

In re C. (A CHILD) (H.I V TESTING)

[FAMILY DIVISION]

[2000] Fam 48

3 September 1999

**JUDGMENT:**

Wilson J: delivered the following judgment.

A. The application

The London Borough of Camden, the local authority, have applied with the leave of the court for a specific issue order under section 10 of the Children Act 1989. The application concerns a baby girl, aged almost five months, who lives with her parents. The order sought by the authority is that the baby should be subjected to a blood test with a view to determining whether she is infected with H.I.V.

The parents, who are not married, are united in vehement opposition to the application. The mother has been represented by leading counsel, Mr. Horowitz. The father, upon whom the mother has by written agreement conferred parental responsibility for the baby, has represented himself, with the assistance of a "McKenzie friend:" see *McKenzie v. McKenzie* [1971] P. 33. Prior to the main hearing, the father explained to me that the decision that he should represent himself, rather than join with the mother in instructing Mr. Horowitz, was strategic in that it would enable him to pursue avenues that Mr. Horowitz might not pursue. Such has indeed proved to be the case. The baby has been represented by the Official Solicitor as her guardian ad litem. The Official Solicitor supports the local authority's application. The hearing has proceeded for four days exclusive of today.

B. The history

The mother is 32 years old. She is not a promiscuous person. In 1990 a man with whom she had had a long relationship told her that he was H.I.V. positive. She took an H.I.V. test known as the Elisa test. The result was positive. The mother was devastated.

The mother has never developed any symptom of Aids and has, on the contrary, remained in very good health. After about 1991 she stopped undergoing the regular blood tests which had been recommended to her. She read widely about H.I.V. and Aids and developed doubts about the validity of the generally accepted theories about their nature, development and optimum treatment. She began to explore complementary therapies. She concentrated on healthy eating and keeping fit. She studied therapeutic movement and became licensed to administer shiatsu massage. For two years she worked for a voluntary organisation critical of the medical approach to H.I.V. and Aids.

In 1997 the mother met the father, who is now aged 36. The father had practised for a number of years in the sphere of holistic health care, including massage and reflexology. Before they began a sexual relationship and lived together, the mother told the father of the diagnosis of H.I.V. The father quickly came to share her sceptical views about the conventional approach to H.I.V. and Aids and immersed himself in the subject. They decided to try to have a baby. Before doing so, the father himself underwent the Elisa test for H.I.V. His result was negative. In July 1998 the mother became pregnant. They were delighted. The mother was well aware of the three limbs of advice conventionally offered to pregnant women infected with H.I.V.: to take medication in the last weeks of the pregnancy; to give birth by unforced caesarian section; and not to breast feed. She had no confidence in the validity of such advice. Nor did she want to come under pressure to accept it. So in December 1998 she had another Elisa test for H.I.V. She hoped that this time it might be negative; but it was still positive. She decided nevertheless not to take any medication.

In April 1999 she had a natural water-birth at home, supervised by a midwife to whom she had divulged her H.I.V. status. The birth was uncomplicated and after a few minutes the mother began to breast feed. The mother has breast-fed the baby ever since. The baby seems fit and well in every respect. On two occasions the baby was brought into court so that the mother, who was cradling her in her arms, could continue to listen to the proceedings. The baby is adorable.

In June 1999 the parents, who had not consulted a doctor for some years but who, since the birth, had co-operated fully with the health visitor, needed to take the baby to a doctor for a developmental examination. They chose a new G.P., to whom the mother's old N.H.S. records were transferred. The G.P. had not read the mother's records by the time when she examined the baby. A few days later, however, she read them. She telephoned the mother and asked her urgently to come to a meeting. On 8 July both parents met the doctor. The doctor expressed grave concern that the baby might already have been infected with H.I.V. and that, if not, continued breastfeeding might make her so. She said that the baby should be tested for the infection. The parents disagreed. The doctor said that she felt obliged to speak to officers of the local authority and experts at Great Ormond Street Hospital.

Later, rather reluctantly, the parents attended a long meeting with Dr. Gibb, a consultant paediatrician at Great Ormond Street. The parents were taken aback to discover that a social worker was also present. There was a long inconclusive discussion. The parents explained that they could not agree with Dr. Gibb that the baby should be tested for infection; nor did they agree with her about the danger of transmission through breast-feeding or the risk that, if she was already infected, she might, without prophylactic antibiotics, succumb to the strain of pneumonia known as P.C.P. (pneumocystis carinii pneumonia).

