This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Case No: FD17P00312

Neutral Citation Number: [2017] EWHC 1710 (Fam)
IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

IN THE MATTER OF THE SENIOR COURTS ACT 1981
AND IN THE MATTER OF HK (SERIOUS MEDICAL TREATMENT) (No.1)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30th June 2017

Before :

THE HONOURABLE MR JUSTICE BAKER

- -

Between :

AN NHS HOSPITAL TRUST	**Applicant**
- and -	
GM (1)	**Respondents**
DK (2)	
HK (by his children's guardian) (3)	

- -
- -

Peter Boyce (solicitor, **the NHS Trust)** for the **Applicant**
Edward Devereux QC (instructed by **Dawson Cornwell**) for the **First Respondent mother**
Alev Giz (instructed by **Philcox Gray**) for the **Second Respondent mother**
Melanie Carew (**Cafcass Legal**) for the **child, by his children's guardian**

Hearing dates: 30th June 2017

- -

Judgment

MR JUSTICE BAKER :

1. I am delivering this judgment ex tempore at about 11.30 pm on 30th June 2017 following an emergency telephone hearing. It sets out the reasons for my decision in relatively brief terms. I will of course make any necessary corrections or additions, or provide more detailed reasons, at the request of any party.

2. This is a tragic case involving a little boy called H who was born on 26th March 2017 and so is therefore now just over 3 months old. The parents, who are not married, come from the Democratic Republic of Congo. The father has been here for about five years, the mother for a year or so. Their first language is French and they do not speak much English at all.

3. H was born by Caesarean section at 41 weeks. He was a healthy baby who was seen regularly by the Health Visitor and initially gave no cause for concern. On 25th May, he had his first vaccinations at the age of about 8 weeks, as all babies do. The mother's case is that shortly after the vaccinations she became concerned about his condition and took him to the doctors and the health visitor the following day. Then, according to the mother, in the early hours of the morning of the 27th May, he woke up crying and he became floppy with red fluid coming out of his nose. She called an ambulance and the baby was taken to hospital.

4. On arrival at hospital, he was found to be having a left-sided seizure with fixed eyes, the right pupil reactive with left equivocal. That seizure lasted for fifty minutes and was terminated after diazepam and lorazepam were administered. He was taken for a CT scan of his head and found to have suffered significant intracranial bleeding, a left-sided subdural haematoma, sub-arachnoid haemorrhage, subfalcine herniation with a midline shift to the right, right-sided unilateral descending transtentorial herniation and partial effacement of the basal cistern. After returning from the CT scan and whilst being reviewed by the neurosurgical team, he suffered an acute deterioration with a decrease in his level of consciousness. He became cardiovascularly unstable with pauses in his breathing and was therefore intubated and ventilated. His pupils remained reactive bilaterally at that stage. He underwent a further CT head scan which revealed further deterioration and it was therefore decided that he should undergo emergency surgery. He was transferred to theatre and underwent a left craniotomy and evacuation of the subdural haematoma. However, severe brain swelling ensued and at that point he became haemodynamically unstable with significant brain herniation and required extensive treatment, blood transfusions and infusions of adrenaline and noradrenalin. At that point, his pupils became fixed and dilated and his intracranial pressure was measuring very high. He was transferred to the paediatric intensive care unit for post-emergency treatment and was again intubated and ventilated.

5. Over the next few hours further investigations were carried out. Ophthalmological examination revealed multi-layered haemorrhages in all four quadrants in both eyes with other signs of damage to the eyes. It was at that stage considered that the symptoms of his injury were highly suggestive of an acceleration / deceleration type injury. Brain tissue continued to herniate through the craniotomy site. A further CT head scan was performed revealing ischemia and infarct on the right and left side with cerebral herniation through the craniotomy. The neurosurgeon responsible for his case, Mr Z, confirmed the extensive nature of the damage, identifying extensive

bilateral injury including some of the deep nuclei although the brain stem was relatively spared at that stage. No sign of brain stem function however was found and the parents were warned of the very poor prognosis. Consideration was given to withdrawing treatment at this stage but the parents indicated strong opposition to that course. An MRI scan was carried out on 1st June from which it was noted that the left hemispheric craniotomy bone flap, which had been left as a result of the surgery was lifting, and the brain herniating through the resulting bone defect. Damage to the left lateral ventricle was noted and other signs of severe damage. Clinically, H remained very poorly. The nursing staff noticed occasional involuntary movements but nothing purposeful. His pupils remained non-reactive and size 4.

