R v Cambridge Health Authority

[1995] 2 All ER 129

R v Cambridge Health Authority, ex p B

COURT OF APPEAL, CIVIL DIVISION

SIR THOMAS BINGHAM MR, SIR STEPHEN BROWN P AND SIMON BROWN LJ

10 MARCH 1995

Medical treatment – Withdrawal of treatment – Refusal to allocate funds – Judicial review – Minor aged 10 years – Minor suffering from acute myeloid leukaemia – Doctors in charge of minor's treatment advising that no further treatment could usefully be administered – Medical experts retained by minor's father advising that further treatment worthwhile – Health authority refusing to fund further treatment – Whether decision lawful – Role of courts in determining whether health authority's decision lawful.

B, a 10 year old girl, was first diagnosed as suffering from non-Hodgkins lymphona with common acute lymphoblastic leukaemia in 1990. Treatment appeared to be successful but in 1993 she developed acute myeloid leukaemia. After further chemotherapy, total body irradiation and a bone-marrow transplant the disease went into remission, but B suffered a further relapse in January 1995 and the doctors treating her gave her six to eight weeks to live. They were of the opinion that B should be given no further remedial treatment but only palliative treatment to enable her to enjoy several weeks or months of normal life prior to progression. B's father sought further medical opinion and, in particular, that of two experts who were of the opinion that further treatment, including a second bone-marrow transplant, was possible. However, because of the unavailability of beds in the only National Health Service hospital prepared to carry out such treatment, it could only be administered privately. The proposed treatment would be administered in two stages, the first being a further course of chemotherapy costing £15,000, with an estimated 10 to 20% chance of success, which would be followed, if remission was achieved, by the second stage, a second bone-marrow transplant costing £60,000 which had a similar 10 to 20% chance of success. In the light of those opinions, B's father requested the health authority responsible for his daughter's care to allocate funds amounting to £75,000 for the proposed treatment. The health authority refused. B's father, acting as her next friend, applied for judicial review of the health authority's decision. Affidavit evidence filed on behalf of the health authority stated that, in reaching the decision not to allocate further funds, consideration had been given to:

(a) whether the proposed course of treatment was appropriate for B, having regard to the clinical judgments of the doctors who had treated B since the disease was first diagnosed and who had performed the first bone-marrow transplant, whose opinion was that a second transplant was not in B's best interests,

(b) guidance given by the Department of Health in respect of non-proven or experimental treatment and the fact that the proposed course of treatment for B was neither standard nor formally evaluated, and

(c) whether the expenditure involved was an effective use of resources given the small prospect of success and having regard to the authority's responsibility to ensure that it had sufficient funds for the treatment of other patients which was likely to be effective.

The judge refused to make an order of mandamus directing the health authority to fund the treatment but made an order of certiorari quashing the health authority's [1995] 2 All ER 129 at 130 - decision not to fund any further treatment and requiring the health authority to reconsider its decision on the grounds, inter alia, that it had not had regard to the father's views as to B's best interests, that it had

wrongly refused to allocate funds because it considered a second bone-marrow transplant 'experimental', that when it referred to the use of resources it had not adequately explained the funding priorities that had led to the decision, and that it had wrongly considered the issue to be the expenditure of £75,000 when, initially, the only expenditure required was £15,000. The health authority appealed.

Held – On an application for judicial review relating to medical treatment the court could only consider the lawfulness of the decision at issue and it was not for the court to decide between conflicting medical opinions or to decide how a health authority's limited budget should be allocated between opposing claims on its resources. On the facts, it was clear:

(i) that the judge had been wrong to criticise the manner in which the health authority had reached its decision, since those taking the decision on behalf of the authority must in reality have been very aware of the wishes of B's family,
(ii) that the health authority's decision was not flawed because of the use of the expression 'experimental' to describe the treatment, since the proposed treatment did not have a well-tried track record of success and was at the frontier of medical science,
(iii) that a court was not in a position to decide on the correctness of the difficult and agonising judgments which had to be made by health authorities as to how a limited budget was best allocated to the maximum advantage of the maximum number of patients, and
(iv) that the health authority had correctly proceeded on the basis of allocating the total amount required or not proceeding at all, since if the first stage were successful the authority would have been bound to continue funding the second stage. It followed that the appeal would be allowed and the judge's order rescinded (see p 136 b c g to p 137 b d to j and p 138 b to j, post).