A few days later, after a further attempt on the part of another social worker to persuade the parents to agree to a test, the local authority successfully applied for leave to issue these proceedings.

#### C. The nature of the issue

The local authority seek a direction that one sample of blood be taken from the baby and that the DNA in the blood be subjected to a Polymerase Chain Reaction ("P.C.R.") test, with a view to establishing whether she is infected with H.I.V. They say that the likely accuracy of the result is extremely high; and that the result, whether positive or negative, will enable the doctors to give, and the parents to receive, focused advice on the best course of action to take, both while she remains asymptomatic and if ever she developed symptoms of disease.

The parents contend that the application for an order is an affront to their parental autonomy. They say, correctly, that they are devoted parents and that, though not medically qualified, they know much more about the subject of H.I.V. and Aids than almost all lay people. The mother stresses that she was diagnosed as positive; has rejected orthodox advice to continue to be regularly tested in respect of her T-cell count and her viral load; has not taken any form of medication; has pursued a healthy lifestyle and has not developed any symptom of Aids for nine years. That, say both parents, confers a particular authority upon the mother's views.

The parents say that they do not believe, or at least that they do not regard it as established, that what is described as H.I.V. is truly a virus. They say that it is more accurately described as oxidative stress on the cells of the body, which causes an increase in metabolism, and that it arises as a result of an unhealthy lifestyle. That, say the parents, is what breaks down the immune system and causes Aids. Alternatively, say the parents, if there is a such a virus, it is not the sole cause of Aids. They also contend that all the available tests for so-called H.I.V. have a ratio of inaccuracy which makes them positively dangerous. So, even if the virus exists, they deduce from the results of the tests on the mother only that she may well have the virus, not that she definitely has it. They say that there is no value in having the baby tested. They would be sceptical of the result, whichever it was, and would not alter any aspect of their care of the baby by reference to it.

The parents say that there is no risk of transmission to the baby of the so-called virus through breastfeeding. If the baby developed symptoms of illness which reasonably required medical treatment, they would seek such treatment in the ordinary way, without reference to the possibility that she was infected, so that she would not be subjected to the aggressive interventions which represent the current orthodoxy but which, in their view, do more harm than good.

#### D. The witnesses

The medical evidence called by the local authority has come from Dr. Novelli, consultant in paediatric infectious diseases at Great Ormond Street Hospital.

An initial order in these proceedings had confined the parents to reliance upon one expert. But I waived that restriction and allowed them to have two experts. The mother has adduced - has been obliged under our rules to adduce - a short report by Dr. Mok, consultant paediatrician at the Royal Hospital for Sick Children in Edinburgh, which is basically unhelpful to the parents' case. Dr. Mok did not give oral evidence. The father has called Professor de Harven, a retired professor of pathology at a university in Ontario and a pioneer in the field of electron microscopy. The parents

have also put into evidence a number of published articles and also a letter, actually in rather ambiguous terms, from Dr. Mullis, the Nobel Prize-winning inventor of the P.C.R. test.

The Official Solicitor's expert has been Dr. Walters, a senior lecturer in paediatric infectious diseases at Imperial College, London, and an honorary consultant paediatrician at St. Mary's Hospital, Paddington.

The parents were very concerned that the Official Solicitor chose to instruct Dr. Walters, who knows Dr. Novelli well and is a co-author with him of published material. The parents considered that the Official Solicitor should have instructed somebody more independent. But expertise at the top level in the field of paediatric H.I.V. and Aids in Britain is reposed in few hands. Anyone listening to the evidence of Dr. Novelli and Dr. Walters would have come unhesitatingly to the conclusion that, although they were largely in agreement, their views were the product, in each case, of an astonishing grasp of the fast-changing understanding of the subject of H.I.V. and Aids worldwide, of current international research, of the areas which have been or still are the subject of disagreement, and of their extensive separate clinical experience.

A subject which never fails to intrigue me is the various extra functions of a hearing in the Family Division. The function often extends so much further than to reach a conclusion upon the issue raised. Sometimes the extra function is cathartic, so that parents who have to come to terms with a terrible reverse can at least feel for the rest of their lives that they did all that they could and that the judge listened empathetically. Another, less common, example of the extra function is to parade before a mother so much evidence of the danger which her new partner represents to her children that she can decide in an informed way whether to continue that relationship.