6. On 9th June, however, Mr Z noted some small signs of improvement with H's eyes opening and movement in all four limbs. He was also at that point breathing but, as had been the position apparently throughout his admission, there was no sign of the cough or gag reflex, save for two very faint coughs observed by one member of the nursing staff. So at that stage it seemed that his condition may have stabilized with some signs of improvement but the overall picture remained very bleak. As I have said, the doctors have been considering the possibility of withdrawing treatment but at this point they postponed consideration of extubation.

7. Meanwhile, however, the parents, concerned about the possibility of treatment being withdrawn, had instructed solicitors and on 6th June had applied to the High Court for an order under the inherent jurisdiction restraining the hospital doctors from taking a course which would result in the withdrawal of treatment and, in particular, extubation. That application came before me sitting as the urgent applications judge that day on short notice to the hospital Trust. Prior to the hearing, I telephoned CAFCASS Legal and spoke to one of the solicitors there, Mr Jeremy Ford. At the urgent hearing, I made an order making H a ward of court and directing the Trust not to withdraw life support or sustaining or supporting treatment, including extubation, until the matter had been considered at a full hearing. I directed a further hearing to take place before me a few days later on 12th June and gave directions for the filing of evidence.

8. The matter then came back before me on 12th June. At that hearing, I had initial evidence from the hospital including reports from the treating clinicians and a second opinion from another doctor within the Trust. At that stage, as I have said, there had been a slight improvement or at least a stabilisation in his position. I made a further order that the Trust should not withdraw treatment for the time being. I also directed the Trust to remove a 'do not resuscitate' notice which had been placed in effect. I listed the matter for a further pre-trial review before me on 29th June, and the final hearing on 6th July. I gave a number of further directions for case management purposes to prepare for that hearing, directing the Trust to file an application setting out the declarations which it seeks in these proceedings. I gave permission for the parents to file further evidence and further gave permission for the parties jointly to instruct an independent expert, namely Mr Peter Richards, consultant neurosurgeon, to provide an independent opinion. I further directed that an application for a reporting restriction order should be filed and served in accordance with the Practice Direction no later than 29th June with a view to the issue of publicity being ventilated at the pre-trial review.

9. The instructions to Mr Richards resulted in his report to this Court dated 24th June. It is a characteristically thorough report in which he considers a number of matters, including the causation of these injuries sustained by H which is not a matter which I need to consider directly when determining this application. As to the treatment, he observed that the medical management of H's illness had been excellent and offered no criticism of that whatsoever. He noted the very great difficulty in surgical treatment of such cases when a doctor is faced with herniation of the brain through the meninges and the skull. He noted the very severe extent of the injuries, in particular significant hypoxic change and a loss of definition of the basal cistern – that is to say, the lake of cerebrospinal fluid in the base of the brain. He observed that, when this feature is seen early after a head injury, it is associated with very poor prognosis for both survival and neurological recovery. He advised that the treatment post-surgery had followed a conventional course but noted that, at the time of examination, there had been no progression in terms of brain stem function. He noted that there had been no real sign of a cough or gag reflex. He advised that clinical experience was that it was likely that, if the brain injury developed, the reflexes would not return.

10. Accordingly he concluded that the clinical picture was of an infant who had suffered severe, irreversible, global brain damage affecting both the cerebral hemisphere and the brain stem and it was unlikely that he would ever be able to clear his own airway, having no cough and gag reflexes. He advised that he had yet to encounter long-term survival from this type of neurologically-impaired state in circumstances such as existed here. He therefore advised that it was appropriate to minimize the baby's suffering – and, he added, the parent's suffering of watching him in this state – by deciding that the tube should be removed and not replaced.

11. That report was available to me at the pre-trial review yesterday, 29th June, when I made further directions for the full hearing next week. I adjourned the application for a reporting restriction order which had not at that stage been served to my satisfaction in a way that gave the media an opportunity to consider the precise terms of the order. At that stage, of course, the proceedings were in chambers but the final hearing was to be in open court, in accordance with normal practice in serious medical cases, and I therefore directed that the reporting restriction order application would be considered at the outset of the hearing next week.

