



Neutral Citation Number: [2024] EWHC 313 (Fam)

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/02/2024

Before :

MRS JUSTICE KNOWLES

Between:

**A Hospital Trust
and
A Mother
and
A Father
and
A Local Authority
and
P, by her children’s Guardian**

Applicant
Respondents

Miss Helen Mulholland KC for the Trust
Mr Nicholas Stonor KC and Miss Sarah Kilvington for the mother
Miss Jacqueline Thomas KC and Miss Kalsoom Maqsood for the father
Miss Lorraine Cavanagh KC and Miss Lauren Maires for the local authority
Mr Michael Gratton KC and Miss Natalie Oakes for P by her children’s Guardian.

Hearing dates: 7 and 8 February 2024

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This judgment was handed down remotely at 10.30am on 15 February 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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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.

Mrs Justice Knowles:*Introduction*

1. In this tragic case I am concerned with the welfare of a little girl called P (initial chosen randomly) who is two years old. The welfare issue before the court is one of the hardest which a judge of the Family Division ever has to determine, namely whether life-sustaining treatment should be withdrawn. On 30 November 2023, whilst she was at home, P suffered serious injury. When paramedics arrived, P was in cardiac arrest with no discernible heartbeat. She was intubated at the scene and taken to hospital, P has never regained consciousness and is currently ventilated and sedated on the paediatric intensive care unit of a large hospital. P has a devastating brain injury which is not treatable and from which she will never recover. The prognosis is that her condition will continue to deteriorate and she will eventually die. The hospital trust has made an application for declarations pursuant to the inherent jurisdiction of the High Court that it is not in P's best interests for life-sustaining medical treatment to be continued and it is in her best interests for a palliative care regime to be implemented. I am asked to decide whether those declarations are in P's best interests. If I decide they are, the inevitable consequence is that P will die.
2. The hospital trust was represented by Miss Mulholland KC and P was represented through her children's guardian by Mr Michael Gratton KC and Miss Natalie Oakes. P's mother ("the mother") was represented by Mr Nicholas Stonor KC and Miss Sarah Kilvington and P's father ("the father") was represented by Miss Jacqueline Thomas KC and Miss Kalsoom Maqsood. The local authority was represented by Miss Lorraine Cavanagh KC and Miss Lauren Maires. I am profoundly grateful to all the advocates for the manner in which this most sensitive of applications was litigated. Their respective clients could not have asked for better representation.
3. The local authority and the children's guardian supported the application made by the trust. Following time to take instructions with the assistance of interpreters, both parents left it to the court to decide what was best for P. Their advocates made clear that the parents wished P might continue to be ventilated but recognised the weight of the medical evidence in favour of discontinuing treatment.
4. No party invited me to hear any oral evidence given the unanimity of views expressed by the medical experts instructed on behalf of both the trust and the parents. After I had announced my decision, both parents addressed the court, asking to spend as much time with their daughter as possible before she died. With the assistance of the hospital, the local authority and others, I was able to accommodate some of what the parents requested but, because the mother is a prisoner on remand awaiting a criminal trial, I sadly could not grant the mother her wish to spend a last night by her daughter's bedside.
5. In coming to my decision, I read the bundle of written statements and reports provided together with detailed position statements provided by the advocates. I benefitted from a careful and balanced analysis of P's situation by her children's Guardian which supported the discontinuance of life-sustaining treatment.
6. I announced my decision on 8 February 2024 and reserved my judgment for a very short time.

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7. This judgment has not identified the Trust, the local authority, the details of instructing solicitors, or any of those directly involved with either P or her parents. I have taken this course in the interests of reporting my decision as soon as possible, balancing this against the need to protect the integrity of both the care proceedings and the criminal trial.

