where contraception advice and treatment were given did not return until 1988-89 (or until 1990 according to the Brook organisation) to their previous levels prior to the Court of Appeal decision in December 1984. These statistics provide clear and powerful evidence of what happens when young people are not assured of confidentiality when they are considering obtaining advice and treatment on sexual matters. There is additionally cogent evidence that

doctors also clearly appreciate the importance of confidentiality to young people, who are considering seeking guidance on sexual matters.

69. I should add that this is not surprising as it was to be expected that the removal of confidentiality would inevitably deter some young people from seeking advice and treatment on sexual matters as they would not want their parents to know of their sexual activities or the results of them. I am fortified in coming to conclusion by the evidence contained in the witness statements and the exhibits which show that:

(a) in 2004, the British Market Research Bureau conducted a survey entitled "Evaluation of Teenage Pregnancy Strategy" which found that when young people aged between 13 and 21 were asked what attributes were most important to them when seeking advice on matters relating to sex and relationships, the single most important factor for them was not surprisingly found to be confidentiality and privacy.

(b) in the same survey, it was found that 88% of those samples of young people agreed with the proposition that *"I am confident that anything I discuss with a doctor or in a clinic remains private*".

(c) in a report published by Save the Children in 2002 entitled *"Get Real: Providing Dedicated Sexual Health Services for Young People",* young people had been canvassed about what they were looking for in sexual health services and one of the most important characteristics was that they were confidential.

(d) the Teenage Pregnancy Unit of the Department of Health recently commissioned research entitled " *Exploring the Attitudes and Behaviours of Bangladeshi, Indian and Jamaican young people in relation to Reproductive and Sexual Health*" which involved interviews with young people aged 13 to 21 from these groups and with a small number of parents. Concerns were expressed that the general practitioner might disclose personal information to other family members registered with the practice. This concern about the lack confidentiality was particularly strong among young people of Indian origin.

(e) the view that a guarantee of confidentiality is crucial to encourage teenagers to obtain contraceptive advice and treatment is widely held within the medical profession as is shown by a BMA publication entitled "Consent, Rights and Choices in Healthcare for Children and Young People" which explained that *"research shows that worries about confidentiality dissuade some young people from approaching their doctors about health matters, although this does not necessarily account for high teenage pregnancy rates since many teenagers who become pregnant have obtained contraceptive advice from their GP*".

(f) in 2000 the *Confidentiality Toolkit* which was a publication endorsed by a wide range of medical professional bodies, explained that "teenagers' early uptake of sexual and other health advice will not be improved until young people develop more trust in the confidentiality of their practice"

(g) the need to ensure that young people have a right to confidentiality is an important feature of " The Nordic Resolution on Sexual and Reproduction Health and Rights of Young People" which was developed and adopted by the Family Planning Associations of Denmark, Iceland, Finland, Norway and Sweden in 1998. Those countries have enjoyed particular success in reducing rates of teenage pregnancy.

70. As I have already explained in paragraph 63 above, Baroness Hale cited with approval the statement of the European Court of Human Rights in **Z v Finland** that without the protection of assured confidentiality,

"those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary to receive appropriate treatment, and even

from seeking such assistance, thereby endangering their own health, and, in the case of transmissible diseases, that of the community".

71. Dr Ann McPherson, an experienced general practitioner, who is also a part-time lecturer in the Department of General Practice at the University of Oxford, confirms this by explaining that she has:

    "no doubt that a more restrictive approach to the right of confidentiality of young persons under 16 than laid down in the [2004] Guidance would have the result of increasing the number of pregnancies and sexually transmissible illnesses".

72. I appreciate that Mr Havers is not proposing that medical professionals will be at liberty to disclose all advice and treatment, which it is proposed to give in respect of contraception and sexually transmitted infections because on his formulation, the medical professional would be entitled not to disclose information where *"to do so would or might prejudice the child's physical or mental health so that it is in the child's best interest not to do so*". Nevertheless the fact that the *general rule* would be that medical professionals could pass on advice and confidential details of treatment to parents would be likely to have the effect of deterring many young people from seeking advice on sexual matters as happened between the decision of the Court of Appeal and that of the House of Lords in **Gillick**, as I have explained in paragraph 68. I consider that the likely foreseeable consequences of such development to be very disturbing, if not chilling.

73. Thus, if, for example, a young person with a sexually transmitted infection was deterred from obtaining medical advice and treatment because of a fear that this information would be passed to his or her parents, this failure to obtain advice and treatment might well not only damage this young person's health but it might also have serious adverse consequences for any of the young person's past, present or future partners. By the same token, if a young person was very likely to begin or to continue having sexual intercourse with or without contraceptive treatment, it is worrying that Mr Havers` formulation might well mean that such a young person would be deterred from obtaining advice and treatment because that young person would be worried about the prospect of his or her parents being be told of this advice and treatment by the medical practitioner; this might well mean that he or she would not use contraceptives with the obvious and inevitable risks. Similarly , the young person who was pregnant might well be deterred from obtaining advice and so she would be unable to decide if she wanted an abortion or she might be forced to seek the assistance of an unqualified abortionist. Although Mr Havers describes his proposal as "modest", it might well have very undesirable and far-reaching consequences for those young people, who would be deterred by it from consulting medical professionals.

74. Sixth, a significant practical problem might well arise in connection with the proviso to Mr Havers` formulation in that it would or might be difficult for a young person to know precisely if and when information on sexual matters would be passed on by the medical professional to the young person's parents. This fact and the risk that his or her parents might be informed might also deter the young person from consulting a medical professional because they would not consult a medical professional on sexual matters unless they were certain that these matters would be regarded as confidential by the medical professional. It will be recollected that Mr Havers` formulation would enable the medical professional to pass on such information without the young person's consent *"unless to do so would or might prejudice the child's physical or mental health so that it is in the child's best interests not to do so"* and it is the practical effect of this proviso which causes me some concern.

75. This proviso means that a consultation between the young person and the medical professional might well start with the young person outlining his or her problem on the relevant sexual matter, whether it be relating to contraception or the possibility of him or her suffering from a sexually transmitted infection. Then, if the medical professional had failed to persuade the young person to tell his or her parents, the medical professional would then be obliged to tell the young person that the advice or treatment, which he was proposing, would have to be communicated to the child's parents *"unless to do so would or might prejudice the child's*

physical or mental health so that it is in the child's best interest not to do so". The young person would probably not know at that point of the consultation with the medical professional if his or her case would fall within the proviso. The resultant uncertainty might either lead to a premature end by the young person of the consultation with the medical professional or it also might have the effect of deterring the young person from initially seeking the necessary advice and treatment when the legal position was explained. Either of these consequences is disturbing because it is highly desirable that the young person should in appropriate cases not be deterred from receiving advice and guidance from the health professional.

76. Seventh, I consider that Mr. Havers' formulation of the limitation on the young person's right to confidentiality might well be inconsistent with what, as I shall explain in paragraph 77 below, Thorpe LJ has described as "*the keener appreciation of the autonomy of the child and the child's consequential right to participate in decision-making processes that fundamentally affect his family life".* It is appropriate at this stage to set out some of the relevant provisions of the UNC which was adopted in November 1989 and so post-dated **Gillick.** It has now been ratified by the United Kingdom. Article 5 of the UNC provides that:

"States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention".