Here, too, there has been an extra function, new in my experience. One of the parents' complaints is that the local authority took proceedings before there had been sufficient discussion of the issues. I have to say that, in the light of the urgency of the subject, I do not find the complaint valid. At all events the hearing before me at times almost took the form of a long and intelligent discussion of the issues relating to the treatment of a baby between knowledgeable parents on the one hand and two top-flight consultants on the other. It was almost as if the rest of us were flies on the wall of the consulting rooms at Great Ormond Street Hospital and at St. Marys. Each doctor was questioned on behalf of the parents for about three hours; and the questions, both from Mr. Horowitz on behalf of the mother and from the father himself, were admirable in every way. So also, as I have concluded, were the answers.

## E. The evidence

### 1. The mother's condition

If, for the moment, we make three assumptions, namely that the virus H.I.V. exists, that it causes Aids and that the mother was infected with it in 1990, what should we deduce from the fact that, apart from the considerable stress of these proceedings, which in fact has led her not to come to court today, the mother feels fine and that she presents no symptoms of Aids?

The unchallenged evidence in the case is that in industrialised countries the median time between infection with the virus and serious clinical manifestations of the syndrome is ten years. So, although we must celebrate the mother's continued good health, there is nothing abnormal about it. The doctors would like to have monitored her since 1990 and in particular to have tested, through her blood, whether her viral load was increasing and whether her T-cell count (or, to be more specific, the ratio of CD-4 cells to CD-8 cells in her T-cells) was diminishing. In either of those events they would have advised the mother to take a combination of medications to counteract it. But, granted that she will not allow them to know what is occurring behind her healthy exterior, they agree that her chosen lifestyle, namely careful diet, exercise, the absence of drugs and an attempt to find contentment and peace for body and soul, is for the best. The stress of further conflict with doctors or in court should, if possible, be avoided.

### 2. The baby's condition

On the same three assumptions, Dr. Novelli and Dr. Walters have persuaded me without difficulty that there is a chance that the baby is already infected with H.I.V. She could have been infected during pregnancy or in the course of the vaginal delivery. Research shows that in Europe those two risks amount to a 15 per cent. chance of infection. But I find that the risk has been increased by the breastfeeding.

Breastfeeding by infected mothers is so rare in Europe that data has to be drawn from the developing countries; that has enabled the parents to argue that the data may not be apposite. But, to my mind, the weight of the evidence is overwhelming, notwithstanding a tentative question mark placed against the general understanding by a South African study

reported very recently in *The Lancet*, vol. 354, 7 August 1999, "Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study." The extra risk of transmission through breastfeeding for the first five months of life is calculated by Dr. Novelli at 5 per cent. and by Dr. Walters at 10 per cent. There is no need for me to choose between these numbers. There is, therefore, either a 20 per cent. or a 25 per cent. chance that this baby is already infected with H.I.V.

### 3. Breastfeeding from now onwards

The mother says that she will continue to breast feed the baby until it feels right not to do so. She says that she might well continue until the baby is between nine months and 18 months old, or even until she is two years old. The general advantages of breastfeeding are clear and, if the baby is already infected, the breastfeeding should probably continue. If, however, the baby is not already infected, I have become convinced by the unanimous evidence of the experts that the breastfeeding should cease. From the research, Dr. Novelli and Dr. Walters both put the risk of transmission through late breastfeeding of this sort at about 3.2 per cent. for each year, i.e. 0.27 per cent. for every month from now onwards. In a letter to the father, the co-author of the recent South African study repeats that statistic and confirms that his study does not undermine it.

### 4. Accuracy of the P.C.R. test

No one suggests that the baby should undergo an Elisa test. That is a test from which the H.I.V. virus is diagnosed by the presence of antibodies generated in reaction to it; and a baby up to 18 months old may possess such antibodies by inheritance from the mother and thus this test might indicate infection in a baby even where there was none. The suggested test is P.C.R., of which there are two varieties, namely by amplification of the DNA and of the RNA found in the chromosomes of the cells. The P.C.R. test on the DNA is said to identify the presence of the virus, whereas the test on the RNA identifies its amount, i.e. the viral load.