Background

8. P's mother is a native of X as is the father and, until she came to this jurisdiction, had not lived anywhere else. The mother does not speak English and requires the assistance of an interpreter. The mother is heavily pregnant and is due to give birth to her third child at the end of February 2024. The father is profoundly deaf and non-verbal and communicates using family signs at home and can understand international sign language. I note that the father spent a number of years living in another European country before moving to the UK.
9. P was born in X. The mother left X shortly after her birth to join the father in this jurisdiction. At that time, P was just a fortnight old and was thereafter cared for by her paternal grandmother and her paternal aunt. Her mother had video call contact with her from time to time. In September 2023, P arrived in the UK to join her parents and her younger sister, Q, now aged 15 months. In X, it appears that P's main carer was her paternal aunt who took P everywhere with her. P was very close to her paternal aunt and loved playing in the garden with her and going to the shops. P's mother and grandmother told the children's social worker about P's love of ice-cream and of an occasion when P distracted a friend by tapping her arm so that she could steal a lick of her friend's ice-cream. P was described as a smiling and clever little girl with a good memory who loved music and, whenever she heard music, liked to dance. Her father said P was an affectionate child who loved cuddles and falling asleep in her parents' arms.
10. P was a healthy child though she was said to have had a lung infection which was treated in Y and P was said to have made a full recovery. P was not registered with a GP prior to her admission to hospital.
11. At 18.39 on 30 November 2023, a 999 call was made from a neighbour. It took some 20 minutes for the paramedics to gain entry to the family home and eventually the mother opened the door holding P in her arms. P was in a state of cardiac arrest and asystolic. The paramedics managed to achieve a return of spontaneous circulation and P was intubated at the scene. P arrived at hospital at 19.21 and, on assessment in the Emergency Department, she was unresponsive with unreactive pupils. She was noted to be cold and her peripheral circulation was poor. It was thought P had experienced a loss of cardiac output for at least 30 minutes.
12. P was admitted to the paediatric intensive care unit and was commenced on neuroprotective measures namely, a bundle of care and treatment that is designed to minimise secondary brain injury following cardiac arrest. She was ventilated and has remained so ever since.
13. In addition to her devastating head injury, P was also found to have a number of other injuries which raised suspicion about the care she had received from her parents. These injuries included multiple retinal haemorrhages in her right eye; a healing

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fracture of her right posterior 11th rib; and likely recent fractures of her right posterior sixth, seventh and eighth ribs. A police protection order was executed on the evening of 1 December 2023 and Q was placed in foster care where she remains. The relevant local authority issued care proceedings on 4 December 2023 and both P and Q were made the subjects of interim care orders. Alongside those proceedings, a police investigation commenced to establish how and by whom P came to be injured in the family home. P's mother has been charged with an offence relating to P's care and is presently on remand in prison.

14. P had a CT scan on 30 November 2023 and an MRI scan on 2 December 2023, both of which showed devastating brain injury, including bleeds inside and outside the brain and large areas of the brain with evidence of hypoxic injury. The pattern of brain injury was thought to reflect trauma to P's head as well as hypoxia or lack of oxygen following a cardiac arrest. On 4 December 2023, sedation was discontinued to allow for an assessment of P's neurological status. In spite of being weaned from sedation, P showed no sign of responsiveness. Her Glasgow Coma Score is 3 and she has unreactive pupils together with no cough or gag reflex. A further MRI scan was performed on 12 December 2023 and this showed further deterioration of her very extensive brain damage.
15. On 13 December 2023, P's endotracheal tube became dislodged and had to be removed to be replaced. Airway support was given, but in spite of this, P had a very abnormal breathing pattern and her oxygen levels fell in spite of being on 100% oxygen. This incident demonstrated that P will not manage without intubation and ventilation.
16. Both parents have each been having supervised contact visits at the hospital each week.

The Proceedings

17. The trust sent its application to the court on the afternoon of 12 January 2024, asking for it to be issued urgently but the court did not issue it until 18 January 2024. Directions to facilitate the hearing before me were given by Henke J on 23 January 2024. Permission was given to the parents and the children's Guardian to obtain an expert opinion on P's condition and, in accordance with that direction, I note that Dr Patrick Davies, consultant in paediatric intensive care at Nottingham Children's Hospital, saw P on 2 February 2024 and provided a report dated 3 February 2024.
18. Provision was also made to assist the parents in participating fully and effectively at the hearing. At the directions hearing before Henke J, both parents had interpreters and no communication difficulties were evident. The father had the benefit of an interpreter in international sign language who confirmed to the court that they could communicate effectively with the father. However, the father's legal team had huge concerns about his capacity to give instructions and to participate effectively in the proceedings. On 5 February 2024, I made a direction at the request of the father's legal team, inviting the Official Solicitor to act on behalf of the father. However, she declined that invitation because there had been no capacity assessment of him. I also made a direction that the father should have the benefit of the same intermediary who was assisting him in the care proceedings.

