
ENGLAND AND WALES / JUDGMENT

I (A Child) [2015] EWCA Civ 1159 (06 October 2015)

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IN THE COURT OF APPEAL (CIVIL DIVISION)

ON APPEAL FROM THE HIGH COURT OF JUSTICE

FAMILY DIVISION

(MR JUSTICE BODEY)

Royal Courts of Justice

Strand

London, WC2A 2LL

6 October 2015

B e f o r e :

LORD JUSTICE JACKSON

LADY JUSTICE BLACK

LADY JUSTICE KING

IN THE MATTER OF I (A CHILD)

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Tel No: 020 7404 1400 Fax No: 020 7404 1424

(Official Shorthand Writers to the Court)

The Applicant appeared in person

Ms K Gollop and Mr M Chisholm appeared on behalf of the Respondents

HTML VERSION OF JUDGMENT

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LORD JUSTICE JACKSON: This judgment is in four parts, namely:

Part 1.

Introduction;

Part 2.

The facts;

Part 3.

The present proceedings;

Part 4.

The application for permission to appeal to the Court of Appeal.

Part 1. Introduction

This is an application for permission to appeal to the Court of Appeal, with the appeal to follow if permission is granted, against the order of Bodey J made last Friday, namely 2 October 2015, which permitted life sustaining treatment to be withdrawn from an 11 year old boy to whom I shall refer as X.

The central issue before this court is whether arguably the Court of Appeal should interfere with the judge's decision that such a drastic course of action is in X's best interest.

In the course of this judgment, I shall use the same abbreviations for individuals as were used by the judge.

At the hearing today, the child's father, referred to by the judge as Mr W, appears in person and represents the arguments and opinions of both himself and his wife, the child's mother. Ms Katie Gollop appears for the NHS Trust responsible for the hospital where X is currently being treated. Mr Malcolm Chisholm appears for the child's guardian.

After these introductory remarks, I must turn now to the facts.

Part 2. The facts

X is an 11 year old boy. Up until June of this year, he was healthy and active. He was a keen footballer and we were told he enjoyed drama. He was due to start at secondary school this term. Unfortunately, in the summer of this year X was struck down by a virus. This attacked and compromised his heart functioning.

X was admitted to hospital with end stage heart failure. On 30 July 2015 X was transferred from the original hospital to his present hospital which the judge has referred to as "the First Hospital". That hospital is unquestionably a centre of excellence.

At the time of X's transfer to the First Hospital, he was supported by extra corporeal membrane oxygenation, which is generally referred to as "ECMO". That is intended to be a short term procedure.

The plan was that the First Hospital would provide support for his heart with devices which would enable him to continue functioning with a view in due course to a heart transplant. There is inevitably a delay before the opportunity for a heart transplant arises. That period of delay and the intervening treatment is commonly referred to as "bridge to transplant".

On 3 August 2015 surgeons carried out a major operation to provide support for X's heart. That operation is described in some detail by Dr A in paragraphs 4 and 5 of his report as follows:

"On 3 August 2015 X had the Heartware implanted in his chest, as a left ventricular assist device. This means that the device takes blood out of the left ventricle and pumps it to the rest of the body, entirely taking over the workload of the left side of X's failing heart.

The hope had been that this left sided support (LVAD) would be sufficient for X, although bilateral ('biventricular') support had also been planned for. The Heartware could not sustain X's circulation and it became immediately apparent that mechanical support would also be required for the right side of X's heart to pump blood from his heart to his lungs. The VAD implanted to support the right side of X's heart is called Levitronics. This is a centrifugal pump attached to the right side of the heart, but which is not implanted into the chest. This was chosen because the Heartware is not well suited to provide support to the right side of a heart."

Following this operation, X suffered massive bleeding. From then on, recurrent bleeding and clotting had been a major problem of his treatment.

Dr C, a surgeon who has operated on X many times, describes the problem as follows in paragraphs 3 to 5 of his statement:

"Since August I have operated on X many times to remove blood clots from his chest and although in the past removal of the clots had been successful, he has bled again and new clots had formed. The main problem is that the irritation from any removal we attempt to carry out to remove the clot resulted in profuse bleeding from numerous microscopic points. And when this bleeding stopped, more clots were formed and settled in his chest.