77. Article 12 of the UNC states that:

" States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 16 states that:

" 1.No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation"

Article 18 provides that:

" 1.States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern".

78. Thorpe LJ (with whom Latham and Wall LJ agreed) has explained in **Mabon v Mabon** [2005] 3 WLR, 460 in relation to the significance of a child's understanding in a context different from the present case with my emphasis added that:

"26. In my judgment the rule is sufficiently widely framed to meet our obligations to comply with both article 12 of the United Nations Convention on the Rights of the Child and article 8 of the European Convention of Human Rights, providing that judges correctly focus on the sufficiency of the child's understanding and, in measuring that sufficiency, reflect the extent to which, in the 21st century, there is a keener appreciation of the autonomy of the child and the child's consequential right to participate in decision making processes that fundamentally affect his family life….

28… Although the tandem model has many strengths and virtues, at its heart lies the conflict between advancing the welfare of the child and upholding the child's freedom of expression and participation. Unless we in this jurisdiction are to fall out of step with similar societies as they safeguard article 12 rights, we must, ***in the case of articulate teenagers, accept that***

the right to freedom of expression and participation outweighs the paternalistic judgment of welfare*".*

79. Although the facts in **Mabon** were very different from those in the present case, these comments do illustrate that the right of young people to make decisions about their own lives by themselves at the expense of the views of their parents has now become an increasingly important and accepted feature of family life. This approach of attaching substantial weight to the young person's article 12 rights is supported by the comment of Baroness Hale of Richmond in **R (on the application of Williamson and others) v Secretary of State for Education** [2005] 2 AC 246 where she explained at paragraph 80 that:

"above all, the State is entitled to give children the protection they are given by an international instrument to which the United Kingdom is a party, the United Nations Convention on the Rights of a Child"

80. In the light of this change in the landscape of family matters, in which rights of children are becoming increasingly important, it would be ironic and indeed not acceptable now to retreat from the approach adopted in **Gillick** and to impose additional new duties on medical professionals to disclose information to parents of their younger patients.

81. Finally, I ought to say that if (which is not the case) I had been in any doubt about Mr Havers` submission, I would have had to bear in mind that in the light of the well-established duty of confidence owed by a doctor to a competent young person, then as Mr Havers correctly accepts, the burden of proving the justification of his exception of that rule would be firmly on the party asserting it, who in this case is the claimant. For the reasons which I have sought to explain, the claimant in this case cannot discharge that duty.

82. I should add that ,as I will explain in Section XII below, the claimant cannot establish that her Article 8 rights are being infringed when she is not notified about proposed advice and treatment. Thus, it follows that I cannot accept Mr Havers` limitation on the duty of confidentiality in the case of advice relating to contraception or sexually transmissible diseases, which for the reasons which I have sought to explain, is contrary to authority and cannot be justified on any basis.

X. The limitation on the young person's right to confidentiality in relation to proposed advice and treatment on abortion issue.

(i) The claimant's case

83. I turn to the further argument of Mr Havers which is that even if he is incorrect in relation to his formulation of the duties and rights of a medical professional in relation to *proposed* advice and treatment on contraception and sexually transmitted illnesses, then it does not follow that he cannot succeed in respect of his limitation on the duty of confidentiality in respect of *proposed* abortion advice and treatment. He points out correctly in my view that abortion alone involves an invasive and irreversible surgical procedure with potentially serious risks, consequential and side effects which have been described fully by the claimant's expert Dr Trevor Stammers. (I ought to add that in the absence of cross-examination, I cannot resolve his disagreements with the defendant's expert Dr Gillian Penny on statistical and other matters but I do not consider the differences to be of crucial importance in resolving the issues raised on this application.) Furthermore, I accept that a decision on whether to have an abortion raises potentially difficult non-medical issues such as moral, ethical, religious and cultural issues. Mr Havers contends that the relevant medical professional consulted by the girl might perhaps be unqualified or not be in a position to advise about those particular non-medical matters. It is also possible that if the girl considering an abortion has gone to a clinic for advice and treatment rather than to her general practitioner, the health professional tending the girl would not have her medical records or have access to them and would almost certainly have no previous knowledge of the girl or of her family. Unlike, for example, a decision on any proposed treatment for a sexually transmitted illness, the decision on whether to have an abortion might well not admit of an easy answer but significantly the decision ultimately made

will be one with which the young person will have to live for the rest of her life. The medical and psychological consequences of an abortion can of course be very serious for the girl concerned. There is also a limited time period within which an abortion can be performed. The statistical evidence gathered over a limited period indicates that about one-third of all abortions carried out on girls under the age of 16 were carried out without at least one parent of the girl being aware that she was having an abortion. Against that background, Mr Havers contends that even if the limitation on the duty of confidence which he propounds does not apply in the case of proposed treatment and advice on contraception or sexually transmitted diseases, it should nevertheless apply at least in the case of proposed abortion advice and treatment.

(ii) The Secretary of State's case

84. Mr Sales and Miss Lieven disagree and they attach importance to the unqualified right of a young person like any other patient for their confidence to be respected by the medical professional. They contend that in the light of the reasoning of the majority in **Gillick** there is no difference between the duty owed by a medical professional in the case of proposed advice and treatment on the one hand in relation to abortion and on the other hand in relation to contraception or sexually transmitted diseases.

*(iii) What did **Gillick** decide about the need for parental notification on sexual matters?*

85. The starting point to resolving this issue must be to consider the basis on which the majority of the Appellate Committee in **Gillick** reached their decision, which of course, only related to contraception in order to ascertain if their reasoning in that case throws any light on the duty of confidentiality owed by a medical professional in respect of proposed abortion advice and treatment.

86. I will not repeat the pertinent points in the reasoning of the majority in **Gillick** which, I have set out in paragraph 13 above and which indicate when and how a doctor can give advice and treatment to a young person without parental consent or knowledge The speeches of Lord Fraser, Lord Scarman and Lord Bridge do not indicate or suggest that their conclusions depended in any way upon the nature of the treatment proposed because the approach in their speeches was and is of general application to *all* forms of medical advice and treatment. Indeed the approach of the majority was to consider in *general* terms the reasons why parental knowledge or consent might be required for medical advice and treatment and then again in *general* terms when that parental knowledge or consent would no longer be required.

87. There does not appear to be any reason why that approach should not also apply to other proposed treatment and advice as the litmus test for determining if any such treatment and advice can be given without parental knowledge will also be whether the young person in Lord Scarman's words in **Gillick** at page 188H-189A "*achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed"* because if he or she is, then again in the words of Lord Scarman which I have also quoted in paragraph 13 above, *"the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates*". Lord Fraser (with whom Lord Scarman and Lord Bridge agreed) also concluded that when the young person was sufficiently mature to understand the advice and its implications, she could be advised and treated without parental involvement subject to his Guidelines.