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19. Finally, I made a production order to facilitate the mother's physical attendance at court on both days of the hearing.
20. Regrettably, the father did not attend a conference with his legal team on 5 February 2024 and only met them on the first morning of the hearing. In a position statement, Miss Thomas KC explained that she had no instructions from her client but had been strongly advised by the intermediary that there were insufficient safeguards to ensure that the father could properly understand and engage with the proceedings. Appended to her position statement was an email from the intermediary requesting that the hearing be adjourned until appropriate language and psychological assessments had been completed. Additionally, it had been directed that the father would have the benefit of both an international sign language interpreter and a British sign language interpreter but only the international sign language interpreter arrived at court. I allowed time for the father's legal team both to establish the effectiveness of his communication via that interpreter and to take father's instructions with the assistance of the intermediary.
21. Most unfortunately, I had to intervene during the lunch adjournment when the intermediary raised concerns about the apparent competence of the international sign language interpreter who was at court. On investigation, those concerns were misplaced since the father was able to communicate effectively with the interpreter. I found myself troubled by what appeared to be a less than helpful attitude shown by the intermediary who did not appreciate firstly, the need for cooperation during an urgent hearing which could not be adjourned and, secondly, the pressures on both parents but particularly the mother who was due to undergo a scan on her unborn child on 9 February 2024 because concerns had been expressed about poor intrauterine growth. However, once I had delivered a firm message about the necessity for cooperation to the intermediary, the father's legal team were able to take instructions and satisfy themselves that the father could participate effectively during the hearing.
22. Prior to the start of hearing, my clerk emailed the advocates to suggest that it would be very helpful if the Trust might produce a short summary in two or three paragraphs of the medical evidence in language which was plain and readily understood. I emphasised that this summary should be directed towards the evidence necessary for the parents to understand the decision which the court was being asked to make so that they could give instructions to their respective legal teams. Miss Mulholland produced a document which I saw and approved and which was, I understand, very helpful. I made this suggestion, mindful of the parents' respective communication problems so evident in the position statements submitted by their advocates.
23. I also record that all the advocates collaborated together to agree a palliative care plan if treatment were to be discontinued. They had assistance from the clinical team treating P, the prison staff supporting the mother, the police, and the head of service at the local authority. This judgment describes that plan in outline only as the fine detail is unnecessary. For that reason, I have not included in this judgment discussion of some of the aspects of that plan about which the court's guidance was sought.

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24. The parties were in agreement as to the legal principles applicable to the trust's application which were summarised by Miss Mulholland in her position statement dated 5 February 2024.
25. The law in this area is well established and settled. It was neatly summarised by MacDonal J in Manchester University NHS Foundation Trust v Fixsler [2021] EWHC 1426 (Fam) at paragraph 57:

“The following key principles can be drawn from the authorities, in particular In Re J (A Minor) (Wardship: Medical Treatment) [1991] Fam 33, R (Burke) v General Medical Council [2005] EWCA 1003, An NHS Trust v MB [2006] 2 FLR 319, Wyatt v Portsmouth NHS Trust [2006] 1 FLR 554, Kirklees Council v RE and others [2015] 1 FLR 1316 and Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust [2017] EWCA Civ 410:

- i) *The paramount consideration is the best interests of the child. The role of the court when exercising its jurisdiction is to take over the parents' duty to give or withhold consent in the best interests of the child. It is the role and duty of the court to do so and to exercise its own independent and objective judgement.*
- ii) *The starting point is to consider the matter from the assumed point of view of the patient. The court must ask itself what the patient's attitude to treatment is or would be likely to be.*
- iii) *The question for the court is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken. The term “best interests” is used in its widest sense, to include every kind of consideration capable of bearing on the decision, this will include, but is not limited to, medical, emotional, sensory and instinctive considerations. The test is not a mathematical one, the court must do the best it can to balance all of the conflicting considerations with a view to determining where the final balance lies. Within this context the wise words of Hedley J in Portsmouth NHS Trust v Wyatt and Wyatt, Southampton NHS Trust Intervening [2005] 1 FLR 21 should be recalled:*

“This case evokes some of the fundamental principles that undergird our humanity. They are not to be found in Acts of Parliament or decisions of the courts but in the deep recesses of the common psyche of humanity whether they be attributed to humanity being created in the image of God or whether it be simply a self-defining ethic of a generally acknowledged humanism.”