Notes

For functions of health authorities in general, see 33 Halsbury's Laws (4th edn) para 163.

Cases cited in argument

Brind v Secretary of State for the Home Dept [1991] 1 All ER 720, [1991] 1 AC 696, HL.
Bugdaycay v Secretary of State for the Home Dept [1987] 1 All ER 940, [1987] AC 514, HL.
Appeal

The Cambridge Health Authority appealed from the order made by Laws J hearing the Crown Office list on 10 March 1995 granting an application by B, suing by her father as next friend, for an order of certiorari quashing the authority's decision on 22 February 1995 not to fund any further treatment of B (who was in the authority's care) by chemotherapy and a second bone-marrow transplant. The facts are set out in the judgment of Sir Thomas Bingham MR.

Nigel Pitt (instructed by Mills & Reeve, Cambridge) for the health authority.

Bruce McIntyre (instructed by Sharpe Pritchard, London, agents for Kerseys, Ipswich) for B.

[1995] 2 All ER 129 at 131

SIR THOMAS BINGHAM MR.

This is an application for leave to appeal (and if leave is granted an appeal) against a decision of Laws J. The case has been listed under the title 'Ex parte B' and the court has made a direction under s 39 of the Children and Young Persons Act 1933 that nothing be published which leads to the identification of the minor involved in the case. The reasons for that order will be quite obvious as I summarise the facts. I would supplement the formal order of the court by a special plea to those involved in reporting this

matter that, so far as possible, the case be reported in such a way that it will not only prevent identification of the child but prevent even the child herself realising that she is the subject of the report. The reason for saying that is that the child is desperately ill to an extent that she herself would not appreciate. Nothing could be more tragic than that she should, by reading a newspaper or watching the television, learn even indirectly of her own condition.

The order which is the subject of appeal is an order of certiorari quashing a decision of the Cambridge Health Authority not to fund any further treatment of the child involved in this case by way of chemotherapy and a second bone-marrow transplant.

B is a child now aged 10. In September 1990 it was first diagnosed that she was suffering from what is technically known as non-Hodgkins lymphoma with common acute lymphoblastic leukaemia. This was treated with chemotherapy over a period of months. In August 1992 that course of chemotherapy treatment was completed, for the time being successfully.

Unhappily, the successful treatment did not endure. In December 1993 the child developed acute myeloid leukaemia and was treated for the second time with a course of chemotherapy. On this occasion she underwent a course of total body irradiation, a fact of some importance since it appears to be accepted by medical opinion that that is treatment which no one can undergo more than once.

In March 1994 B underwent a bone-marrow transplant. Again, for a substantial period of months there was every reason for her family to hope and believe that the transplant had been successful. Unhappily that turned out not to be so. In January 1995 she suffered a further relapse of acute myeloid leukaemia. It is that relapse that has given rise to the present proceedings.

At all times B's family, and in particular her father, have strained every nerve to procure for her the best possible treatment. They have always had, as one would expect, her best interests at the very forefront of their minds. The father has deposed that when this further relapse took place he consulted doctors at Addenbrooke's Hospital in Cambridge, including Dr Broadbent, the doctor who had treated B over the years since 1990. At that stage, Dr Broadbent's medical judgment was that the child had a very short period of some six to eight weeks to live and that no further treatment could usefully be administered.

Other doctors who had had the care of B at earlier stages (in particular two doctors at the Royal Marsden Hospital in London, one of whom had performed the bone-marrow transplant in March 1994) were consulted, who shared the opinion of Dr Broadbent; the health authority was invited to allocate funds for the treatment of B. The treatment involved was potentially a further course of chemotherapy which, in this case, would be a third course. If that was successful, and only if successful, that would be followed by a second bone-marrow transplant operation.

B's father was unwilling and understandably reluctant to accept the views expressed by Dr Broadbent and others. He approached doctors in the United States. Certain doctors there differed from the view which had been expressed

by the English doctors and thought that there was a substantial chance of further treatment being successful. Unhappily, however, medical treatment in the United States does not come free and does not come cheap. The cost of treatment by these experts in the United States was, at least to English eyes, prohibitive. B's father accordingly sought help from additional doctors in this country. In particular he approached a notable expert in this field, Professor Goldman of the Hammersmith Hospital, a professor at the Royal Postgraduate Medical School.