On one occasion when we went back to explore him and to evacuate the clot the bleeding would not stop and we were exhausting the blood bank. The mechanical devices were not working well due to insufficient blood flow. There was nothing we could do surgically or medically, so we decided not to do anything further. I spoke to X's parents at that point and explained to them that either he was going to stabilise himself or he was going to die.

The bleeding stopped after about 48 hours. At this stage the lung had collapsed because of the volume pressure of the clot on the lung. We decided to take X to theatre again in order to create a space to allow the lung to re-inflate. However the same problem arose in that X started bleeding and we could not stop the bleeding to the extent that we again exhausted the hospital blood bank.

Once again, I spoke to X's parents and told them we would see if X's bleeding stopped by itself. Whilst the bleeding did stop eventually, another clot was formed and this is the substantial clot that remains in X's chest.

Moreover, X's lungs are so extensively damaged from his critical illness and clots around them that a heart transplant is no longer an option for him."

As explained in that passage of Dr C's statement, X's lungs failed. Because of that, he was converted once more to ECMO. There was a Berlin Heart which had been inserted into X on 13 August. That was removed when ECMO was resumed. An oxygenator was put on the right side of X.

On 10 September 2015 doctors carried out a CT scan. This showed a large collection of blood. It constituted a clot which surrounded the left lung and occupied the space between the chest wall and the heart. That was one of the particular problems to which Dr C has referred in the passage quoted from his statement.

Regrettably, after that other organs started to fail. X's kidney function deteriorated. His skin started to break down such that contact with bed sheets caused blisters. By mid September, the doctors treating X concluded that he was no longer a candidate for a heart transplant. Such was the deterioration of X's lungs and general condition that there was no prospect of a heart transplant being successful.

The medical staff at the First Hospital sought a second opinion from Dr D. Dr D is a consultant in paediatric cardiothoracic anaesthesia and intensive care at a hospital many miles from the First Hospital. The judge referred to this latter hospital as the Second Hospital and we shall follow suit.

Dr D attended the First Hospital. He met the father of X. He then examined X. He studied the medical records. He had a further meeting with the child's father. Taking matters shortly, he came to the same conclusion as the medical staff at the First Hospital, namely that further treatment of X had no prospect of success.

The nurses caring for X became increasingly concerned about his suffering. There is before this court, as there was before Bodey J, a witness statement from Nurse G, who is the lead nurse caring for X. That witness statement is dated 1 October. Relevant parts read as follows:

"7. Over the course of the next couple of months, X had many surgical procedures requiring anaesthesia. The nurses have now become concerned that X is uncomfortable as he is;

- Lying in a bed unable to move himself (with a pressure sore on his sacral area),
 - He frowns and grimaces when turned or moved and also appears to have pain on movement of his joints;
 - His sternotomy wounds sites, drive line and pressure sore have required input from the tissue viability Nurse. This is due to loss of integrity of X's skin from copious fluid loss at the drive line site and his reduced nutritional status.
8. X's pain requirements have escalated to the maximum levels of analgesia that can be given. He also requires frequent boluses of Ketamine for any procedure (cares, turning, new lines, etc). The frequent use of Ketamine is unusual in the ICU setting. One of the biggest concerns by the nurses at the bedside is how to maintain X's comfort and care. They feel the pain relief was initially well managed. However, the nurses are now concerned that X may have developed a tolerance to the analgesics and therefore his pain is not managed as well. This is evidenced by the grimacing on X's face every time care is given and as stated above by the increased use of Ketamine

...

10. With regard to the Nursing care and treatment that X is receiving on a daily basis, X has;
- A tube in his nose where he is Intubated and ventilated that requires frequent suctioning. It is hard to know what X's level of consciousness is, but the Nursing staff are of the view that this is uncomfortable and at times painful for him;
 - Two tubes in his nose, (nasogastric/naso-jejunal tube) for feeding. Again, these are quite big tubes and are positioned in his nostril and are uncomfortable for X.
 - Due to the levels of sedation he is unable to clear oral secretions and requires frequent suction which unavoidably can damage the mucosa and cause bleeding;
 - Regular eye care to maintain lubrication;
 - IV access for IV fluids/medication. Care is given to prevent the IV infiltration or infection;

- Sternotomy wound is currently dry, but his skin is not healing due to organ, (namely the skin), failure;
- Electrical cables connected to a power source for the LVAD. The exit for this cable is on the side of the abdomen, ("drive line site"). This area of skin around the drive line site has broken down and the skin tissue bleeds, requiring regular dressing changes. Having an open wound and broken skin that requires frequent cleaning and dressing changes causes X pain. Ketamine is required each time such care is given.
-

A pressure sore on his sacrum. This is a grade 2 (grade 4 being the most severe). Pressure area care is given every 4 to 6 hours and involves turning X to a different position. This is painful for X and he requires Ketamine before pressure area care is given.