- iv) *In reaching its decision the court is not bound to follow the clinical assessment of the doctors but must form its own view as to the child's best interests.*
- v) *There is a strong presumption in favour of taking all steps to preserve life because the individual human instinct to survive is strong and must be presumed to be strong in the patient. The presumption however is not irrebuttable. It may be outweighed if the pleasures and the quality of life are*

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sufficiently small and the pain and suffering and other burdens are sufficiently great.

- vi) *Within this context, the court must consider the nature of the medical treatment in question, what it involves and its prospects of success, including the likely outcome for the patient of that treatment.*
- vii) *There will be cases where it is not in the best interests of the child to subject him or her to treatment that will cause increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's and mankind's desire to survive.*
- viii) *Each case is fact specific and will turn entirely on the facts of the particular case.*
- ix) *The views and opinions of both the doctors and the parents must be considered. The views of the parents may have particular value in circumstances where they know well their own child. However, the court must also be mindful that the views of the parents may, understandably, be coloured by emotion or sentiment. There is no requirement for the court to evaluate the reasonableness of the parents' case before it embarks upon deciding what is in the child's best interests. In this context, in *An NHS Trust v MB Holman J*, in a passage endorsed by the Court of Appeal in *Re A (A Child)* [2016] EWCA Civ 79, said as follows:*

“The views and opinions of both the doctors and the parents must be carefully considered. Where, as in this case, the parents spend a great deal of time with their child, their views may have particular value because they know the patient and how he reacts so well; although the court needs to be mindful that the views of any parents may, very understandably, be coloured by their own emotion or sentiment. It is important to stress that the reference is to the views and opinions of the parents. Their own wishes, however understandable in human terms, are wholly irrelevant to consideration of the objective best interests of the child save to the extent in any given case that they may illuminate the quality and value to the child of the child/parent relationship.”

- x) *The views of the child must be considered and be given appropriate weight in the light of the child's age and understanding.”*

26. With respect to the approach which ought to be taken to withdrawal of treatment, in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591, Baroness Hale said at paragraph 21:

“Hence the focus on whether it is in the patient's best interests to give the treatment rather than whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it”.

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27. In the same case, it was made clear that “*best interests*” involved more than a consideration of the medical - a true assessment of best interests involves scrutinising the patient’s welfare in the wider sense. Baroness Hale said in paragraph 39:

“The most that can be said therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the wider sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be.”

28. Finally, P and her family have rights under the European Convention on Human Rights particularly P’s right to life under Article 2, and her right to, and respect for, private and family life under Article 8. In this case, P’s rights and those of her parents to freedom of thought, conscience and religion under Article 9 are likely also to be engaged. These Convention rights ought always to be seen through the prism of the child’s best interests - insofar as there is a conflict between a Convention right or rights and P’s best interests, it is her best interests which are determinative.

The Medical Evidence

29. The medical evidence is found in statements from P’s treating clinician, Dr A, dated 18 December 2023 and 5 February 2024; a report dated 8 January 2024 from Dr Fiona Reynolds, a consultant in paediatric intensive care at Birmingham Children’s Hospital, obtained by the Trust as a second opinion; a statement from Dr B, a consultant paediatrician, dated 8 December 2023; and finally the report of Dr Patrick Davies dated 3 February 2024, instructed as an expert in these proceedings. I have read all of this material very carefully. No party invited me to hear oral evidence from any of the medical personnel and I did not need to do so since the reports were clear.
30. What follows is a summary of the medical evidence relevant to the decision I must take.
31. Dr A confirmed that there was no treatment for P’s brain injury which was irreversible and permanent. P would never recover her awareness of the world around her or be able to interact with it. She required ongoing ventilation to keep her alive and she cannot breathe effectively by herself. There was no prospect of any recovery. Whilst P was not yet in organ failure, P was likely to deteriorate over time. Her brain injury was likely to progress, for example, causing problems with her salt or sodium levels and P’s brain would continue to atrophy, swelling and dying and turning to liquid.
32. The interventions necessary to keep P alive were burdensome and without any benefit. P cannot see and does not open her eyes. She has no meaningful interaction with the world around her and is unresponsive to external stimuli. She is likely to experience pain when being ventilated and suctioned (to assist with her ventilation) but cannot demonstrate any response to pain in order to show the medical and nursing