Dr. Novelli, supported by Dr. Walters, states that both the sensitivity (i.e. the incidence of a positive result if the virus is present) and the specificity (i.e. the incidence of a negative result if the virus is absent) of the P.C.R. test on DNA, if performed under rigorous laboratory conditions, are extremely high; say, about 95 per cent. for a baby aged three months and higher for an older baby. Indeed, they almost entirely discount the chance of a false positive; and they address the very small chance of a false negative by routinely recommending a second test. Dr. Walters says that the introduction of the P.C.R. test upon DNA in about 1996 represented a breakthrough in H.I.V. paediatric care and has since become the mainstay of its diagnosis.

Both doctors add, however, that the test will not reveal any infection communicated within the previous eight weeks. So, for example, a negative result obtained now would not reveal infection communicated from breastfeeding within the last eight weeks. Thus they say that, even if the result was now negative, a further test should be taken eight weeks after the date when breast feeding ceased.

It is in particular to the accuracy of the P.C.R. test that the evidence of Professor de Harven is addressed. But, in his assault upon its accuracy, the professor articulates the fundamental doubts about the nature of so-called H.I.V. and the cause of Aids which inform the parents' own philosophy. The professor spent his professional life identifying viruses with electron microscopy. But, he says, so-called H.I.V. has never been thus visible. So, asks the professor, what is the evidence that it exists? There is none which satisfies him. He says that the genome, namely the full sequence of constituents of a virus, has never been satisfactorily identified in the case of H.I.V.; and that, when different sequences are found, the experts are driven to save their theories by saying that the sequences are all H.I.V. and that the virus is simply mutating. The professor does not accept that the collection of pathologies which are called Aids is caused by a virus. He suggests that the very fact that there is still no cure for Aids raises a question against the conventional analysis of its causation. He says that there is no specificity (absence of false positives) whatsoever in a P.C.R. test and that all testing for H.I.V., whether of adults or of children, should cease until the cause of Aids is better understood.

The professor, who was extremely charming, was the first to accept that his is a dissident view. It is none the worse for that. Orthodoxies are there to be challenged; and I would hope that there is no better place to do so than in a court of law. But, to my mind, the doubts of the professor, who is not an expert in H.I.V. or Aids, are as nothing in comparison with the body of evidence that, when, by the methods which he condemns, this so-called virus is found to be absent, there is no development into Aids; but that, when it is found to be present, there is such development, whether sooner or later; but that, in the latter case, the development can now successfully be checked, at least temporarily, by the suppression of viral replication and other treatments.

Dr. Novelli disputes that the major genes within the genome of H.I.V. are unknown. He says that the virus has been isolated and that the mutations are very small. But more telling even than his theoretical refutation of the professor's argument are his and Dr. Walters's anecdotes about their lives as clinicians in two of the three H.I.V. paediatric units in London. At Great Ormond Street Dr. Novelli has been closing his wards; his patients are out-patients, taking antiretroviral treatment. Since 1997 his hospital has had one death in this sphere; before then, there were six each year. Dr. Walters's evidence is to the same effect: he has not attended a child's funeral for three years; before then, he had to attend them regularly.

That evidence makes it very hard for the professor, or the parents, to argue against the value of the newly conventional methods for diagnosing and treating children with H.I.V.

#### 5. P.C.P.

On the evidence before me, 20 per cent. of babies infected with H.I.V. will develop a serious Aids-related illness within the first year of life unless they are treated with a prophylactic. Two-thirds of those babies will develop P.C.P. Indeed P.C.P. is a very strong indication of H.I.V. Of those who develop P.C.P., 30 per cent. will quickly die. On these figures this baby, if infected, stands a 4 per cent. chance of dying from P.C.P. before she is one year old, unless she is treated with a prophylactic. In fact the odds improve slightly as her first year of life progresses; but they remain chilling.

The recommended prophylactic is the antibiotic drug named Septrin, which Dr. Novelli and Dr. Walters say is very widely and successfully used. Dr. Walters even suggests (Dr. Novelli disagrees) that the baby should begin to take Septrin today because she is not yet known to be uninfected. Both doctors accept that the drug can have side-effects. But, in their estimation, the balance of risks is heavily in favour of prescribing it, at any rate once H.I.V. is identified.