- Muscle wastage and contractions of his joints. This is partly due to the length of time that X has been in CICU. Physio and passive limb exercises are given. However, from X's facial expressions and the need to give a bolus dose of ketamine before each session, this is clearly a painful procedure for X.
- An indwelling urinary catheter due to fluid retention X's scrotum is swollen and makes catheter care more difficult and uncomfortable for him.
- X is grossly oedematous over most of his body. This is due to fluid retention. His skin is tight, shiny and blistered in places. The nursing team caring for X feel cruel when they are delivering care as they can see he is in pain despite the use of Ketamine. A number of the nurses have said to me that they feel having to give such treatment is not humane."

In those circumstances, all of the medical staff treating X came to the conclusion that it was in his best interests to withdraw life sustaining treatment. Accordingly, the NHS Trust responsible for the First Hospital commenced the present proceedings.

Part 3. The present proceedings

On 28 September 2015 the relevant NHS Trust issued an application for a declaration that it would not be unlawful to withdraw medical support devices which were effectively keeping X alive.

The application was and indeed is opposed by X's parents, who are both devout Muslims. It was said by them that X was also opposed to the application. The application made by the NHS Trust was supported by Cafcass acting as the children's guardian.

The application came before Holman J on 28 September 2015. Holman J gave directions leading to a hearing on 2 October. That hearing on 2 October was before Bodey J.

It proceeded in open court, as does this hearing, but on the strict understanding that any report of these proceedings must be anonymised so that neither X nor his family nor the treating hospitals and doctors may be identified.

Bodey J had before him a comprehensive collection of medical notes. They comprised a report from Dr A, a consultant on the cardiac intensive care unit in the First Hospital; a report from Dr B, a consultant paediatric cardiologist at the First Hospital and director of cardiothoracic care and transplantation at that hospital; a report from Dr C, a cardiothoracic surgeon; a report from Dr D, the doctor previously referred to who has provided a second opinion; a report from Dr E, a locum consultant and intensivist at the intensive care unit at the First Hospital; a report from Dr F, a consultant on the cardiac unit at the First Hospital; and finally, the report or witness statement from Nurse G to which I have previously referred.

That is the evidence on the medical side. The judge also had before him the statement of the child's guardian which was essentially supportive of the position of the NHS Trust.

The judge also had the evidence of X's father, who was, of course, speaking for both parents. The judge heard oral evidence on 2 October from Dr A and Dr C, but not from the other doctors whose reports he had read. The judge also heard oral evidence from the father.

So far as Dr A is concerned, the judge summarised his evidence in paragraphs 13 to 15 of his judgment. I will not read those paragraphs out. They essentially follow and elaborate upon the report of Dr A and expand upon the medical treatment which I have previously referred to.

Dr A explained that X was unable to talk, but he was able to communicate by nodding and minimal movements. I interject to say that that evidence is consistent with what the father has told us today about X's condition, at least in the past.

Dr A also described the deteriorating blood test results from X and the poor quality of his urine. He was adamant that if the life supporting mechanical devices were left in place, death was inevitable and these mechanical devices would simply be prolonging the process.

He adhered to that position in cross-examination. Dr A said in cross-examination that if treatment continued as at present, there was likely to be progressive renal failure and liver failure leading over a number of weeks to death. If the devices were removed, death could occur as quickly as within minutes.

Dr C, as previously mentioned, gave oral evidence. He was adamant that there was no means by which the major blood clot could effectively be removed in order to alleviate X's condition.

The judge summarised the father's evidence at paragraph 20 of his judgment. No criticism is made of that summary. The father explained to the judge that he and his wife were able to come and pray together with X. X nodded to indicate that he could hear. X liked to see his younger brothers on Skype and was able to smile at them.

The father said that he helped with nursing care by massaging X. He thought that the skin on X's back was perfect, but perhaps a little bit swollen.