(*iv) In the light of the very important issues which have to be resolved before a young person can agree to an abortion, can Lord Fraser's Guidelines be adapted so as to permit a medical professional to give advice and treatment on a possible abortion without parental knowledge or consent?*

88. As I have explained in paragraph 83 above, Mr. Havers attaches importance to the very complex issues that have to be resolved before any woman can decide whether she should have an abortion. The issue that now has to be resolved is whether these issues are so important and so difficult that a medical professional is under no obligation to keep confidential

advice and treatment which she proposed to give in respect of abortion unless to do so would or might prejudice the young person's physical or mental health.

89. The answer is to be found in Lord Fraser's guidelines, which specify with emphasis added that the medical professional is only *"justified in proceeding without the parent's consent or even knowledge provided he is satisfied… (i) that the girl (although under 16 years of age) will understand his advice*". As I pointed out in paragraph 13 above, this requirement means that she will have to appreciate all aspects of the advice because Lord Scarman then explained what he meant by *"sufficient understanding of what is involved to give a consent valid in law"* when he said with emphasis added at page 188 C that:

"*when applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is* ***much*** *to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given; she must also have a sufficient maturity to* ***understand what is involved.*** *There are* ***moral*** *and family questions, especially her relationship with her parents; long term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment"*

90. There is no reason why this approach cannot be adapted so that a girl could only be considered to have understood advice if she understands properly "*what is involved*". This would constitute a high threshold and many young girls would be unable to satisfy the medical professional that they fully understood all the implications of the options open to them. These requirements would be underpinned by two matters of which the first is that the sanction for medical professionals was as explained by Lord Fraser that a doctor who did not adhere to his guidelines could *"expect …to be disciplined by his own professional body*". The second matter is that the medical professional is required to take into account all aspects of the young person's health in deciding if what he is proposing satisfies the test of showing that unless the girl receives the proposed abortion advice, her physical or mental health or both are likely to suffer. In summary, there is no reason why Lord Fraser's Guidelines and Lord Scarman's criteria should not be adapted and applied to advice and treatment for abortion even though abortions raise, as I have explained, more serious and more complex issues than contraception. I conclude that they should be adapted and I set out in paragraph 154 below how they should now read.

91. I am fortified in coming to this conclusion by the fact, as I have set out in paragraphs 67 to 69 above, that young people would be deterred from taking advice on sexual matters such as abortion without the assurance of confidentiality. In addition, as I have explained in paragraph 10 above, Lord Fraser pointed out at page 174 D that his guidelines were not *"a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so*". I should add that as I will explain in Section XII below, the claimant cannot establish that her Article 8 rights are being infringed when she is not notified about proposed advice and treatment on abortion. For all these reasons, I do not consider that there should be any different rule on waiving confidentiality when abortion advice or treatment is discussed than when contraceptive advice or other treatment is under consideration. Hence I am bound to reject Mr Havers' submission.

XI. The provision of actual advice and treatment on sexual matters issue.

92. Mr Havers contends that the claimant is entitled to a declaration that a medical professional is not entitled to *provide actual* advice and treatment on contraception, sexually transmitted infections and abortion without parental knowledge unless to do so would or might prejudice the young persons physical or mental health so that it is in the young persons best interest not to do so. Mr Sales and Miss Lieven submit that this claim is an attempt to reverse the decision in **Gillick** and should be rejected. I have already dealt with many aspects of these issues in sections IX and X above

93 .Starting with the claim in respect of contraception, I agree with the submission of Mr Sales and Miss Lieven that the decision in **Gillick** is determinative as, in the words of Lord Fraser at page 166G, one of the strands of the argument in **Gillick** was *"whether giving [contraceptive] advice and treatment to a girl under 16 without her parents' consent infringes the parent's rights".* As I have explained, the majority of the Appellate Committee answered that question in the negative in relation to contraception, which was the only matter under consideration in that case. As I will explain, I have considered whether article 8 of the ECHR would mean that **Gillick** would now be decided differently but for the reasons set out in section XIII below, I have concluded that **Gillick** remains good law. I am bound by that decision in **Gillick** with the result that Mr Havers' submissions in respect of advice and treatment for contraception fail.

94. Turning to the claim in respect of advising on and providing treatment for abortion and sexually transmissible diseases, **Gillick** provides a very helpful starting point because, as I explained in paragraph 13 above, the majority decision is based on an analysis of the parental right to determine whether or not their minor child below the age of 16 will have medical treatment, which according to Lord Scarman at page 188H-189A: *"terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to fully understand what is proposed*". Lord Fraser also regarded the parent's authority as being a "*dwindling right*"(page 172 H) and "*that once the rule of the parents' absolute authority over minority children is abandoned , the solution to the problem in the appeal can no longer be found by referring to rigid parental rights at any particular age. The solution depends on what is best for the welfare of the particular child*"(page 173D).

95. This reasoning is inconsistent with the relief sought by Mr Havers because his case depends on some form of parental authority, which continues until the sixteenth birthday of their offspring. Although, as I have explained, an abortion is a form of major invasive treatment with serious consequences, there is nothing in the speeches of the majority in **Gillick,** which suggests that parental authority has any place in decision-making for a young person, who in the words of Lord Scarman, which I have quoted in the last paragraph "*achieves a sufficient understanding and intelligence to enable him or her to fully understand what is proposed".* In fact as I have sought to explain in section XI above, Lord Fraser's Guidelines can be and should be adapted to deal with advising and providing treatment for all sexual matters. The approach of the medical professional to a young person who seeks advice and treatment on sexual issues without notifying his or her parents or permitting them to be notified should be in accordance with Lord Fraser's Guidelines as adapted for abortions and sexually transmitted illnesses and I will set them out in paragraph 154 below.

96. As I will explain in Section XII below, the claimant cannot establish that her Article 8 rights are being infringed when she is not notified about advice and treatment on sexual matters given to a young person. In consequence, the claimant fails on this issue.

XII. The Guidance Unlawfulness Issue

97. I will deal in turn with Mr Havers' separate reasons as to why the 2004 Guidance is unlawful before considering them cumulatively.

(i) Should the 2004 Guidance have stated that it would be "most unusual" for a health professional to treat a young person on sexual and abortion matters without parental knowledge?

98. Mr Havers contends that the 2004 Guidance is unlawful because it misrepresents the decision of the House of Lords in **Gillick** whilst purporting to clarify it. The thrust of his complaint is that whereas in **Gillick** in the words of Mr Havers' skeleton argument,

"the starting point was that any important medical treatment of the child under 16 would normally only be carried out with the parent's approval , that it is and should be most unusual for a doctor to advise a child on contraceptive matters without the knowledge or consent of the parents but that there may be circumstances in which a doctor may do so",

the 2004 Guidance sets out the law to the contrary effect by indicating that for a medical professional to involve the parents of the young person would be the *exception* rather than the rule.