At the moment the parents are strongly opposed to the baby taking Septrin, even if she was identified as having the virus. They are very concerned about the side-effects; and, having known people who have died of P.C.P. while taking Septrin, they are by no means convinced that it even works. They also regard the baby's chance of contracting P.C.P. as negligible.

#### 6. Regular monitoring

If the baby proved to be infected with H.I.V., the doctors would propose that she be monitored regularly in a specialist unit. Every month or two they would wish to examine her; but, in particular, to conduct further blood tests in order to monitor her immune system, in particular her viral load and her T-cell count.

At present the parents consider that they should be their baby's only monitors and that they would reject that proposal, which would, they say, inappropriately cast the baby into a category of special risk.

#### 7. Combination therapy

Dr. Novelli and Dr. Walters say that many practitioners in the United States would now prescribe three or four anti-retroviral drugs in combination for a child as soon as H.I.V. infection was diagnosed, but that in the United Kingdom there is a tendency to greater conservatism. They would recommend combination therapy only when Aids-related symptoms developed or there was an undue rise in the viral load or fall in the T-cell count.

At present the parents would reject any such therapy for the baby. They say, of course correctly, that the combinations are so new that, even if they have short-term benefits, their long-term consequences are unknown.

#### F. The relevance of the parents' wishes

Section 1(1) of the Children Act 1989 provides that the baby's welfare shall be the paramount consideration in my determination of this application.

It is accepted on all sides that the parents' wishes are of great importance; but it is still worthwhile to reflect how they interlock with the over arching inquiry into the baby's welfare. When the parents advance arguments with which the court agrees, there is no difficulty. The more problematical evaluation is of the relevance of the parents' wishes when such are based on arguments with which the court does not agree.

The leading authority is *In re T. (A Minor) (Wardship: Medical Treatment)* [1997] 1 W.L.R. 242. In that case a baby aged 18 months suffered from a liver defect from which he was likely to die within a year. Three doctors recommended a liver transplant. The parents, who were abroad with the child, rejected the recommendation. When he had been but weeks old, the boy had had an unsuccessful operation which had caused him considerable distress and which

had influenced the parents' thinking. The proposed transplant was accepted to be a very major form of surgery, with a necessity for extensive post-operative treatment and for a substantial extra dimension of parental care throughout childhood. Only one of the three doctors said unequivocally that the operation should be performed even without parental consent. The Court of Appeal ruled that the judge at first instance had been wrong to direct the transplant. Butler-Sloss L.J., at p. 251F, made clear that, even if, which was debatable, the judge had been right to declare the parents' stance unreasonable, the question of its reasonableness was not the primary issue. And Waite L.J. said, at p. 254:

"All these cases depend on their own facts and render generalisations - tempting though they may be to the legal or social analyst - wholly out of place. It can only be said safely that there is a scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course a certainty) that the greater the scope for genuine debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature."

Those last words have led me to wonder whether in some, if not all, circumstances it is possible, and, if so, helpful, to discern in the law a butttable presumption that the united appraisal of both parents will be correct in identifying where the welfare of their child lies. Support for that proposition is arguably derived from section 1(5) of the Act of 1989, which prohibits the court from making any order under the Act unless it considers that to do so would be better for the child than not to do so. Not to do so is to leave the decision in the hands of those with parental responsibility for the child; and so any applicant for an order has, in effect, to persuade the court that there are positive grounds for taking the matter out of those hands. Furthermore, under article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1953) (Cmd. 8969), the parents and the baby all have a right to respect for their family life; and it will be interesting to see, once the Human Rights Act 1998 is in force, whether that article will require our inquiry into a child's welfare to be analysed in that way.

At all events I collect from *In re T. (A Minor) (Wardship: Medical Treatment)* [1997] 1 W.L.R. 242 the proposition that the views of these parents, looked at widely and generously, are an important factor in the decision, even to some extent irrespectively of the validity of the underlying grounds for their views.