He put particular weight on the fact that on two previous occasions when staff at the First Hospital had proposed the withdrawal of support, X had in fact recovered. The father believed that X had turned the corner twice before and he could do so again. The father obviously had in mind the occasions when Dr C had done his best and said that it was a matter now for the child's body to see whether or not the bleeding would stop and on both of those occasions, the bleeding had stopped.

The father was of the opinion that life sustaining treatment should continue, a heart transplant should take place and that it had a real prospect of success.

The judge, despite working under pressure of time, carefully considered all of the evidence on both sides of this troubling case and he made findings of fact which he set out in paragraph 26 of his judgment as follows:

"I accept the expert evidence, and the oral evidence given by Dr A that there is no hope of any intervention which can now save X's life. I accept that sadly he is dying. I do not find that staff at the First Hospital have exaggerated X's condition. Where there are differences in the evidence as between them and the father, it may be that there are changes in X's external condition from time to time which give one observer a rather different impression from another. Or it may be that the father views the state of his much-loved son through the eyes of a father who fervently wishes to see improvements, when there are none, or none which are really significant. Sadly, I do not consider that the father's hopes for his son are realistic given the unanimous medical evidence which I have considered in detail. It seems clear to me that if death is inevitable, it would be better for X (and, so far as I can determine, what X would want) that his end should come in an orderly way with his family around him through the withdrawal of life support; rather than unpredictably as to time and manner and as part of a painful and slow decline, with his essential organs kept going only by artificial means. The evidence points all one way, as the Guardian observed. There are disadvantages of delay which are not counter-balanced by any realistic prospect of anything changing; or to repeat the above citation from Dr C's statement: "

There is no chance of success and, whilst there are risks of further treatment, there are no benefits

".

Having made those findings of fact, the judge granted the declaration sought. The parents were aggrieved by the judge's decision. Accordingly, they applied for permission to appeal to the Court of Appeal.

Part 4. The application for permission to appeal to the Court of Appeal

By an appellant's notice dated 5 October 2015, namely yesterday, the parents applied for permission to appeal to the Court of Appeal. Only the father is named in the appellant's notice, but it is quite clear that it is a proposed appeal brought on behalf of both parents.

The grounds are concisely stated by the father. Section 10 of the appellant's notice says that the judge erred in the exercise of his discretion and the judge made an error in weighing up the benefits and burdens to X in the continuation of treatment.

The appeal having been commenced yesterday, this court gave directions for the hearing to proceed today owing to the importance, gravity and urgency of the matter. I have previously outlined the representation on all sides. I express my gratitude not only to counsel, but also in particular to the father, who has explained his arguments clearly and concisely despite the obvious pressures under which he is operating.

First thing this morning, the NHS Trust, at the request I believe of the court, furnished to us an updating statement of Dr A dealing with developments in X's medical condition. Clearly this is fresh evidence which ought to be admitted because it deals with events which have occurred since the hearing below, satisfies the requirements of Part 52 of the Civil Procedure Rules and the well-known requirements in the

Ladd v Marshall

test.

What Dr A says in his latest witness statement, one that is clearly prepared overnight last night, is this. He last saw X at 6.15 pm yesterday evening. X has become much more swollen in the last 48 hours. He is now barely recognisable because his neck, face, ears and eyes are blue. X can no longer open his eyes when requested and if doctors need to look at his eyes, they have to open them manually. It is said that X's skin is splitting. Dr A has not actually seen that.

Dr A considers that the swelling has been exacerbated by progression to renal failure, which is now much worse than was the position last Friday. Last Friday, X was able to produce some poor quality urine in response to diuretic infusions, but now he cannot manage that.

Dr A considers that there is dead or infected tissue within the compressed left lung and that is the cause of the progressive renal failure. Dr A opines that the dead tissue is producing toxins which are driving both inflammation and the swelling which Dr A has observed.

Dr A describes this as a systemic inflammatory response. The consequences are that X's blood pressure is lower, his circulation is increasingly inefficient and there are elevated lactic acid concentrations measurable in his blood.

Another consequence is diarrhoea, which is probably a sign of gut failure. Dr A states that X had been on continuous milk feed on Friday at the rate of 65 millilitres per hour. This has now had to be reduced to 5 millilitres per hour because of the frequency of the diarrhoea.

Dr A considers that the lower blood pressure, the circulation failure, the elevated blood lactate and the renal failure and gut failure are signs of systemic inflammation secondary to tissue death. Dr A says that he and his colleagues are powerless to stop this process. They anticipate ever increasing liver failure and skin break down.