99. In response, Mr Sales stresses correctly in my view that Lord Scarman explained at page 180F in **Gillick** that a court should construe the pre-Gillick Guidance or any guidance of that kind issued by the Secretary of State in the following way:-

"The *House must be careful not to construe the guidance as though it were a statute or even to analysis it in the way appropriate to a judgment. The question to be asked is: what would a doctor understand to be a guidance offered to him, if he should be faced with a girl under 16 seeking contraceptive treatment without the knowledge or consent of her parents?"*

100. I must consider the 2004 Guidance in this way appreciating that the medical professional reading the 2004 Guidance would note that it states with my emphasis added that:

"*If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing…*

The benefits of informing their GP and the case for ***discussion with a parent*** *or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent* ***but cannot be persuaded to involve her parent****, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker"*

101. The 2004 Guidance then proceeds to state that *"additionally it is considered good practice for the doctors and other health professionals to follow* [Lord Fraser's guidelines]", one of which is then explained in this way with my emphasis added "the health professional **cannot persuade** the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice". This shows that it remains the initial and significant duty of the medical professional to try to persuade the young person to inform his or her parents or to allow the medical professional to inform his or her parents. Furthermore, as I have explained, Lord Fraser's Guidelines can and should apply with modification to advice and treatment on sexually transmissible diseases.

102. I agree with Mr Havers that it is not *expressly* stated anywhere in the 2004 Guidance that it should be the "exceptional" practice to offer contraceptive advice or abortion advice or treatment to young people without first involving the parent but I do not consider that this means that the 2004 Guidance is unlawful for the following reasons, some of which are overlapping and which I set out in no particular order of importance.

103. First, there is nothing in the speeches of the majority in **Gillick,** which lay down as a matter of law the assertion that a medical professional should regard it as an 'exceptional' practice or unusual to offer contraceptive advice or abortion advice to young people without involving their parents. The significant feature of **Gillick** was to set out the conditions, which had to be complied with before a young person could be advised on or treated in relation to contraception.

104. Second, as I have indicated, it is made very clear in the 2004 Guidance so that all medical professionals reading it would understand that they should initially try first to ensure that the parent of the young person is notified either by the young person or by the medical professional with the young person's consent *before* any advice or any treatment can be given to the young person and second that the medical professional should try to *persuade* the young person to ensure that his or her parents are notified. This is consistent with the majority view in **Gillick** and it constitutes a very sensible practice.

105. Third, by saying that *"it is good practice*" for Lord Fraser's guidelines to be considered, the 2004 Guidance was setting out the established procedure and the judicially accepted conditions and safeguards which have to be complied with before a young person could be given contraceptive advice. Fourth, I do not understand why the 2004 Guidelines should have referred to the fact that it would be "*most unusual*" for a medical professional to give contraceptive advice or treatment without the parents of the young person being notified because what **Gillick** lays down are the conditions to be satisfied and that is what the 2004 Guidelines also state.

106. Fifth, there is nothing in the 2004 Guidelines which indicates or suggests expressly or impliedly that a medical professional should disregard what had been said by the majority in **Gillick.**

107. Finally, in any event, even if the decision in **Gillick** meant that it was necessary to state that giving advice or treatment on sexual matters without the parents of the young person being notified was unusual, I do not understand what would be gained by stating this expressly in the 2004 Guidance in the light of the significant provisions of this document to which I have referred and which indicate clearly and properly how medical professionals should handle young people in relation to sexual matters.

(ii) Does the failure of the "Confidentiality" section in the 2004 Guideance to refer to the need to notify parents mean that parents are not notified unless they become involved because of local agreed Child Protection Protocols?

108. Mr Havers contends that the section entitled "Confidentiality" in the 2004 Guidance does not refer to any notification or involvement of the parents of the young person concerned unless they happen to be notified or become involved through the application of locally agreed child protection protocols. This submission focuses on just one section of the 2004 Guidance rather than on the *whole* document and which in Lord Scarman's words which I quoted in paragraph 99 above is " *how it would be understood by a doctor*" or a medical professional if the 2004 Guidance is addressed to them. Such a person would also have correctly and inevitably attached importance to the section in the 2004 Guidance, which deals with "*Good practice in providing contraception and sexual health to young people under 16"* which, as I have sought to explain, specifically refers to the fact that "it is considered good practice" to follow Lord Fraser's guidelines, which themselves refer at page 174 D to the doctor being unable to "*persuade [the girl] to inform her parents or allow [the doctor] to inform the parents that she is seeking contraceptive advice".*

109. This section of the 2004 Guidance also makes it clear that where an abortion is under consideration, the girl patient should if possible be persuaded "to involve a parent". Both these provisions show that this complaint of the claimant is unjustified especially as I have already explained in Sections IX, X and XI of this judgment above that the medical professional remains under a duty to respect the confidentiality of information from a young person and not to notify his or her parents.

(iii) Did the 2004 Guidance fail to make it clear that Lord Fraser's Guidelines were legal pre-conditions?

110. Mr Havers contends that the 2004 Guidance fails to make clear that Lord Fraser's guidelines were legal pre-conditions to a medical professional providing advice or treatment to a young person without the knowledge or consent of his or her parents. It is said that the 2004 Guidelines merely state that "*it is considered good practice for doctors and other health professionals to follow the criteria outlined [in Lord Fraser's Guidelines]".* I have considered Mr. Sales' contention that Lord Fraser's guidelines were not meant to be pre-conditions which I cannot accept because Lord Fraser stated with my emphasis added in **Gillick** at page 174D that

*"the doctor, will, in my opinion be justified in proceeding without the parents' consent or even knowledge provided **he is satisfied** on the following matters [namely his guidelines]*"

111. It is noteworthy that Lord Fraser did not state these were merely matters to be taken into consideration but instead he set out his guidelines as conditions which had to be satisfied by using the words "*provided he is satisfied on the following matters*…" Thus any health professional reading in the 2004 Guidance that it was *"considered good practice to follow the criteria"* in Lord Fraser's guidelines would in my opinion have readily appreciated that he or she should continue to follow them. The 2004 Guidance is as its full title shows dealing with "Best Practice Guidance" and it was stressed that Lord Fraser's Guidelines in **Gillick** constituted the conditions for advising young people on sexual matters without parental consent. There is nothing in the 2004 Guidance, which states or shows that Lord Fraser's guidelines are to have any reduced importance or value; indeed on the contrary the 2004 Guidance reasserts their continuing importance and relevance.

112. In reaching this conclusion, I have not overlooked Mr Havers' submission that the 2004 Guidance is incorrect when it records Lord Fraser's final guideline as stating *"the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent".* What Lord Fraser actually said in **Gillick** at page 174E was that "*[the girl's] best interests require [the doctor] to give her contraceptive advice, treatment or both without the parental consent*". I am unable to accept that the 2004 Guidance contains a material error in recording what Lord Fraser had said or even if it did, that any such error was of any real significance so as to lead to a conclusion that the 2004 Guidance was unlawful.