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staff how she is feeling. Ventilation through an endotracheal tube is known to be uncomfortable and distressing and a patient with awareness and the ability to express their reaction would inevitably struggle against ventilation to try and remove that discomfort. The need for suction to clear P's secretions needs to be done regularly and is also a very unpleasant and uncomfortable experience. Monitoring of P's blood gases requires regular blood tests which are painful and unpleasant. The only benefit of continuing with these interventions would be the prospect of some recovery to offer a balance against the burdens of treatment currently being experienced by P. There was no such prospect in P's case and thus no benefit or justification in continuing.

33. Dr A confirmed that it was the strong consensus belief of the intensive care, neurology and paediatric teams that continuing life-sustaining treatment was not in P's best interests. All were in agreement that removal of her endotracheal tube and withdrawal of ventilatory support in a controlled and dignified manner would allow P to die peacefully. Dr A's second statement set out in detail the practical arrangements for the withdrawal of ventilation if the court so determined.
34. Dr Reynolds examined P on 29 December 2023, reviewed her medical records, and also spoke with the mother. She concluded that P had sustained a devastating neurological injury which was irreversible. P was dependent on others for all aspects of her care and had lost the ability to enjoy her life. It was hard to know whether she was experiencing pain: her muscle spasms in response to the innocuous movements of her limbs required during normal nursing care would be painful for someone who was conscious. However, the absence of an observed response to painful stimuli should not equate with an acceptance that P should be exposed to such stimuli because there was no benefit to enduring them. Dr Reynolds agreed with Dr A that continued mechanical ventilation should be withdrawn in a managed way with appropriate pain relief so that P could die in the presence of her parents. P may breathe for a period of time after ventilation was withdrawn but, if this occurred, re-intubation and connection to mechanical ventilation should not be introduced.
35. Dr Davies examined P on 2 February 2024 and reviewed the entirety of her medical records together with the court bundle. He also discussed P's care with her bedside nurse and with both the mother and father. On examination, P was completely unresponsive. She had extremely high tone and was stiff in all four limbs. On handling, she became even stiffer and had some shaking. This was dystonia which was similar to a whole body cramp. She did not respond to deep tracheal or oral suction, demonstrating no cough or gag. When taken off the ventilator, P was able to breathe at an unusually slow rate of 10 breaths per minute.
36. Dr Davies confirmed that P had sustained a devastating brain injury due to lack of oxygen. Since the time she was injured, there has been no improvement and indeed P had deteriorated overall. P was not dead from a circulatory perspective because her heart continued to beat and she would also not fit a diagnosis of brain stem death as she could trigger some breaths and her pupils had some reaction. However there was extensive and severe damage to P's brain, particularly in her cortex. This part of the brain was responsible for all higher functions including movement, learning, and communication. Without a functioning cortex, P had no ability to be conscious and would never be able to move, think, learn, or communicate. If there was any hope of improvement, this would have become apparent by now and thus the extent of P's

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brain damage was permanent. There were no interventions which could improve her brain function.

37. Dr Davies doubted whether P would be able to breathe independently and sustainably for the long term, either due to a lack of respiratory drive or a lack of an ability to maintain her airway. P was not a candidate for long-term ventilation which was only suitable for patients who had the ability to gain overall benefit from such an intervention.
38. Overall, Dr Davies concluded that continuation of intensive care was futile for P and indeed such intervention was harmful and conveyed no benefit. P demonstrated no clear pain response but did have episodes of dystonia on stimulation which was likely to be very painful. Continuing intervention involved many invasive procedures which were known to be painful and would at some point inevitably lead to a fatal complication. Though it was technically possible to care for a child on intensive care for many years, this would only be ethical if there was any chance of meaningful survival. P had lost all her dignity, and compassionate extubation and high quality palliative care were in her best interests.