We adjourned briefly at the beginning of the hearing this morning so that the father, Mr W, could consider the updating statement from Dr A. After Mr W had done that, he argued his application for permission to appeal, setting out essentially four submissions.

His first submission or argument is that Dr D, who provided the second opinion, has been misinformed. His second argument is that the First Hospital's analysis of the benefits and burdens of continuing to give life sustaining treatment is flawed. His third argument is that X's condition is not as bad as the doctors are making out. His fourth argument is that there are other treatment options which neither the First Hospital nor Dr D have properly considered. I shall take those four arguments in turn.

The first argument relates to the information supplied to Dr D. We have in the bundle at our pages 36 to 39 document headed "CICU summary" from the First Hospital. That appears to be factual information supplied by the First Hospital to Dr D.

During the course of his submissions, Mr W handed up to us another copy of that document which differs slightly from the version in the bundle. In particular, after the entry "3 August 2015, chest exploration for bleeding", there is in brackets "3.47 and 12.55". After the entry dated 15 August which reads "chest re-exploration due to D saturation/high airway pressures and CVP", there is on the version handed up by the father the additional words "(midnight and 4.30)".

The father submits that the document which he handed up to us was the one provided to Dr D. The suggestion in that document that on those two dates there were two separate chest explorations makes X's condition appear to be much worse than it really was and Dr D was misled.

Ms Gollop for the NHS Trust contends that the version handed up to us this morning is the first version of the statement. It was corrected after the father had raised concerns and what was supplied to Dr D was the second version, which was that which appears in the bundle.

It is not possible for us in the context of this appeal to ascertain the correct chronology of these two documents. As we understand it, this particular matter was not explored at the hearing on Friday when oral evidence was called.

What is clear, however, from Dr D's statement is that Dr D had meetings with X's father both at the beginning and at the end of the visit. That was an opportunity to correct any misunderstandings.

More importantly, however, it seems that the discrepancy on which Mr W relies is not one which would impact on Dr D's overall conclusion.

In the case of 15 August, there clearly were two re-explorations of the chest fairly close in time to one another. There is some uncertainty as to whether the first re-exploration was before or after midnight on the night of 14 to 15 August 2015. The second one was undoubtedly after midnight.

The version of the document handed up to us refers to "midnight". It is a moot point whether that is actually a reference to the dividing line between 14 and 15 August. The fact is that there were two re-explorations close to one another in time and whether the first one was slightly before or slightly after midnight is not, in the scheme of things, a matter of great moment.

In my view, the discrepancy which Mr W relies upon between the two versions of the CICU summary is not a matter of significance which affects Dr D's conclusion that X was beyond the reach of effective medical treatment.

I turn now to Mr W's second argument. This involved a fairly close examination of the benefits and burdens sheet, the balance sheet in effect, which medical staff at the First Hospital had drawn up. The staff had set that document out over four pages in 16 separate sections in boxes with benefits on one side and burdens on the other side. For ease of reference during argument, I have numbered those 16 boxes 1 to 16.

Mr W and his wife had clearly been observing their son closely. So also had the medical staff. It is clear that there are some differences in the observations made on the one side by the medical staff and on the other side by the father.

I have carefully considered each of the points which Mr W raises about this schedule. It does seem to me that overall they do not affect the picture which is being presented. They are essentially points of detail such as, for example, how long it took to turn X over, how many nurses were needed for the operation and so forth.

In relation to box 1, Mr W made forceful submissions about X's ability to communicate. He told us that the other day X pointed to his leg. He was asked if his leg was hurting and he nodded to indicate that it was. But on further questioning, Mr W told us that that particular incident had happened on 20 or 21 August. That does actually fit with the oral evidence given by Dr A to the judge, which is summarised in the judge's judgment at paragraph 14.

Mr W also told us that the last occasion on which X, his son, nodded in order to indicate assent when asked a question by his mother was two days ago. That would be on Sunday. Of course, sadly the position is that since then X's condition has deteriorated in the manner described by Dr A.

It seems to us that both the nursing staff and the doctors and the father have been describing the extent of X's ability to communicate as accurately as they can and of course, they are talking about different points in time.

There is some dispute between the parties as to the regularity of suction and whether suction is ever not done at particular times.