113. In any event, even if I am wrong and the 2004 Guidance does not comply with Lord Fraser's guidelines, the Secretary of State has powerful arguments open to him as Lord Scarman noted in his speech when stressing the importance of keeping the law up-to-date with developments when he explained at page 183B-C that *"the law ignores these developments at its peril".* Similarly Lord Fraser explained at page 171E that *"social customs change, and the law ought to and does, in fact, have regard to such changes when they are of major importance".*

114. Both Mr Sales and Miss Lieven submit that there has been a change in attitudes to the rights of children and they relied on the UNC and on the comments of Thorpe LJ in **Mahon's** case to which I referred in paragraph 78 above.

115. In my view, the comments of Thorpe LJ together with the UNC provisions provide further support for the general movement towards now giving young people greater rights concerning their own future while reducing the supervisory rights of their parents. In the light of this change in the landscape of family matters, it would be wrong and not acceptable to retreat from **Gillick** and to impose greater duties on medical professionals to disclose information to parents of their younger patients.

(iv) Does the 2004 Guidance mean that the parents of a young person are excluded from involvement in important decision making about the life and welfare of the young person?

116. Mr Havers complains that the 2004 Guidance means that the parents of a young person are excluded from involvement in the making of important decisions about the life and welfare of the young person but this submission fails to appreciate that in **Gillick,** the majority of the House of Lords explained that the doctor could provide advice and treatment to a young person even if his or her parents did not consent provided that certain conditions were satisfied. I have already set out in paragraphs 11 and 12 what Lord Fraser and Lord Scarman considered appropriate conditions. It is quite true that the pre-Gillick Guidance stresses that it was *"most unusual to provide advice about contraception without parental consent*" while the 2004 Guidance does not use this wording. As I have explained in paragraphs 103 to 107 above, the criticism concerning the absence of the words "most exceptional" in the 2004 Guidance does not in any way invalidate this document.

117. Furthermore, I am unable to accept any of Mr Havers' complaints about the 2004 Guidance whether considered individually or cumulatively because, in my view, the 2004 Guidance is not unlawful unless the article 8 rights of the parents mean that the 2004 Guidance is unlawful and that is the issue to which I must now turn.

XIII. The Article 8 Issue

(i) The Issue

118. The claimant contends that the 2004 Guidance is unlawful because it "fails to discharge the State's positive obligation to give practical and effective protection to [her] rights under 8(1)". It is also suggested that the decision in **Gillick** has to be reconsidered in the light of article 8. The Secretary of State with the support of Fpa disputes that article 8(1) is engaged but contends that in any event, the approach in the 2004 Guidance and the decision of the majority in **Gillick** can be justified under article 8(2) of the Convention. I will consider first if the claimant has a prima facie right under article 8(1) and, if so, then whether the Secretary of State can invoke article 8(2) of the Convention. I will also bear in mind that as Lord Bingham explained in **R (Ullah) v Special Adjudicator** [2005] AC 23, 40 [20],

" the duty of national courts is to keep pace with Strasbourg Jurisprudence as it evolves over time, no more but certainly no less".

(ii) The Claimant's Case on the Existence of a Parent's Article 8(1) right to be notified

119. Article 8 provides that:

"(1) Everyone has the right to respect for his private and family life, his home and his correspondence.

(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others"

.

120. Mr Havers attaches significance to **X v Netherlands** (1974) 2 DR 118 in which the European Commission stated in page 118 in paragraph 1 that:

"As a general proposition, and in the absence of any special circumstances, the obligation of children to reside with their parents and to be otherwise subjected to particular control is necessary for the protection of children's health and morals although it might constitute, from a particular child's point of view, an interference with his or her own private life".

121. Mr Havers contends that this statement shows that the Commission held that forcing a 14 year old girl, who had run away from home because her parents objected to her boyfriend, to return home was an exercise of respect for the life of her family and so it was justifiable.

122. He points out that the European Court of Human Rights subsequently articulated the meaning of family life in article 8 in **Nielsen v Denmark** (1988) 11 EHRR 175 at page 191 in paragraph 61 as follows:

"It should be observed at the outset that family life in the Contracting States incorporates a broad range of parental rights and responsibilities in regard to the care and custody of minor children. The care and upbringing of children normally and necessarily require that the parents or an only parent decide where the child must reside and also impose, or authorize others to impose, various restrictions on the child's liberty. Thus the children in a school or other educational or recreational institution must abide by certain rules, which limit their freedom of movement and their liberty in other respects. Likewise a child may have to be hospitalised for medical treatment. Family life in this sense, and especially the rights of parents to exercise parental authority over their children, having due regard to their corresponding parental

responsibilities is reconsidered by the [ECHR] in particular by article 8. Indeed the exercise of parental rights constitutes a fundamental element of family life"

123. According to Mr Havers' written skeleton argument, these cases establish that:

"(1) Article 8 recognizes that parents have a broad range of rights in regard to their children, the exercise of which constitutes a fundamental element of family life.

(2)Those rights include the right to parental authority over their children, having due regard to their corresponding parental responsibilities.

(3) Ensuring respect for family life may include enforcing those rights, for example forcing a girl to return home.

(4) Ensuring respect for family life will or may take precedence over avoiding any interference with the child's private life".

124. Mr Havers` submission is that in the words of his skeleton argument:

"Depriving parents of at least the opportunity to discuss with their children the proposed provision of contraceptive advice and/or treatment in relation to any other sexual or reproductive matters imposing a duty of confidentiality on the relevant doctor or health professional constitutes a plain interference with and/or failure to respect the parents right to respect for their family life and, in particular, their parental rights".

(iii) The Secretary of State's Case on the Existence of a Parent's article 8(1) Right to be Notified

125. Mr Sales supported by Miss Lieven submits that the two Strasbourg cases on which the claimant relies are not authority for the existence of the article 8 (1) right of a kind, which could have been infringed or was infringed by the 2004 Guidance. He points out that **X v The Netherlands** (1974) 2 DR 118 was a decision regarding the alleged right of a child to live where she pleased. Thus, as the passage cited makes clear, the case only establishes an obligation for the State to provide for children, in normal circumstances, to reside with their parents, should their parents wish. So, Mr Sales submits that the case did not concern parental rights, still less parental rights to be consulted about medical advice or treatment sought by a competent child. I agree with that submission because the nature of the dispute in that case was far removed from the issues raised in the present application. Apart from that, this decision is now over thirty years old and bearing in mind that the ECHR is a living instrument, there are now more recent cases which, as I shall explain in paragraphs 144 and 145 below, show that much greater weight is now being given in ECHR jurisdiction to the interests of a child, which are now said to be the paramount consideration. In any event, the statement of principle in **X v Y** was expressed to be *"a general proposition and in the absence of special circumstances*" which are said by the Secretary of State to apply in the present case and to which I will return.