12. This afternoon, 30th June, I was informed that there had been a significant deterioration in H's condition and that the parties wished to make an urgent application to me. I was in fact on circuit and not sitting as the urgent applications judge that day or the out of hours judge, but I took the view that it would be difficult and inappropriate for any other judge to take on the case at short notice, so consequently I agreed to make myself available this evening and gave directions to facilitate a telephone hearing.

13. In the following few hours, while I was travelling back from circuit, the following steps have taken place in accordance with my directions.

14. First, the Trust, through its solicitor Mr Boyce, has filed a further application with a draft order seeking a declaration that it is in the best interests of H that the current treatment plan be revised with immediate effect so that it is lawful and in H's best interest for (a) there to be no neurological intervention (b) in the event of cardiac arrest, that no form of cardiac resuscitation is to be given and (c) there to be no

escalation in treatment to that currently provided i.e. no invasive intervention including renal replacement and inotropes.

15. Secondly, the application has been served on those acting for the parents and the guardian appointed to represent H.

16. Thirdly, the report which the guardian has prepared in these proceedings has been filed and served. Although that report addresses the issue arising on the original application concerning extubation – the issue which is to be determined next week – and not the immediate crisis which has arisen and to which I shall return in a moment, it contains quite relevant background information.

17. Fourthly, at my request the doctors involved in this case, namely Mr Z, the consultant neurosurgeon, Dr D, the clinical lead for paediatric intensive care at the hospital, and Mr Richards, the independent medical expert, have all made themselves available to give evidence at this telephone hearing. I am very grateful to all of them for doing so on a Friday evening.

18. Finally, at my direction, Mr Brian Farmer of the Press Association has made himself available for this telephone hearing. The reason for that was that it seemed plain that the order that I was being invited to make was a substantive order in respect of H's medical treatment and that such a hearing should ordinarily take place in open court. There is no good reason why that should not apply in respect of a telephone hearing. Where possible, it is important that the press are able to attend in some form at least all such hearings including those over the telephone. Accordingly, Mr Farmer has attended throughout. I indicated in the course of the hearing that I would make an urgent reporting restriction order in the terms of the application which has been filed. I recognise that in due course there may have to be some refinement of the order but I took the view that, in these urgent circumstances, it was important for the hearing to take place in public subject to a reporting restriction order which precludes at this stage identification not only of the child and the family but also of the Trust and the treating clinicians. Accordingly that is the order that is in place at the moment. As I have said, it may be amended in due course.

19. I have therefore conducted this hearing by telephone which has now been going on for over two hours, in the course of which I taken evidence from Mr Z, and Dr D and Mr Richards.

20. What has happened leading to this application can be summarised as follows. A CT scan carried out a few days ago revealed ongoing evidence of deterioration but nonetheless H's clinical condition remained relatively stable until about 48 hours ago when there was a change in the pattern of H’s movements. Then, in the course of the early hours of this morning, there was a very significant drop in the level of his haemoglobin from 100 to 50, indicating some form of blood loss. No external bleeding was noted and it was therefore thought likely to be an internal bleed, possibly intracranial. As a result, the neurosurgical team were consulted and Mr Z and his colleagues concluded that it would not be in H's interests for there to be further neurosurgical intervention and therefore it was not appropriate for there to be any further CT imaging to confirm one way or the other whether intracranial bleeding was indeed the cause of the drop in haemoglobin. As Mr Z explained in evidence, he could see no neurological justification for further CT scanning since no neurosurgical

intervention was justified in H's interest. Furthermore, the act of carrying out the CT scan imaging process would by itself expose H to some further risk, involving as it does moving him from the paediatric intensive care unit where he is currently to the radiography department located some distance away in the hospital. Accordingly that is what has prompted this application. Meanwhile, it appears from Dr D's evidence that H's haemoglobin has been stabilised by the process of blood transfusion. It therefore seems to be the case that, if indeed he suffered some sort of internal bleeding earlier today, that is not a process that is ongoing, although the evidence for that as yet is of course incomplete.