It seems to me that this point and the other points which Mr W raises about the schedule are essentially points of detail. What is clear from the schedule, and in particular those parts which are not challenged, is that X is undergoing extremely painful and uncomfortable treatment and has been enduring many invasions of his body for a period of many weeks with no prospect in sight of any respite.

The second line of argument which the father deployed really leads into the third line of argument, which is that X's condition is not as bad as the doctors make out.

Mr W points out that his son does not have any brain injury. So far as I can see, the father is right and the medical reports do not suggest that there is any brain injury. The problem is that X's body is gravely impaired and is deteriorating.

The judge, having heard the oral evidence of Dr A, Dr C and the father, made the findings of fact to which I have referred in paragraph 26 of his judgment. They are essentially that the doctors' description of X's condition is an accurate description.

We cannot go behind those findings of fact. This court does not hear the oral evidence. It is, absent special circumstances, bound to accept the trial judge's findings of fact.

Linked to the third argument is Mr W's fourth and final argument that other forms of treatment are available. They have not been properly considered and they should be pursued.

Mr W draws our attention to an e-mail exchange which he had with Dr D on 30 September of this year. In that e-mail exchange, Mr W asks whether a thoracotomy was a practicable way to proceed and whether it was the case that the drawbacks would outweigh the benefits.

Mr W said that Dr D had mentioned that the chances of the left lung recovery were less than 20 per cent. He asked whether there was any evidence to suggest this and whether such an operation would go ahead if X were at the Second Hospital.

Dr D responded that a thoracotomy was a possible approach. It was up to the surgical team to decide whether that was a feasible and safe option; whether they thought that the risks of bleeding, death and pain outweighed the likely benefit; whether they thought that reoperation would cause more bleeding and not be of any benefit to X. Dr D was clear that the chance of success of a surgical approach was less than 20 per cent and probably much less. But anyway, that was only one stage in a long journey.

It is clear from what Dr D has written that the medical staff at the Second Hospital would not be prepared to carry out that operation, nor would the medical staff at the First Hospital. When one considers X's overall condition, it is, to my mind, clear that that particular operation could not be a stage in any course of treatment which would save X's life.

Mr W also tells us that he has spoken to an outside doctor who suggested various forms of treatment, in particular intramural fibrinolysis. Mr W says he has suggested this to the medical staff at the First Hospital, but they have ignored the possibility of these procedures.

It seems to me that the medical staff at the First Hospital are in the best position to assess X's overall condition. If they thought there was any prospect of that procedure succeeding, they would undoubtedly have pursued it.

It is necessary, after considering the individual arguments of the father, to stand back. The judge, as I said, has heard the oral evidence. I do not believe that we can possibly disturb his findings of fact in this case.

I turn now to the law. The judge stated the law correctly but concisely in his judgment. No criticism is made of that statement of law. But since the father is a litigant in person, I must, of course, apply my own mind to the principles which the judge stated and their applicability to the present case.

As the judge said, a good starting point for consideration of the law is the Court of Appeal's decision in

Portsmouth Hospitals NHS Trust v Wyatt

[2005] EWCA Civ 1181

;

[2005] 1 WLR 3995

. In that case, a child was born prematurely with grave respiratory and kidney problems. The judge granted a declaration that treatment may be withheld. The Court of Appeal upheld that decision.

Wall LJ gave the judgment of the court. At paragraph 87, he said this:

"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 patient (

In re J

) [1991] (Fam) 33. There is a strong presumption in favour of a course of action which will prolong life, but that presumption is not irrebuttable (

In re J

). The term "best interests" encompasses medical, emotional, and all other welfare issues (

In re A

) [2001] 1 FLR 549. the court must conduct a balancing exercise in which all the relevant factors are weighed (

In re J

) and a helpful way of undertaking this exercise is to draw up a balance sheet (

In re A

)."

Well, as previously mentioned, the medical staff at the First Hospital had drawn up such a balance sheet in the present case.

A further relevant authority which was not drawn to the attention of the judge, but which Black LJ has drawn to the attention of counsel in this case, is in

Re: Jake (A Child)

[2015] EWHC 2442 (Fam)

. This is a decision of Sir James Munby, President of the Family Division, given as recently as 19 August 2015.

In that case, the President had to decide whether medical treatment could be withheld from a gravely ill 10-month old child. He set out the legal principles at paragraphs 33 to 35 of his judgment. I note those principles, but do not actually read them out.

