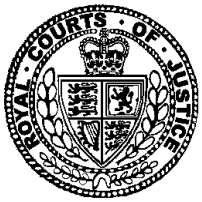

Neutral Citation Number: [2022] EWHC 1873 (Fam)

Case No: FD22F0026

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
IN THE MATTER OF A (A Child)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/07/2022

Before:

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between:

GUY'S & ST THOMAS' NHS FOUNDATION TRUST	**Applicant**
- and –	
(1) A (A Child) (through his 16.4 Guardian)	**1st Respondent**
(2) B (Father)	**2nd Respondent**
(3) C (Mother)	**3rd Respondent**
LBB	**Intervener**

- -
- -

Mr David Lawson (instructed by **Hill Dickinson LLP**) for the **Applicant**
Ms Katie Gollop QC (instructed by **Duncan Lewis Solicitors**) for the **First Respondent**
Ms Helen Mulholland (instructed by **Advocate**) for the **Second and Third Respondent**
Ms Yasmeen Jamil (instructed by **Bexley Borough Council**) for the **Intervener**

Hearing dates: 13th July 2022

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

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.

MR JUSTICE HAYDEN:

1. I am concerned in this application with A, a boy who is 3 months of age.

2. On 10 June 2022, A was found limp with abnormal breathing. An ambulance was called. Around the time of the call, he sustained a cardiac arrest. A was taken to the Queen Elizabeth Hospital (QEH), to the Accident and Emergency department. Return of spontaneous circulation only occurred when he arrived at hospital, it is thought therefore that there had been a gap of about 30 minutes. He was stabilised at QEH and was taken to the Evelina Children's Hospital (ECH) where he was admitted. A was observed to have fixed and dilated pupils.

3. It is not necessary for me to consider, in this short extempore judgment, the circumstances which led to A's collapse, other than to say that between 12th and 13th June, skeletal survey X-rays were undertaken which showed multiple fractures throughout his skeleton and significant fractures to his ribs bilaterally. Most of the rib fractures appear to have callus formation which indicate that they preceded A's collapse. In addition to these fractures, retinal haemorrhages have been identified which are both bilateral and multifocal. I understand there are now proceedings in the family court in East London. The Local Authority, who has made the application in the family court, sought and was granted leave to intervene in this application.

4. The application, which was originally listed before me today, sought a declaration that brain stem death had occurred and that, accordingly, it was lawful to cease ventilation and medication. In entirely unforeseen circumstances and unprecedented in the experience of all in this court, the situation changed dramatically. The application is no longer pursued in its present form. Because of these developments, which I outline below, the case remained listed. There is now a large measure of agreement as to the way forward, but it is important for this case and more generally that I put what has occurred into the public domain as it may prove to have wider resonance. There also remains one important contentious issue which it has been necessary for me to resolve.

5. A had brain stem testing on a number of occasions. On the 17th June 2022, the first brain stem test elicited no response. A was off the ventilator for 7 minutes, during which time he made no attempt to breathe. On the 18th June 2022, the tests were repeated, and he made one gasp at 10 minutes. In the light of that, further brain stem tests were repeated on the 19th June 2022 by Dr R and Dr L. No brain stem responses were elicited in either set of tests and A was ascertained to have died at 13:15 on 19th June 2022.

6. At the parent's request, the tests were further repeated, on the 22nd June 2022, by Dr E and Professor X from Kings College Hospital. Again, these revealed no brain stem response. The MRI scans revealed signs of both subdural and subarachnoid haemorrhaging. The independent report concluded that death had been confirmed following the *"irreversible cessation of brain stem functioning".*

7. Some time on Saturday night and Sunday morning of 2nd and 3rd July 2022, a very experienced and entirely suitably cautious nurse on PICU contacted Dr Z, Paediatric Intensive Care Consultant, to say that, notwithstanding that A's death had been ascertained and recorded, she was becoming concerned that she might be detecting attempts to breathe. She believed that she had seen A both move and attempt to breathe. Inevitably and for obvious reasons Dr Z considered this was unlikely but she was also

aware that she was dealing with an extremely experienced nurse. Notwithstanding the inherent unlikeliness of such a development, Dr Z manifestly kept an open mind as to what she was being told. It soon became clear that A was indeed breathing.