But *In re T.* also shows that the views of the parents may have another significance. The intervention proposed for the child may be, in effect, unworkable without their consent. In *In re B. (A Minor) (Wardship: Medical Treatment)* [1981] 1 W.L.R. 1421, the court overruled the parents and authorised an operation to be performed in order to remove an intestinal blockage in a Down's syndrome baby. In *In re T. (A Minor) (Wardship: Medical Treatment)* [1997] 1 W.L.R. 242, 252 Butler-Sloss L.J. distinguished that case as follows:

"Unlike the intestinal obstruction of the Down's syndrome baby which could be cured by a simple operation, T.'s problems require complicated surgery and many years of special care from the mother."

A different, yet allied, situation may arise where to override the parents' wishes is to risk causing them such emotional distress as will disable them from caring properly for the child or, at any rate, as will indirectly affect the child's own emotional stability to a significant extent.

For all these reasons a court invited to override the wishes of parents must move extremely cautiously. My only reservation about the submissions of Mr. Horowitz upon the law relates to his assertion that the lack of a crisis or emergency in this case gives the parents' views an even greater authority. If this baby is infected, then, since she is not receiving Septrin, we arguably have an emergency. But in any event I do not see the nexus between an emergency and a lesser degree of autonomy for the parents, unless, for example, the emergency were to preclude them from having time to reach an informed view.

#### G. The advantages of the proposed test

I must remind myself that all that is sought is a direction for one test. Understandably the local authority have found it difficult, in the light of the evidence, to decide what programme of testing might best be included in any order. In particular, should they ask that, if the first test was negative, there should be a second test eight weeks after the cessation of

breastfeeding? Bearing in mind that breastfeeding following any negative test is presently a substantial issue for the parents, I think that the local authority are wise to keep the present legal conflict within the bounds of one test.

Although the issue revolves only around testing, indeed only around one test, its apparent simplicity has proved deceptive. It has been necessary, as this judgment has shown, for the court to investigate fairly fully the likely medical reaction to a positive result and, indeed, to a negative result, as well as to investigate the subject to which I now turn, namely the likely consequences of the continued absence of any testing of this baby at all.

Dr. Novelli and Dr. Walters both say that, if the baby is not tested for H.I.V., the professionals who should be advising on her care, and all good parents as they decide how to respond to that advice, are under a grave handicap which can only be to the prejudice of the baby. If, in the absence of a test, the baby develops illness, a doctor treating her who knows of the possibility that she is infected will have to cater for that possibility in the proposed treatment; if, in fact, the baby is uninfected, it is likely that the proposed treatment will be unduly aggressive. If, as the parents currently propose, the doctor treating her would not know of the possibility that she is infected, the proposed treatment would not be devised by reference to it; and if, in fact, the baby is infected, it is likely that the proposed treatment would then be dangerously slight. It may be said that, even if there was a positive test, the parents might still choose to keep the doctor unaware of it. Having listened to them and developed a respect for their integrity, I doubt that they would do so. But, whatever cannot be achieved by further court order, disclosure of the baby's H.I.V. status to treating professionals could, in my view, be ensured.

I turn to the converse. If a test were conducted and returned positive, the firm professional advice could be given to which the afflicted baby is entitled. The issue of breastfeeding would fall away. In its place would arise the issues around Septrin, regular monitoring, including further testing, and, in the event of a decline, combination therapy. It may be said that the parents have made clear that they would reject advice to that effect. But their current rejection of it is asserted in ignorance of the facts. They will naturally cling to the hope that their baby is not infected; and that will inform, and on this hypothesis distort, their present response.

If the worst comes to the worst, there can be further proceedings. Is it helpful for me now to anticipate their possible result? Any comments at this stage might prove misplaced. On the other hand I am eager to spare the parents the stress of further proceedings. With diffidence I suggest that, if the baby was infected, the court might well order monitoring, including further regular testing; and that, if she went into decline, it might well order combination therapy.

Whether the court would order the baby to take Septrin as a prophylaxis is very difficult. It would depend obviously on the case against it then mounted by the parents and the extent to which they had, by then, given informed consideration to the case in favour of it. At one stage of his submissions the father asked me to assume that the baby was mine. So I feel emboldened to comment that, if this baby was mine, and infected, then, on the evidence before me, she would take Septrin. But the parents' view in this respect would be very important.