Analysis

39. I make it plain that how P came to sustain her brain injury is not a matter for me to determine. Indeed it would be wholly inappropriate for me to do so given that there are both ongoing criminal and care proceedings in which that issue is likely to be considered. Moreover, the causation of P's brain injury is irrelevant when considering her best interests in the context of the continuation or otherwise of her medical treatment.
40. I have approached the heavy burden of making this decision by undertaking a holistic appraisal of the evidence, looking at what is often called "*the bigger picture*" informed throughout by P's best interests.
41. Throughout the hearing, the parents conducted themselves with immense dignity. However, no one who was in court could fail to have been moved by their pain and distress. Those emotions sprang from an understanding of the relevant medical evidence about P's condition which had been summarised at my suggestion in plain and unambiguous language by the Trust. The parents' hope that P might have more time to recover originated in their love for her and in a belief that she might, even now, overcome her devastating injury. Their strong Islamic faith also influenced their stance. Though they did not challenge the evidence or make submissions opposing the Trust's application, I have assumed that they would want their child to live and would not want her treatment to be withdrawn. Both made clear they left the ultimate decision to me.
42. The relevant medical evidence in this case is unanimous and stark. I accept that P has sustained a catastrophic brain injury from which she will never recover and for which there is no treatment which might improve her functioning. The extent of the damage to P's brain is severe and renders her unable to interact with the world around her. She will never again be the little girl who loved to dance and eat ice-cream. Her condition has deteriorated since she was admitted to hospital and I accept the evidence of Dr A that she is likely to deteriorate with time as her brain continues to atrophy and die.

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43. P's treatment comprises artificial ventilation by endotracheal tube together with the ancillary tasks which render that intervention practical. Though it is unclear whether P experiences pain, the maintenance of ventilation by, for example, suctioning is known to cause pain and discomfort in those who are not deeply unconscious as P presently is. Moreover, P's presentation has developed during her time in hospital. Dr Davies' clinical examination showed her to be experiencing severe muscle spasms which are known to be very painful. I am satisfied that P's quality of life is very poor indeed and that she is more likely than not to be in pain. P cannot signal her pain or distress – it can only be intuited from what clinical experience tells us that others experience when artificially ventilated.
44. I am satisfied that P has reached the limit of what medical intervention can achieve for her and she is deteriorating slowly but surely. There is no discernible benefit to P from continuing with treatment other than the preservation of life itself and the burdens of her treatment are onerous and likely causing her pain which she cannot communicate. I have factored into my thinking what P's attitude to treatment might have been, assuming that, in accordance with her Islamic faith, she would have wished for treatment to continue but, as her parents did, accepted the weight of the medical evidence against this. The strong presumption in favour of taking all steps to preserve life is not absolute and must be weighed in the balance against other factors to arrive at a best interests decision for P.
45. With a heavy heart and on the basis of the above analysis, I have concluded that P's best interests are served by permitting the Trust to withdraw invasive treatment in accordance with the palliative care plan so carefully negotiated by the advocates in conjunction with the clinical team treating P. That plan envisages extubation and the removal of assisted ventilation in the presence of P's parents who will be able to stay with her until she dies, whether that time be calculated in minutes, hours or even days. This will be a carefully managed process with medical staff on hand to ensure that P has appropriate pain relief and sedation to make her as comfortable as possible. P's extended family will also be permitted to say goodbye to her and she and her parents will have comfort and support from the hospital imam and their own imam, if he is available.

Conclusion

46. I grant the Trust's application and make the declarations that it is not in P's best interests for life-sustaining treatment to be continued and that it is in her best interests for a palliative care regime to be implemented. This process should take place as soon as possible for P's sake and the sake of her parents who are under almost unbearable strain.
47. That, with immense sadness, is my judgment.

Postscript

P's treatment was discontinued at about 12.10 on 9 February and she died at 18.48 later that same day. Her parents were with her until the end.

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The court records its immense gratitude to the medical and nursing staff who have cared for P with such dedication. It also wishes to thank the prison staff who have supported the mother throughout with great compassion and humanity. The police should also be commended for their pragmatic approach to the necessary criminal justice formalities consequential on P's treatment being discontinued and her death. The court also thanks the social work team who have gone above and beyond what might have been expected to provide a humane response to P's parents. Finally, the court expresses its gratitude to the interpreters who attended court and assisted the parents to communicate but went beyond this in agreeing to help in whatever way they could to facilitate parental contact at the hospital later on 8 February and also on 9 February.