We have two letters of 14 and 17 February written by Professor Goldman to Dr Pinkerton of the Royal

Marsden. In his letter of 14 February, Professor Goldman wrote, having summarised briefly the further relapse which had overtaken B:

'I had a long discussion with the father about possible options for further therapy. In essence I agreed with the alternatives that you set out. The compromise that I thought might be reasonable would be to offer the patient further chemotherapy with the hope of achieving a complete remission. A reasonable combination might be MAE [and I omit the chemical names for which that is an abbreviation] because this should not involve excessive additional cardiotoxicity. If complete remission could be achieved, then one might contemplate a second transplant, either with the original sibling donor or conceivably with a matched unrelated donor. I rank the chance of success with this approach as less than 20 per cent.'

In his letter of 17 February, Professor Goldman wrote, having had the benefit of a discussion with the consultant paediatrician at the Royal Marsden:

'I stand by my view that it would be reasonable to give [B] further chemotherapy with cytotoxic drugs in the hope of achieving complete remission. I realise of course that this may not succeed but I regard it as the best palliative approach to a patient with acute myeloid leukaemia in relapse after bone marrow transplantation, whatever the age of the patient. If the patient were fortunate enough to achieve complete remission, one could contemplate a second transplant procedure. Obviously this is a high risk strategy and one would need to think very carefully about approaches designed to prevent relapse on a second occasion. This however would not be a totally impossible task. This second transplant could in certain circumstances be carried out at the Hammersmith Hospital in London. If a decision to give further chemotherapy now were accepted, the issue arises as to where this might take place. I understand that neither you [that is Dr Mellor] nor Dr Broadbent in Cambridge is keen to undertake further treatment of this nature. We would do so at the Hammersmith but just at present we have no bed availability and it seems unlikely that any bed would be available within the next 2–3 weeks. In these circumstances, I have no option but to suggest to [the father] that he seeks treatment in the private sector. I know for example that Dr Peter Gravett would treat [B] with extreme efficiency and with some luck, a second remission could be achieved.'

The officer of the health authority with responsibility for contracting for the purchase of medical and surgical services outside his authority is a highly qualified physician named Dr Zimmern. On 21 February he wrote to B's father recording that he had spent much of the day in detailed discussions with

colleagues about B's care, including discussions with Professor Goldman. He said he understood totally the father's concerns and the sense of distress which he must feel. He added:

'Should there be any misunderstanding I should state quite clearly that any decision taken by the [authority] will be made taking all clinical and other relevant matters into consideration and not on financial grounds. The [authority] has funded, and continues to fund, bone marrow transplantations. The [authority] is also supportive of second, and in difficult cases, third opinions and is grateful to have had the benefit of Professor Goldman's opinion from the Hammersmith following her out-patient consultation, which we understand was arranged by yourself. Dr Broadbent confirms that she subsequently sent a fax to Professor Goldman, at your behest, outlining [B's] clinical condition. I understand from Professor Goldman that his opinion was subsequently sent to Dr Pinkerton and Dr Mellor at the Marsden and to Dr Broadbent at Addenbrooke's. I have had the benefit of seeing that correspondence and of noting Professor Goldman's views. He has subsequently confirmed to me that the line of treatment that he indicated might be a possibility for [B] was at variance with majority opinion and would be properly categorised as experimental rather than standard therapy.'

The next paragraph is a reference to the policy of the Marsden not to perform second bone-marrow transplants. Dr Zimmern continued:
'At present no formal request for funding has yet been made to the [authority] from any hospital, but I should like to emphasise that any decision on this issue will be taken in the light of all the clinical advice available to it in the context of [Department of Health] guidance on the funding of unproven or experimental treatments, at all times with [B's] best interest in mind. At this stage, I have to say that on the evidence provided to us it is unlikely that we will authorise further intensive chemotherapy for B but will always keep under review the nature of the clinical advice that we receive.'