21. The picture emerging from the evidence that I have heard from Mr Z, Dr D and endorsed by Mr Richards is of a child with a very grim prognosis. His brain has continued to deteriorate and, in some respects, may now be liquid. From what I have heard, there is manifestly no prospect of any recovery and indeed all the evidence points to his condition deteriorating still further. Tragically, it seems this baby will not survive long. It is clear from the unanimous view of the doctors that there is nothing to be gained from any further neurosurgical intervention. All that can be offered, says Dr D, is a process of palliative care. Dr D would be willing to continue to provide blood transfusions to maintain his haemoglobin levels although Dr D warns that there are risks, particularly to lung function, from repeated blood transfusions.

22. On behalf of the Trust, Mr. Boyce asks me to make the orders as set out in the application and draft order cited above. The law relating to applications of this sort is well established and has of course been the subject of much consideration very recently in connection with the equally tragic case of Charlie Gard. I have in mind that case law and in particular the approach recommended by the Court of Appeal in the case of *Wyatt v Portsmouth NHS Trust* [2005] EWCA Civ 118 [2006] 1 FLR 554 at para 87:

> "In our judgment, the intellectual milestones for the judge in a case such as the present are, therefore, simple, although the ultimate decision will frequently be extremely difficult. The judge must decide what is in the child's best interests. In making that decision, the welfare of the child is paramount, and the judge must look at the question from the assumed point of view of the child. There is a strong presumption in favour of a course of action which will prolong life, but that presumption is not irrebuttable. The term 'best interests' encompasses medical, emotional, and all other welfare issues".

I also bear in mind the clear principle established in the case law, including the *Wyatt* case to which I referred, but also dating back to the decision of the Court of Appeal in *Re J (a minor) (wardship: medical treatment)* [1991] Fam 33 in which Lord Donaldson, Master of the Rolls, observed at page 41:- "

> "No one can dictate the treatment to be given to the child - neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist upon treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents."

Importantly, therefore, the courts cannot compel a doctor to act in a way that he considers to be contrary to the patient, although it may of course be the case that another doctor would take a different view.

23. Both parents have been represented by counsel this evening but neither parent has been present on the call. Both Mr Devereux QC on behalf of the mother and Ms Giz on behalf of the father have urged this court not to take a decisive step in these circumstances. The hearing was convened at short notice and the parents have been unable to give clear instructions. Mr Devereux in particular informs me that he is hampered by the absence of instructions. His client understandably is experiencing very great distress and confusion. The course that Mr Devereux on behalf of the mother therefore invites the court to take is to refuse this application today and consider the matter in a few days' time, on Monday or Tuesday of next week, when his client has had a chance to consider the recent developments, to consider the guardian's report, and to advise and instruct her legal team accordingly.

24. Having cross-examined the doctors, including Mr Richards, Mr Devereux acknowledged the very grave circumstances which H is in. But he submitted that it is not yet established that the best interests of H manifestly point in the direction of the order being made as applied for by the Trust. He submitted that it is easy for anybody, including the court, to be overwhelmed by the medical evidence and to overlook other features. He submitted that there had been no thorough analysis of where H's best interests lie in a way which includes interests other than the medical, and of course in making that submission he was alluding to the observations of the Court of Appeal in the ***Wyatt*** case, to which I have referred above, that the term 'best interests' encompasses not only medical, but also emotional and all other welfare issues. Mr Devereux submitted, rightly, that there is a very strong presumption in favour of preserving life save in exceptional circumstances, and that the evidence of H's deterioration and the recent developments over the last 24 hours do not justify this court taking such a rapid and radical step as to authorise the change in treatment programme as proposed by the Trust without giving the parents a fair opportunity to be heard in due course. H is, Mr Devereux submitted, a remarkable baby and this court should afford him respect to the extent of allowing this further delay before making the decision sought by the Trust.

25. Ms Giz endorsed Mr Devereux's submissions and also was able on behalf of her client, the father, to put before me his own words about his position today. Anybody hearing those words would find them profoundly moving. The father cannot, he says, accept that the treatment should be confined to palliative care and blood transfusion. He says he has promised his baby life. He prays for him to be strong and to fight. He cannot do anything that would shorten his life. If the baby dies naturally, that is one thing, but, says the father, he cannot do anything himself that would, to use his words, "put the knife in him". He wants H to get better. If he stops breathing, he wants attempts to be made to resuscitate him. He wants the doctors to bring him back to life. As I have said, those words, simple but profound, express in terms which any father would understand the anguish which this man, and of course the mother as well, manifestly feel.