126. Turning to **Nielsen v Denmark** (1988) 11 EHRR 175, Mr Sales contends correctly in my view that it does not go further than establishing a limited parental right, but it is a right first only in relation to where the child must reside and other restrictions on the child's liberty, such as admission to hospital. The judgment referred to family life as incorporating "*a broad range of parental rights and responsibilities in regard to the care and custody of minor children*" (paragraph 61). It is significant that the complaint in that case (unlike the application in the present case) was not made under article 8 but under article 5(1) and so it is only an authority on the application of article 5(1) of the ECHR. Thus, **Nielsen** does not deal with any alleged parental right to be informed of medical advice or treatment on medical matters sought by a young person, where the young person wishes to have confidentiality. Indeed, the rights mentioned by the European Court in the passage cited by Mr Havers relate to *"the rights of parents to exercise parental authority over their children".* I agree with Mr Sales that the

claimant does not- and because of **Gillick,** cannot- claim any right to exercise authority over what treatment her competent children receive on contraception. **Nielsen** is not relevant to the present application and is in any event too general in tone to provide any support at all for the different right which is claimed on the present application by the claimant, and which is to be informed by a third party of information which one of her children has decided not to impart to her but which that young person wishes to keep as confidential. More importantly neither of the cases relied upon by Mr Havers deals with the important issue raised on this application of when any parental right or parental authority ends or when it can be overridden.

(iv) Conclusions on the Existence of a Parent's alleged Article 8(1) right to be notified

127. I am unable to accept Mr Havers` contention that by permitting a medical professional to withhold information relating to advice or treatment of a young person on sexual matters, the article 8 rights of the parents of the young person were thereby infringed. In considering this issue, it must always be remembered first, that in **Z v Finland ...**supra) the European Court emphasized the significance and compelling nature of the patient's article 8(1) right to confidentiality of health information as I explained in paragraph 63 above. A similar approach was adopted in **MS v Sweden** [1999] 28 EHRR 313 in which it is said at page 337 in paragraph 41 that *"respecting the confidentiality of health data is a vital principle in the legal systems of all contracting parties to the Convention*". Although these cases deal with the position of an adult, there is no good reason why they could not apply to protect the confidentiality of health information concerning a young person, especially because, as I have explained in paragraphs 40 and 41 above, that a duty of confidentiality is owed to a young person by medical professionals.

128. Second, it is noteworthy that in **Kjeldsen and others v Denmark** (1976) 1 EHRR 711, the Strasbourg Court rejected complaints by a group of parents some of whose children were under 11 years of age under, *inter alia*, article 8, that their children had received sex education at school without their consent. Although the Article 8 point might not have been fully argued in that case, if the parents in that case had no right to control what information their children should receive on these matters, it is not easy to see how and why they could have a sufficient interest under article 8 to override a young person's article 8 rights to seek to maintain confidentiality in relation to his or her private medical information on sexual matters..

129. In order to decide whether parents have what Mr Havers describes as *"the right to parental authority over a child*" having regard to their having parental duties, the age and maturity of the young person is of critical importance. Lord Lester QC and Mr David Pannick QC state convincingly and correctly in my view that *"as a child matures, the burden of showing ongoing family life by reference to substantive links or factors grows"* **(Human Rights Law and Practice**- 2nd Edition (2004) paragraph 4.8.48). This conclusion presupposes correctly that any right to family life on the part of a parent dwindles as their child gets older and is able to understand the consequence of different choices and then to make decisions relating to them.

130. As a matter of principle, it is difficult to see why a parent should still retain an article 8 right to parental authority relating to a medical decision where the young person concerned *understands* the advice provided by the medical professional and its implications. Indeed, any right under article 8 of a parent to be notified of advice or treatment of a sexual matter as part of the right claimed by Mr Havers must depend on a number of factors, such as the age and understanding of their offspring. The parent would not be able to claim such an article 8 right to be notified if their son or daughter was, say, 18 years of age and had sought medical advice on sexual matters because in that case the young person was able to consent without parental knowledge or consent for the reasons set out in paragraph 1 above. The reason why the parent could not claim such a right is that their right to participate in decision-making as part of the right claimed by Mr Havers would only exist while the child was so immature that his parent had the right of control as was made clear in **Gillick**. As Lord Fraser explained in **Gillick ,"***the parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child and towards other children in the family"* (page 170D).

Lord Fraser and Lord Scarman in **Gillick** at pages 172H and 186D both adopted the statement of Lord Denning MR in **Hewer v Bryant** [1970] 1 QB 357, 369 that the parent's right as against a child is "*a dwindling right".* As Lord Scarman explained, a parental right yields to the young person's right to make his own decisions when the young person reaches a sufficient understanding and intelligence to be capable of making up his or her own mind in relation to a matter requiring decision (page 186D) and this autonomy of a young person must undermine any article 8 rights of a parent to family life. In my view, any article 8 right of the kind advocated by Mr Havers must be seen in that light so that once the child is sufficiently mature in this way, the parent only retains such rights to family life and to be notified about medical treatment if but only if the young person so wishes.

131. Indeed whether there is family life and hence a right to family life in a particular family is a question of fact. The European Commission on Human Rights has explained that the existence of family ties depends upon *"the real existence in practice of close family ties*" **(K v United Kingdom** (1986) 50 DR 199,207). It is not clear why the parent should have an article 8 right to family life, where first the offspring is almost 16 years of age and does not wish it, second where the parent no longer has a right to control the child for the reasons set out in the last paragraph and third where the young person in Lord Scarman's words at page 188 *"has sufficient understanding of what is involved to give a consent valid in law".*

132. There is nothing in the Strasbourg jurisprudence, which persuades me that any parental right or power of control under article 8 is wider than in domestic law, which is that the right of parents in the words of Lord Scarman "*exists primarily to enable the parent to discharge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and make his own decisions"* (**Gillick** page 185E). The parental right to family life does not continue after that time and so parents do not have article 8 rights to be notified of any advice of a medical professional after the young person is able to look after himself or herself and make his or her own decisions. This leads to the next question which is whether the 2004 Guidance interferes with those rights.

133. As I explained in Section XII above, there is nothing in the 2004 Guidance, which enables or permits a medical professional to give advice or treatment on a sexual matter unless the medical professional is satisfied that in the words of the 2004 Guidance on "Duty of Care" that the young person *"understands the advice provided and its implications".* Furthermore in the section of the 2004 Guidance which deals with "*good practice",* it is stated that it is good practice for medical professionals "*to follow…the Fraser Guidelines [which required that the young person understands the health professional's advice]".*

134. There is the additional safeguard mentioned after both the provisions which is that the treatment and advice must be in the young person's best interests. In those circumstances, I conclude that there is nothing in the 2004 Guidelines, which interferes with any of a parent's article 8 rights.

135. Nevertheless, if I am wrong and that the 2004 Guidance interferes with a parent's article 8(1) rights, I must still consider whether the Secretary of State can invoke the provisions of article 8(2).

(v) The Secretary of State's Case on Article 8(2) that the 2004 Guidance will not be regarded as an interference with a parent's article 8 right

136. Mr Sales, with Miss Lieven's support, contends that even if the claimant's article 8 rights are infringed, I should conclude that the 2004 Guidance falls within article 8(2) with the result that any article 8 rights of the claimant would not have been interfered with because in the wording of article 8(2), the 2004 Guidance was "*in accordance with the law"* and "*necessary in a democratic society… for the protection of health… or for the protection of the rights… of others*" as well as being proportionate. Mr Havers disagrees and so I will have to consider each of these three requirements in turn.