Having received the advice which I have described from Professor Goldman, B's father then communicated, as was proposed, with Dr Gravett. Dr Gravett wrote a long letter dated 23 February expressing the view that, so far as the chemotherapy was concerned, the chances of obtaining a complete remission in the circumstances were, in his judgment, 10 to 20%. He acknowledged that it would be impossible to repeat the irradiation treatment again and indicated that the initial chemotherapy might cost about £15,000 and, if the bone marrow transplant stage was reached, a further £60,000. In para 5 he referred to a fax which he had received from Professor Goldman and expressed the view that if the family and the patient agreed that the treatment which was proposed had a worthwhile chance of success he was willing to give it. In the result, the authority, the respondents, through Dr Zimmern, maintained their refusal to fund further chemotherapy.

In a letter of 27 February 1995 Dr Zimmern has made the authority's position clear. He wrote to Dr Gravett:

'You have been extremely frank within your letter in your assessment of the prognosis of the treatment which you propose to offer and have confirmed that the treatment is of an experimental nature. You have also [1995] 2 All ER 129 at 134 made it clear to me that prognosis in the case of secondary AML [acute myeloid leukaemia] is worse than that of the primary variety. You confirmed that your own Unit at the London Clinic would not be able to take children of [B's] age and that you propose to carry out the treatment at the Portland Clinic. You were also able to tell me that you had discussed the case with [B's] paediatrician, Simon Mellor, and was conversant with his opinion that [B] should not undergo a second BMT [bone-marrow transplant]. Given your assessment, together with the advice that I have received from [B's] medical advisers at both Addenbrooke's and the Marsden, and in view of [Department of Health] guidance on the funding of treatment not of a proven nature, I regret that my [authority] is unwilling to fund this treatment.'

It was the contents of that letter, which were communicated to B's father, which prompted the present application for judicial review.
Before the learned judge and before us there are several affidavits sworn by B's father. They exhibit a certain amount of learned medical material, the opinions of the American doctors and a certain amount of the correspondence from the English doctors who were willing, in principle, to undertake this treatment. On the authority's side, there were three sworn affidavits. The first of these is sworn by Dr Broadbent, the physician who has had the responsibility for treating B since her illness was first diagnosed. She describes her state of mind in para 3 of her affidavit:

'I have considered very carefully whether a second allogeneic transplant operation would be in [B's] best interests. I have considered the prospects of success and the suffering which [B] would undergo as a result of such treatment. First [B] would have to undergo a course of intensive chemotherapy with the hope of achieving a complete remission. Such chemotherapy would in itself cause considerable suffering. Only if complete remission could be achieved could a second allogeneic transplant be considered. In fact a complete remission is unlikely to be achieved. Further, the prospects of a second transplant being successful are only in the region of 10 per cent. I took the view that it would not be right to subject [B] to all this suffering and trauma when the prospects for success were so slight.'

In para 4 she describes:

'… any further definitive treatment by way of intensive chemotherapy or a second transplant as being treatment of an experimental nature rather than for the genuine therapeutic needs of [B].'

There is an affidavit sworn by Dr Pinkerton of the Royal Marsden. He also expresses the opinion that a further course of intensive chemotherapy with a view to a second possible transplant operation would not be appropriate. He expresses the judgment that the chances of a successful outcome would be slight, only in the region of 10%. He believed that a course of palliative therapy would be in the best interests of B and said:

'This would enable her to enjoy several weeks or months of normal life prior to progression. A further course of intensive chemotherapy and a second transplant would mean several uncomfortable and distressing [1995] 2 All ER 129 at 135 weeks or months in hospital which in all probability [B] would not survive.'

He concluded at (para 4):

'This is a very sad case and I fully understand [the father's] endeavours to do everything possible for the sake of his daughter. However, I remain of the view that it would not be in [B's] best interest to subject her to a distressing course of treatment which is most unlikely to be successful and carries a high risk of early morbidity.'