8. In a report prepared for this hearing, Dr Z states as follows:

> *"On 1 July 2022 and over the weekend of 2/3 July 2022 the clinical team noted a change in [A's] clinical state, such that he appeared to exhibit breathing intermittently. This breathing initially appeared in response to hypercarbia (which is defined by an increase in carbon dioxide in the bloodstream), but not in response to hypoxia (deficiency in the amount of oxygen reaching the tissues).*
>
> *[A] now has consistent shallow irregular breathing when disconnected from the ventilator for short periods of time. Intermittent larger breaths result in extensor movement of head and neck en masse.*
>
> *9. The clinical diagnosis of brain death was immediately rescinded, and [A's] parents informed.*
>
> *A repeat detailed clinical examination was undertaken by me and [Dr K], a paediatric neurologist. [A] remained flaccid, unresponsive to pain, with no spontaneous or provoked movement. All brain stem reflexes were absent, apart from breathing.*
>
> *Based on this change in clinical status, paediatric neurology recommended a repeat EEG and MRI brain scan. These were undertaken on Monday 4 and Tuesday 5 July 2022. The results remain extremely abnormal with an unresponsive (isoelectric) electroencephalogram and evidence of maturation of devastating whole brain injury on MRI. The repeat skeletal survey, 28 June 2022, also confirmed maturation of previously noted fractures."*

9. The breathing initially appeared in response to increased CO_2 in the blood stream, not in response to a deficiency in the amount of O_2 reaching the tissues. As it evolved, A has demonstrated the capacity to breathe in a way described as *"consistent, shallow and irregular"* when disconnected from the ventilator for short periods of time. There are intermittent visible longer breaths, and his parents believe that these are accompanied by some movement of the head which appears to them, entirely understandably, to be voluntary but may in fact be an extensor movement of his head and neck together.

10. There was no hesitation by the hospital in immediately rescinding the clinical ascertainment of death. The speed and sensitivity with which that was done has been a great comfort to the parents and through their advocate, Ms Mulholland, they have paid tribute to the nurses and treating clinicians with whom, despite what has occurred, they plainly continue to have a good and co-operative working relationship. I hope that will

guide them in what will remain difficult days and weeks ahead. I should record that both parents regard what has happened as a miracle. Faith is important to each of them.

11. On 4th July, the parents made a statement together describing the extent of their pain. I am not sure there can be any greater pain than that experienced by parents in their circumstances. As I have said in other cases, it is a pain of such visceral complexion that it often causes people instinctively to recoil rather than empathise. It is every parent's worst conceivable nightmare.

12. It follows from what I have said above that we are in unfamiliar medical territory and so it has been agreed that there should be further independent expert evidence to look at A's circumstances neurologically and more generally.

13. That investigation must proceed at A's pace and not be driven by the exigencies of the litigation. At this hearing, I have been invited by the Trust to make a declaration confirming that it would be lawful and in A's best interests not to resuscitate in the event of cardiac collapse. It is clear that A's neurological status is deeply compromised; however, his condition is otherwise medically stable. In the highly unusual circumstances of this case, I am not, at this juncture, prepared to make the declaration sought. As I understand the evidence, whilst cardiac arrest cannot be excluded, A's general medical stability does not signal that cardiac arrest is imminent. Dr Z emphasises, and I note, that there are no guarantees. She tells me that, A's heart is strong and there is no particular reason to believe that resuscitation would be unsuccessful. A is alive but that should not occlude the parlous situation he is in neurologically. His parents wish and pray for a recovery, but the evidence indicates that is not likely.

14. I do not believe the evidence, at this stage, establishes that it will never be possible for A to go home, even if that should only mean, to die at home with his parents. In those circumstances, it seems to me clear that the care he is receiving in intensive care has a real objective and cannot properly be characterised as futile, at least at this stage. The objectives are to identify the full range of potential options for A, however limited they may be. There is, therefore, still an identifiable and clear destination in the ICU journey. At this point, this would, to my mind, justify CPR in the event of a cardiac arrest. I am also bound to say that in the light of this highly unusual history, I do not consider it would be appropriate to make a DNAR order until the wider clinical picture has become clearer.

15. I have indicated a very tight timescale for garnering further expert evidence. When that becomes available, it may be that I will be required to review this interim decision on a DNAR notice. It is important that I signal this to the parents.

16. I am clear, and it requires to be reiterated, that A receives loving and attentive care from his parents who listen carefully to his nurses and doctors and, notwithstanding what has happened, they retain both respect and confidence in them. Equally, it is obvious that nothing of what has occurred undermines what has manifestly been outstanding care in the PICU. There must now be a cautious and reflective response to what has occurred in order to assess and gauge its significance for A and indeed, potentially, for others. For the avoidance of doubt, this is an entirely different situation from that advanced to Arbuthnot J in *Barts Health NHS Trust v Dance & Ors [2022] EWHC 1435 (Fam); Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] EWCA Civ 935*.

There, brain stem testing was incomplete. Here, it appears to have been consistently repeated with full adherence to clinical guidelines.

17. Accordingly, I am going to adjourn these proceedings for further expert evidence. It may be that an amended application will be made for me to consider where A's best interests lie in any treatment plan. The case will be heard in the third week of August, at which point I will have the expert reports which have been identified as necessary. I have found the parents account of their pain to be deeply moving, and my thoughts are with them and with their son.