(vi) " …in accordance with the law…."

137. As I have explained my conclusion is that the 2004 Guidelines comply with the law of England and Wales in an area of the law which after **Gillick** must be regarded as clear and sufficiently certain so *"that it be accessible to the persons concerned and formulated with sufficient precision to enable [the citizens] if need be, with appropriate advice to foresee to a degree that is reasonable in the circumstances the consequences which a given action may entail"* (**MS v Sweden** (1997) 28 EHRR 313, 321 at paragraph 48). This requirement is satisfied after the decision in **Gillick.**

(vii) …"necessary in a democratic society… for the protection of health…or for the protection of the rights ..of others "

138. Mr Havers submits correctly that the burden of proof of this exception is on the Secretary of State and he then contends that the expert evidence does not support the Secretary of State's case. It is true that the Secretary of State cannot in my view point to any statistical evidence which unequivocally supports his case that the abandonment of the principle of confidentiality would inevitably lead to increases in sexually transmitted illness and other matters. Nevertheless as I have explained, there is clear evidence that an assurance to young people of medical confidentiality increases the use of contraceptive and abortion services by those under the age of 16 and Mr Havers does not dispute this.

139. Mr Sales contends that in order to understand why the 2004 Guidance is necessary for the protection of health, it is imperative to appreciate why and how it came to be drafted. It must be realized that the United Kingdom has had the highest rate of teenage conceptions and teenage births in Western Europe. In a report entitled *Teenage Pregnancy published by the Capital Social Exclusion Unit 1999* ("the Report"), a target was set by the Government of halving the rate of conception among those aged under 18 years by 2010. The Report sets out a detailed action plan for achieving that target. It identified poor rates of use of contraception among teenagers as one of the important factors leading to first the high levels of teenage conceptions and second the level of sexually transmitted infections. The Report states that it found that half of those, who were under the age of 16 and a third of those who were aged between 16 and 19 in the United Kingdom used no contraceptives on the first occasion on which they had sexual intercourse.

140. It is very significant that according to the Report, one of the main reasons for this factor was a fear on the part of the teenagers that their parents would find out if they had consulted their doctor for contraceptive advice or treatment. The Report explains that this fear arose because the young person's right of confidentiality when seeking medical advice or treatment was not widely appreciated. In the light of this conclusion, the Department of Health adopted as a major priority the need to improve sexual health and to reduce the incidence of sexually transmissible illnesses, which were serious problems particularly amongst those under 16 years of age. According to the Report, this problem could only be effectively addressed if young people could be encouraged to make use of sexual health services so as to receive contraceptive advice and treatment as well as treatment for sexually transmitted diseases. It is noteworthy that the assurance of confidentiality was regarded as critical for the promotion of this objective and it is necessary to stress this. This corresponds with the statistical evidence to which I referred in paragraphs 68 and 69 above. There was evidence as explained by Dr Adshead that both medical professionals and young people did not appreciate the duty of confidentiality owed by health professionals to young people, who were their prospective patients. All these factors demonstrated the need for the Secretary of State to publish new guidance stressing the importance of confidentiality. There is also much evidence, in the witness statements that the 2004 Guidance has been welcomed for understandable reasons by medical professional bodies and by many others interested in the welfare of young people.

141. There are in my view four different ways in which the Secretary of State can establish that if, contrary to my conclusion in paragraph 134 above, there had been infringement of a parent's article 8 (1) rights, such interference could be justified as being *"necessary in a democratic society for the protection of health… or the rights of others".* It is necessary to bear in mind that the word *"necessary*" in article 8(2) is not synonymous with the word

"indispensable" but the treatment would be justified *"if the interference complained of [which in this case was the proposed advice or treatment] corresponded to a pressing social need, whether it was proportionate to the legitimate aim pursued, whether the reasons given by the national authority to justify it are relevant and sufficient*" (**Sunday Times v UK** (1979) 2 EHRR 245 at 255 , 275 and 277-278). This approach is logical because inherent in the interpretation of the Convention is its aim to strike a "*fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights"* (see **Sporrong and Lonroth v Sweden** (1992) 5 EHRR 35, 52). Any restriction on a guaranteed freedom, such as that set out in article 8(1) of the Convention, must be proportionate to the legitimate aim pursued (**Handyside v United Kingdom** (1976) 1 EHRR 737) and I will consider the requirements of proportionality as a separate issue in paragraphs 150 and 151 below

142. First, as I have explained, there is clear evidence that confidentiality increases the use of contraceptive and abortion services for those under the age of sixteen and that conclusion corresponds with common sense. The use of contraceptives will also reduce the risk of the need subsequently for treatment for sexually transmitted diseases and for abortion. By the same token, in the case of sexually transmissible diseases, it is much more likely that a young person, who does not want his or her parents to know of his or her sexual activities, would go and obtain advice from a medical professional or if that young person knew that his or her parents would not be notified of the advice or of the young person's condition by a medical professional. In other words, many young people, who need help on sexual matters from medical professionals, would be or might be deterred from obtaining such advice and treatment if their parents would have to be notified and this conclusion justifies the approach in the 2004 Guidance.

143. A second and overlapping factor is the disturbing consequences of the young people being deterred from obtaining advice and treatment on sexual matters. The young person, who had or suspected that he had a sexually transmissible disease, might be deterred from obtaining advice or from being treated thereby causing the risk of a consequential deterioration not only of the health of that young person, his present and past partners as well as the risk of infection of his or her present and future partners. By the same token, the girl who was intent on sexual intercourse and who did not obtain professional medical advice on contraception because she knew that her parents would be notified might become pregnant and become a candidate for an abortion or she might also run the risk of picking up a sexually transmissible illness. There is also the risk that if the pregnant girl knew that a medical professional would have to notify her parents, she might be deterred from obtaining advice or having an abortion and that she might instead use an unqualified abortionist with the inevitable risks to her health. All these are real dangers which would justify any interference with any article 8 (1) rights of a parent.

144. A third reason why I do not consider that the 2004 Guidance interferes with any article 8 rights of a parent is that it is established that a child's article 8 rights overrides similar rights of a parent. In **Hendricks v Netherlands** (1992) EHRR 223, the Commission explained at paragraph 23 that:

" The Commission has consistently held that, in assessing the question of whether or not the refusal of the right of access to the non-custodial parent was in confidentially with article 8 of the convention the interests of the child pre-dominate"

145. Similarly in **Yousef v Netherlands** (2003) 36 EHRR 345, it was said at paragraph 73 that:

"The court reiterates that in judicial decisions where the rights under article 8 of the parents and those of the child are at stake, the child's rights must be the paramount consideration".