Finally, an affidavit was sworn by Dr Zimmern. He refers to the opinions which he had obtained from Dr Broadbent, Dr Mellor and Dr Pinkerton. He also referred to the American opinions which had been expressed, to his discussions with Professor Goldman and his exchanges with Dr Gravett. He summarised his conclusions in these paragraphs which are sufficiently important to justify quotation:

'First and foremost I had to consider whether the proposed course of treatment was clinically appropriate for [B]. I also had to consider whether it would be an effective use of the [authority's] limited resources, bearing in mind the present and future needs of other patients. The opinions of Dr Broadbent, Dr Pinkerton, Professor Goldman and Dr Gravett were broadly similar as to the prospect of a successful outcome. I also noted that Professor Goldman had agreed that the proposed treatment could and would be described as experimental. In other words, he agreed with Dr Broadbent, Dr Pinkerton and Dr Mellor that the treatment could not be justified purely on therapeutic grounds and that the fundamental justification would be experimentation. I attached great weight to the clinical judgment of Dr Broadbent who had been treating [B] ever since her first referral in September 1990 at the age of 5 years. I also attached great weight to the clinical judgment of Dr Pinkerton who had carried out the first bone marrow transplant operation. Having considered all the medical opinions put before me I decided to accept the clinical judgment of Drs Broadbent, Pinkerton and Mellor that a further course of intensive chemotherapy with a view to a second transplant operation was not in the best interests of [B]. I have also been influenced in my decision by the consistent advice and directions of the Department of Health with regard to the funding of treatments which have not been proven to be of benefit. The ethical use of resources demands that new and expensive treatments are evaluated before they are transferred to the NHS for service funding. The doctors to whom I spoke were consistent in their advice that the proposed treatment was neither standard nor had been formally evaluated. I also considered that the substantial expenditure on treatment with such small prospect of success would not be an effective use of resources. The amount of funds available for health care are not limitless. The [authority] has a responsibility to ensure that sufficient funds are available from their limited resources for the provision of treatment for other patients which is likely to be effective.'

In the course of his judgment quashing the decision of the authority, the learned judge made four

criticisms of the manner in which the authority had reached its decision. Before I turn to those, however, it is important that I should state very clearly, as the judge did, that this is a case involving the life of [1995] 2 All ER 129 at 136 a young patient and that that is a fact which must dominate all consideration of all aspects of the case. Our society is one in which a very high value is put on human life. No decision affecting human life is one that can be regarded with other than the greatest seriousness.

The second general comment which should be made is that the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.

The four criticisms made by the learned judge of the authority's decision were these. First, he took the view that Dr Zimmern as the decision-maker had wrongly failed to have regard to the wishes of the patient, as expressed on behalf of the patient by her family, and in particular by her father. Our attention was directed to the affidavits that I have mentioned. The point was made that nowhere does one see an express statement that among the factors that led Dr Zimmern to his decision was a consideration of the wishes of the family. In that situation, the learned judge held that the authority had failed to take a vitally important factor into consideration and that the decision was accordingly flawed.

I feel bound for my part to differ from the judge. It seems to me that the learned judge's criticism entirely fails to recognise the realities of this situation. When the case was first presented to the authority, it was presented on behalf of the patient, B, as a case calling for the co-operation and funding of the authority. At all times Dr Zimmern was as vividly aware as he could have been of the fact that the family, represented by B's father, were urgently wishing the authority to undertake this treatment; by 'undertake' I of course mean provide the funding for it. He was placed under considerable pressure by the family and, in the first instance, perhaps unfortunately, made reference to his policy of not corresponding directly with patients or their relatives about what he called 'extra-contractual referrals', meaning requests for the purchase of medical services outside the health authority.

The inescapable fact is, however, that he was put under perfectly legitimate, but very obvious, pressure by the family to procure this treatment and he was responding to that pressure. It was because he was conscious of that pressure that he obviously found the decision which he had to make such an agonising one and one calling for such careful consideration. To complain that he did not in terms say that he had regard to the wishes of the patient as expressed by the family is to shut one's eyes to the reality of the situation with which he was confronted. It is also worthy of note, and there is no hint of criticism in this, that the accusation that he did not take the patient's wishes into account was not made in the grounds annexed to Form 86A. It was not, therefore, recognised as an accusation calling for a specific rebuttal.

The second criticism that is made is of the use of the expression 'experimental' to describe this treatment. The learned judge took the view, and Mr McIntyre on behalf of B urges, that that is not a fair or accurate description given the estimates of success which have been put by reputable practitioners, and given the willingness of Dr Gravett to accept that there was a worthwhile chance of success. The fact, however, is that even the first course of treatment [1995] 2 All ER 129 at 137 had a chance of success of something between 10 and 20 %. It was only if, contrary to the probabilities, that was totally successful, that it would be possible to embark on the second phase of the treatment which itself had a similar chance of success.