26. On behalf of the guardian, Ms Carew contends that the Court should make the order sought by the Trust. The guardian's view is that there is overwhelming evidence that H's position is futile. He has suffered a further deterioration recently and there is a real

risk of significant deterioration in the near future. Any intervention would be pointless and there is a likelihood that such intervention would cause further harm. Ms Carew acknowledges that there is before the Court no thorough analysis of the balancing factors that should normally be taken into consideration when making this decision but she submits that in fact the evidence is all one way. I paraphrase her submission in saying that. There is in reality nothing, she says, that can be put in the balance in favour of the arguments advanced by the parents. On the contrary, all the evidence and arguments are in favour of allowing the application.

27. This Court recognizes the strong presumption in favour of the preservation of life so with respect to Ms Carew I do not accept that there is nothing that can be put in the balance against the Trust's application. That factor – the strong presumption of the preservation of life – is of fundamental importance and it carries great weight in any consideration of the best interests of the child in this type of case. I also take into account the wishes of the parents and the feelings of the parents and I have taken into account the importance of all of the matters raised on their behalf today. H's life is important and respect for him and his personal integrity and autonomy require this court to give the very strongest weight to his right to life and to remain alive.

28. On the other hand, I accept Ms Carew's submission on behalf of the guardian in support of the Trust's application that the medical evidence is manifestly clear. There is no benefit to be gained from further neurological intervention and there is a very significant risk, as I find, that any further attempt at intervention would be harmful to him and of no benefit. I accept the evidence of Mr Z that a CT scan would have no benefit in terms of treatment since there is no neurological treatment which can be carried out which would be of benefit to H. It is of course possible that a CT scan would demonstrate that there was not intracranial bleeding but I am satisfied that that discovery would be of no real benefit to H. I accept that there is in effect nothing more that can be done for this child by way of neurological intervention and that the consequences of any such intervention are likely to be harmful.

29. Accordingly it seems to me carrying out the balancing exercise that the balance manifestly comes down in favour of allowing the application on behalf of the Trust this evening. For that reason, I propose to make an order that it is in H's best interest that the current treatment plan be revised with immediate effect so that it is lawful and in his best interests for there to be no further neurosurgical intervention. Furthermore, I am satisfied that it is in his best interests that, in the event of a cardiac arrest, there should be no form of cardiac resuscitation.

30. The third aspect of the Trust's application today has been for a declaration that it is in H's best interest for there to be no escalation of treatment beyond that currently provided. The application for the draft order adds "i.e. no invasive intervention including but not restricted to renal replacement and inotropes". It seems to be that I have today not heard sufficient evidence to form a clear view as to how his treatment should now proceed beyond what I have already decided as to neurological intervention and resuscitation. It is plainly appropriate for him to continue to receive blood transfusions in accordance with Dr D's proposals, but beyond that I do not think I have had sufficient evidence to make a clear declaration as to what further treatment should or should not be provided.

31. I acknowledge that the parents have had little notice of this hearing and have not attended in person, but arguments on their behalf have been put forward fully and fairly by counsel. H's best interests require that I make an urgent interim declaration this evening. It will last until Monday evening. I propose to list the matter for a further hearing on Monday afternoon. At that point, I will consider whether to extend the declarations I am making this evening – taking into account further submissions on behalf of the parents after they have had a further opportunity to give instructions to their lawyers – and also whether to make a further declaration in respect of future treatment as sought by the Trust ahead of the full hearing on Thursday.

32. At this stage therefore, I confine my order to the first two aspects of the draft put forward by Mr Boyce, namely, that it is lawful and in H's best interest for there to be no further neurosurgical intervention and, in the event of a cardiac arrest, no form of cardiac resuscitation. That declaration will continue in those terms until 6pm on Monday. I shall list this matter for a further hearing at 2pm on Monday. I direct the Trust to provide further evidence of its treatment proposal in the light of his current condition and my declaration today. That evidence shall be filed and served by 12noon on Monday. At that hearing, I hope to be in a position to provide clearer and further directions for palliative treatment in a way which I do not feel able to do this evening. That is my order.