146. Clayton and Tomlinson explain that under ECHR Jurisprudence:

*" the right of the child to respect for his private life or to exercise freedom or thought conscience and religion in a manner which is at variance with the new directives of his parent, has been receiving increased attention so that the weight given to parental authority may be reduced" (***The Law of Human Rights** *Volume 1 paragraph 13-116).*

147. A final reason is that in this particular area relating as it does to social policy, the Judiciary should show a substantial deference to the Executive on these issues. Lord Bridge in **Gillick** stated at page 193G-194B that:

"We must now say that if a government department, in a field of administration in which it exercises responsibility, promulgates in a public document, albeit non-statutory in form, advice which is erroneous in law, then the court, in proceedings in appropriate form commenced by an applicant or plaintiff who possesses the necessary locus standi, had jurisdiction to correct the error of law by an appropriate declaration. Such an extended jurisdiction is no doubt a salutary and indeed a necessary one in certain circumstances, as the **Royal College of Nursing** *case [1981] A.C. 800 itself well illustrates. But the occasions of a departmental non-statutory publication raising, as in that case, a clearly defined issue of law unclouded by political, social or moral overtones, will be rare. In cases where any proposition of law implicit in a departmental advisory document is interwoven with questions of social and ethical controversy, the court should, in my opinion, exercise its jurisdiction with the utmost restraint, confine itself to deciding whether the proposition of law is erroneous and avoid either expressing ex cathedra opinions in areas of social and ethical controversy in which it has no claim to speak with authority or proffering answers to hypothetical questions of law which do not strictly arise for decision".*

148. Indeed any judgment on the matters set out in the 2004 Guidance is one in respect of which the courts would and should give to the Executive a discretionary area of judgment. In **R v DPP ex parte Kebilene** [2000] 2 AC 326, at 380, 381, Lord Hope of Craighead said that:

"In some circumstances it will be appropriate for the court to recognize that there is an area of judgment within which the Judiciary will defer, on democratic grounds, to the considered opinion of the elected body or person whose act or decision is said to be incompatible with the Convention…It will be either for such an area of judgment to be recognized where the Convention requires a balance to be struck, much less so where the right is stated in terms which are unqualified. It will be easier for it to be recognized where the issues involve questions of social or economic policy, much less where the rights are of high constitutional importance of a kind where the courts are well placed to assess the importance of them".

149. Applying Lord Hope's approach means that the Secretary of State is entitled to a substantial degree of deference when the 2004 Guidance is considered for two reasons, of which the first is that the issues raised on this application and in the 2004 Guidance relate to what Lord Hope describes as "*questions of social policy".* The second reason is that this case concerns article 8, which is a qualified right in the light of the provisions of article 8 (2).

(viii). Proportionality

150. Although no specific argument was raised on the issue of proportionality, I am quite satisfied that the 2004 Guidance is proportionate. In reaching that conclusion I bear in mind that Lord Steyn explained in **R v Secretary of State for the Home Department ex parte Daly** [2001] 2AC 532, 547 that adopting the approach in **de Freitas v Permanent Secretary of Ministry of Agriculture** [1999] 1 AC 69 at page 80, the requirement of proportionality means that a court must ask itself whether:

" 27…(i) . the legislative objective is sufficiently important to justify limiting a fundamental right; (ii) the measures designed to meet the legislative objectives are rationally connected to it and; (iii) the means used to impair the right or freedom are no more than is necessary to accomplish the objective".

151. As to (i), the objectives of reducing pregnancies among young people, of curing diseases among young people and of ensuring that pregnant girls are properly advised and treated if they are suffering from sexually transmitted diseases or if they are pregnant are sufficiently important aims to justify interfering with the parents' family rights because of among other matters the problems set out in the Report, including the self-evident problems of risks of pregnancies and the dangers of sexually transmissible diseases to which I have already referred in paragraphs 134 to 140 above. In addition I have explained in paragraphs 67 to 69 above the importance of confidentiality to young people seeking advice on sexual matters. As to (ii), the measures in Lord Fraser's Guidelines and in the 2004 Guidance were designed to meet these objectives as well as being rationally connected to it. Finally as to (iii), the terms of Lord Fraser's Guidelines and of the 2004 Guidance go no further than are necessary to achieve the objectives to which I have already referred.

152. For all those reasons it follows that first the 2004 Guidance does not engage article 8(1), but even if it does, any infringement of the parent's article 8 (1) rights can be justified under article 8 (2) in the light of the matters to which I have referred. Thus the principles in **Gillick** continue to be valid and applicable being unaffected by article 8.

XIV. Conclusion

153. As I have explained, this judgment is concerned with how medical professionals should deal with young people, who want advice on sexual matters but who cannot be persuaded to inform their parents or to permit the medical professionals to inform their parents. There is nothing in this judgment which is intended to encourage young people to seek or to obtain advice or treatment on any sexual matters without first informing their parents and without discussing matters with them. On the contrary, it is to be hoped that all young people will do so because in Lord Fraser's words in **Gillick** at page 173E

"*in the overwhelming majority of cases, the best judges of a child's welfare are his or her parents*".

154. Thus, my task has been to determine the circumstances in which a medical professional could advise or treat a young person for sexual matters when all attempts to enable their parents to be notified and consulted have failed. The solution to this task is to be found in the decision of the House of Lords in **Gillick,** by which I am bound and which for the reasons, which I have sought to explain, provides much guidance on the circumstances in which medical advice and treatment can be given without parental knowledge or consent on contraception, on sexually transmissible diseases and on abortion. This leads to the conclusion that the medical professional is entitled to provide medical advice and treatment on sexual matters without the parent's knowledge or consent provided he or she is satisfied of the following matters

(1) that the young person although under 16 years of age understands *all* aspects of the advice [In the light of Lord Scarman's comments in **Gillick** at page 189C set out in paragraph 13(v) above he or she must *"have sufficient maturity to understand what is involved*" that understanding includes all relevant matters and it is not limited to family and moral aspects as well as all possible adverse consequences which might follow from the advice;

2) that the medical professional cannot persuade the young person to inform his or her parents or to allow the medical professional to inform the parents that their child is seeking advice and/or treatment on sexual matters [As stated in the 2004 Guidance, where the young person cannot be persuaded to involve a parent, every effort should be made to persuade the young person to help find another adult (such as another family member or a specialist youth worker) to provide support to the young person];

(3) that (in any case in which the issue is whether the medical professional should advise on or treat in respect of contraception and sexually transmissible illnesses) the young person is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment or treatment for a sexually transmissible illness ;

(4) that unless the young person receives advice and treatment on the relevant sexual matters, his or her physical or mental health or both are likely to suffer [In considering this requirement, the medical professional must take into account all aspects of the young person's health] and

(5)that the best interests of the young person require him or her to receive advice and treatment on sexual matters without parental consent or notification

155. I repeat that these Guidelines like those on which they are based in Lord Fraser's Guidelines were, as he stated at page 174 E of **Gillick** ;

"not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would be failing to discharge his professional responsibilities, and I would accordingly expect him to be disciplined by his own professional body accordingly".

156. Thus there are two important aspects of the requirements which I have set out in paragraph 154 above. First, these guidelines have to be strictly observed and second if they are not, the medical professional concerned can expect to be disciplined by his or her professional body. . The 2004 Guidance is not unlawful for any of the reasons contended for by Mr. Havers. Thus, for the reasons which I have sought to explain, the claimant is not entitled to the relief which she seeks.