The plain fact is that, unlike many courses of medical treatment, this was not one that had a well-tried track record of success. It was, on any showing, at the frontier of medical science. That being so, it does not, in my judgment, carry weight to describe this decision as flawed because of the use of this expression.

The third criticism that is made by the judge is of the reference to resources. The learned judge held that Dr Zimmern's evidence about money consisted only of grave and well-rounded generalities. The judge acknowledged that the court should not make orders with consequences for the use of health service funds in ignorance of the knock-on effect on other patients. He went on to say that 'where the question is whether the life of a 10-year-old child might be saved by however slim a chance, the responsible authority … must do more than toll the bell of tight resources'. The learned judge said: 'They must explain the priorities that have led them to decline to fund the treatment', and he found they had not adequately done so here.

I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before the court.

Mr McIntyre went so far as to say that if the authority has money in the bank which it has not spent, then they would be acting in plain breach of their statutory duty if they did not procure this treatment. I am bound to say that I regard that submission as manifestly incorrect. Unless the health authority had sufficient money to purchase everything which in the interests of patients it would wish to do, then that situation would never ever be reached. I venture to say that no real evidence is needed to satisfy the court that no health authority is in that position.

I furthermore think, differing I regret from the judge, that it would be totally unrealistic to require the authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B then there would be a patient, C, who would have to go without treatment. No major authority could run its financial affairs in a way which would permit such a demonstration.
The fourth criticism which the learned judge made was that the authority had wrongly treated the problem which they faced as one of spending £75,000 when, in the first instance, the treatment only involved the expenditure of £15,000. It was therefore a two-stage process, so it was held and submitted to us, and not a one-stage process as the authority wrongly thought. Again, I [1995] 2 All ER 129 at 138 regret that I differ from the judge's view. It is of course true that if the first stage were unsuccessful, then £15,000, or even less than £15,000, would be the maximum that the authority would end up spending. It would not, however, be reasonable for the authority to embark on this expenditure on that basis since, quite plainly, they would have to continue if, having expended the £15,000, it proved successful and the call for the second stage of the treatment came. It was, therefore, an inescapable decision whether they should embark on this process at all. Having weighed the matter up and taken advice, particularly bearing in mind the suffering which even embarking on the treatment would inflict, the authority thought that they should not fund the treatment at all. I regret that I find it impossible to fault that process of thinking on their part.

Such is my sympathy with the father and B herself that I have been tempted, although disagreeing with the judge's reasoning, to leave the order which he made in being and invite the authority to reconsider the matter in the light of the judge's conclusions. I have, however, concluded that that would be a cruel deception since I would be bound to make clear that, in my judgment, the authority could, on a proper review of all the relevant material, reach the same decision that they had already reached and I would

feel obliged, expressly, to dissociate myself from the learned judge's opinion that it would be hard to imagine a proper basis upon which this treatment, at least its initial stage, could reasonably be withheld. In my judgment, it would be open to the authority readily to reach that decision since it is, as I think, the decision they have already reached.

While I have, as I hope is clear, every possible sympathy with B, I feel bound to regard this as an attempt, wholly understandable but none the less misguided, to involve the court in a field of activity where it is not fitted to make any decision favourable to the patient.

SIR STEPHEN BROWN P.

After the most critical, anxious consideration, I feel bound to say that I am unable to say that the health authority in this case acted in a way that exceeded its powers or which was unreasonable in the legal sense. The powers of this court are not such as to enable it to substitute its own decision in a matter of this kind for that of the authority which is legally charged with making the decision. It is a desperately sad case and all those who have heard it, particularly those who have to take some part in deciding issues concerned with it, must be aware of the gravity and anxiety which attaches to the making of such a decision. I find myself in agreement with the decision which Sir Thomas Bingham MR has already given and I therefore agree that the appeal should be allowed.

SIMON BROWN LJ.

For reasons given by Sir Thomas Bingham MR and Sir Stephen Brown P, I too grant the appeal.
Appeal allowed.
Carolyn Toulmin Barrister.