If a test were conducted and returned negative, then again firm professional advice could be given. Apart from questions of a confirmatory test and/or a test eight weeks after the date, whenever it was, when breast-feeding ceased, the urgent question would then arise of whether the breastfeeding should at once cease. It may be said that the definite advice that would be given to that effect would be rejected by the parents. But, again, their present stance is necessarily uninformed. The mother desperately wants to continue to breast feed and the parents may, perhaps even unconsciously, be justifying that stance by reference to the horrifying possibility that, contrary to their hopes, the baby is already infected. I am clear that, as good parents, they would owe it to the baby radically to reconsider their stance on breastfeeding if any test proved negative.

The local authority have made clear at the outset of the proceedings that their strong provisional view is that they would not want to ask the court to order the mother not to breast feed the baby, however misguided her stance was. Should I, nevertheless, hang over the mother's head the possibility of a court prohibition against her breastfeeding the baby? My belief is that the law cannot come between the baby and the breast. Indeed, if she cannot be persuaded by rational argument that she must curb her instinct to feed, I doubt whether the mother would comply with a court order, which would be in effect impossible to enforce. The parents will respond better to this judgment if they realise that it has intellectual integrity and makes no idle threats.

#### H. Conclusion

I rate the advantages of the proposed test set out in section G to be very substantial. The principal disadvantage is the effect of its imposition on the parents: the affront to them; the stress of medical and legal intrusion into their lives, which they have striven to make, as they see it, healthy and peaceful; and the prospect of further conflict with orthodox

medicine, and even perhaps with the law, in the wake of the result. Mr. Horowitz says in terms that the mother "opposes testing because she opposes the inevitable sequel to testing." Clearly, however, in terms of the need for the proposed directed intervention to be supported by active commitment by the parents in the long term, this case is at the end of the spectrum opposite to that in *In re T. (A Minor) (Wardship: Medical Treatment)* [1997] 1 W.L.R. 242.

One has to be appropriately imaginative about the position of the parents. They are far from lone voices in their dissent from mainstream opinion. But, in particular, I must never forget the mother's own tragic plight, having been infected with H.I.V. in circumstances which can attract no moral blame. She, and the father who loves her, cling to their theories with the intensity of the shipwrecked mariner who clings to the plank of wood. Her right is to fight her infection, but here I refer to her owninfection, in her own way. The mother said in evidence that, when the baby was older, she would talk to her about the possibility of infection, and, if she then wanted to take a test, she would allow her to do so. On the evidence before me, that is a hopeless programme for the baby's protection.

Although the conception and the breastfeeding of the baby have both been premeditated, I must also not ignore the possible effect on the mother of being confronted now with clear evidence that she has created a child suffering a potentially deadly infection.

The concluding words of the father's eloquent final submissions were these: "Whatever the outcome of this case, we would have lost if we had not stood up for our rights." But this case is not at its heart about the rights of the parents. And if, as he in effect suggested in his evidence, the father regards the rights of a tiny baby as subsumed within the rights of the parents, he is wrong. This baby has rights of her own. They can be considered nationally or internationally. Under our national law I must determine the case by reference to her welfare (section 1(1)); and, in particular, I must have regard to her physical needs (section 1(3)(b)); to her background, namely her mother's infection (section 1(3)(d)); and to the harm which she is at risk of suffering (section 1(3)(e)).

The United Kingdom has ratified the United Nations Convention on the Rights of the Child (1989) (Cm. 1976). Article 5 provides:

"States parties shall respect the responsibilities, rights and duties of parents . . . 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 recognised in the present Convention."

Article 6 provides:

"(1) States parties recognise that every child has the inherent right to life. (2) States parties shall ensure to the maximum extent possible the survival and development of the child."

Article 24 provides:

"(1) States parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness . . ."

The Convention does not have the force of law but assists in our interpretation and development of the law. It is interesting to note that, in requiring respect for the responsibilities and rights of the parents, article 5 links them to the provision of appropriate direction and guidance in the child's exercise of her or his own rights.

In order that her rights should be properly articulated, the baby in this case has been represented by the Official Solicitor. A court will always look critically at the submission of the child's representative and in my experience in a significant minority of cases disagree with it. In this instance, however, I agree with the Official Solicitor that the case for testing the baby is overwhelming. I order it to take place. I do not propose to be very flexible about the timing of it. But in relation to the other circumstances, such as where and by whom it is to be conducted, I would like, following a short adjournment, to receive further submissions, in particular from the parents. That will take place in private and I propose that nothing further will be said in open court.