The judge attached particular weight to the guidance published by the Royal College of Paediatrics and Child Health. The third edition of that guidance is very recent, being dated March 2015. In view of the weight which the court attached that guidance in the case of in

In re Jake

, I shall consider its applicability in the present case.

The guidance deals with the effect of limited quality of life. It says in one paragraph about inevitable demise:

"In some situations death is not imminent (within minutes or hours) but will occur within a matter of days or weeks. It may be possible to extend life by treatment but this may provide little or no overall benefit for the child. In this case, a shift in focus of care from life prolongation per se to palliation is appropriate.

In both 'Imminent death and Inevitable demise' (above) the early provision of sensitive palliative care is ethically justified and in accordance with principles of good medical practice."

In my view, that paragraph is of some relevance to the present case.

The other important paragraph comes under the heading "Limited quality of life where there is no overall qualitative benefit". Heading B in that section reads "Burdens of illness or underlying condition". That paragraph reads as follows:

"Here the severity and impact of the child's underlying condition is in itself sufficient to produce such pain and distress as to overcome the potential or actual overall benefits in sustaining life. Some children have such severe degrees of illness associated with pain, discomfort and distress that life is judged by them (or on their behalf if they are unable to express their wishes and views) to be intolerable. All appropriate measures to treat and relieve the child's pain and distress should be taken. If, despite these measures, it is genuinely believed that there is no overall benefit in continued life, further LST should not be provided, for example, in advanced treatment-resistant malignancy."

Both Miss Gollop for the NHS Trust and Mr Chisholm for the guardian place reliance on that paragraph. They submit that this case falls within it. I accept that submission. It seems to me that that paragraph is entirely apposite to the present case.

The sad fact is that X is now dying. He is beyond medical help. Life prolonging treatment will cause him intolerable suffering to no useful purpose. In my view, the order made by the judge accorded with X's best interests.

There is no prospect that the parents' proposed appeal would succeed. There is no other compelling reason why permission should be granted. Accordingly, in my view, permission to appeal must be refused.

LADY JUSTICE BLACK: I agree.

In very short summary, the decision which Bodey J took was one which he took having read all of the evidence and heard from Dr A and from the father. He has not been demonstrated to have approached his decision on the wrong legal basis or to have ignored material that was relevant or to have weighed the material that he had in a way that was not open to him.

In those circumstances, an appeal could not succeed even without recent developments in X's condition. The new evidence shows that matters have deteriorated markedly even since Friday when Bodey J made his decision. That places even more obstacles in the way of an appeal.

Nothing that I can say can make this decision any easier for the father and for the rest of X's family, but I would like to pay tribute to the father's dedication to his son and to the way in which he has ensured that X's best interests have been at the forefront of every decision that has been made about X. He has done everything for his son that any father could do with dignity and determination.

X's mother would have been here too, I know, had she been able to be. She is dedicated too to her much loved son and what the father has said today is said on her behalf as well, I know. My thoughts are with her and with the father and with the rest of the family.

LADY JUSTICE KING: I also agree and particularly associate myself with the observations of Black LJ.

It would be presumptuous of me to pretend that I, or anyone not directly affected, can truly understand just what this family is going through and has been going through since X was taken ill in July.

Since that time, the parents have stoically endured what must have been a roller coaster of emotion; from initial shock and despair to hope upon his transfer to the First Hospital, a heart transplant might yet save his life.

It is wholly unsurprising that the parents, notwithstanding the overwhelming medical evidence, are unable to accept that the deterioration in X's condition, and in particular the deterioration in his lung function, means that the longed for heart transplant is no longer an option and that X is now in organ failure and his death inevitable.

It was in those circumstances, that upon the application of the NHS Trust, it fell to Bodey J to consider whether continued life sustaining treatment is in the best interests of X.

For the reasons given by Lord Justice Jackson, there is in my judgment, no prospect of the father succeeding in an appeal against the judge's decision, he having heard from Dr A and the father orally and having considered and applied the law. The conclusion that the judge reached that the time has come to withdraw life sustaining treatment cannot be said to be wrong.

The parents' strong faith has been of comfort and support both to them and, also in the time before he was in extremis, undoubtedly to X. One can only trust that that faith and the support of the close knit and loving family of which X is a part will offer some comfort, both to the parents and to X's younger brothers, in the dark days that lie ahead.

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