Neutral Citation Number: [2021] EWHC 163 (Fam)

Case No: FD21P00054

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/01/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN

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Between :

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	**Applicant**
- and –	
MR OZZY GODFREY	**1st Respondent**
- and –	
DANNY GODFREY (by his litigation friend, the Official Solicitor)	**2nd Respondent**

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Miss Katie Gollop QC (instructed by University Hospital Bristol and Weston NHS Foundation Trust) for the **Applicant**
Miss Nageena Khalique QC (instructed by the Official Solicitor) for the **Second Respondent**

Hearing dates: 29th January 2021

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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.

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THE HONOURABLE MR JUSTICE HAYDEN

Mr Justice Hayden :

1. This is an application concerning Danny Godfrey. He is a little boy who was born on 17th January 2021. Danny is presently an inpatient in a Neonatal Intensive Care Unit which falls under the aegis of the University Hospitals Bristol and Weston NHS Foundation Trust. It is the Trust who makes this application, pursuant to the inherent jurisdictional powers of the High Court. They seek a declaration that it is lawful and in Danny's best interests to discontinue mechanical ventilation. The likely consequence of this will be to bring Danny's life to an end.

2. It is important to record that this application is supported by Danny's family, both on the maternal and paternal side. For reasons, which I will come to in a moment, Mr Ozzy Godfrey, Danny's putative father does not have 'parental responsibility' and has not been registered on the birth certificate. Though Mr Godfrey and his father attended to register the birth, there were technical reasons why he was not identified as the father. I will return to this issue below.

3. When the case came before me this morning, Danny had not been joined as a party. I am extremely grateful to the Official Solicitor who was able to provide representation on short notice. Miss Nageena Khalique QC has advanced his interests and has been able to absorb the documentation.

4. Danny's mother was Danielle Jones, she was born in March 2002. At 18 years of age she gave birth to her son Danny. Danielle was living at home with her parents. She had been in a relationship, of some duration, with her boyfriend, Mr Ozzy Godfrey, who is also 18 years of age. When Danielle became pregnant she did not tell anybody about her pregnancy. As Miss Gollop QC, who appears on behalf of the Trust has impressed upon me, it was not only her parents that Danielle did not tell. She did not tell her boyfriend. She did not tell any of the healthcare professionals and she did not avail herself of any ante-natal treatment. This was a completely concealed pregnancy.

5. There is no need for me to speculate what was going on in Danielle's mind. It is not helpful or necessary.

6. On 17th January 2021, Danielle was at home when, for no apparent reason, she collapsed. An ambulance was called, and the paramedics quickly discovered that she was pregnant. The critical care team had no options open to them other than to commence CPR on arrival, and to perform a caesarean section. It is calculated that there was a period of around half an hour (minimum) between Danielle's collapse and the arrival of the critical care team. Her baby, Danny, was delivered at 12:20, in a pale, floppy and unresponsive condition. He was immediately given oxygen, and although it is difficult to be accurate, on arrival at hospital in due course, his gestational age was estimated at approximately 36 weeks, just 2 weeks short of full-term. Tragically, Danielle died before she reached the hospital.

7. This was manifestly a dreadful beginning to Danny's short life. I have heard this morning, from the Consultant in Neonatal medicine at the hospital where Danny is being treated (Dr A). Dr A is one of five Consultant Neonatologists who has been concerned with Danny's care. He has prepared a statement which sets out the treatment that Danny has been receiving and in which he evaluates Danny's prognosis and future welfare needs.

8. Danny was delivered at home by way of perimortem caesarean. It was immediately obvious, upon delivery, that Danny's wellbeing had been significantly compromised. He was given breathing support by the critical care team, initially by facemask, but very quickly upgraded to the insertion of an endo-tracheal tube. With the support of that tube, it was possible to ventilate Danny and to provide him with oxygen. He was taken to the hospital, and an initial blood-gas test showed a very high level of acid in the blood. In simple terms, that was a powerful indicator that the supply of oxygen to his brain had been significantly compromised. His physical presentation, his floppiness and lack of any response at all, coupled with the blood-gas readings, indicated to the doctors that he had suffered what is termed an hypoxic ischaemic encephalopathy (HIE) i.e. deprivation of blood, oxygen and brain swelling.

9. Danny was quickly transferred to intensive care for support and to undergo therapeutic hypothermia (TH) treatment. I was told that this is now recognised treatment for any infants presenting with HIE. It consists of reducing the infant's core temperature, very significantly, to 33.5 degrees C. This is undertaken to provide a block to evolving brain injury. At the same time, Danny was receiving mechanical ventilation; he had a central venous and arterial catheter inserted; he received antibiotic treatment and intravenous fluid support. His brain activity was assessed regularly by ongoing clinical examination reinforced by cerebral functioning monitoring (CFM), which consists of single channel EEG and amplitude integrated EEG traces.

10. Throughout his time in the neonatal intensive care unit, Danny's presentation has been described as highly abnormal. He has displayed no evidence at all, of any interaction or consciousness. He has revealed no heart variability in response to any kind of stimulus. It has been ascertained that he does not have a gag reflex. He displays extended posture and presence of clonus at the right ankle i.e. involuntary muscle contractions. His pupils have not responded to light, and he has demonstrated no normal movements, although there have been some infrequent clonic movements which are indicative of seizure activity.

11. Danny has revealed very little by way of sustained breathing effort. There was nothing at all initially, but more recently some weak periods of breathing effort have been noted while on the ventilator, but these have not been sustained. All this indicates a very serious and significant brain injury.

12. As I indicated above, throughout his time in the intensive care unit, Danny's brain electrical activity has been profoundly abnormal. They show three patterns, described by Dr A thus :

    i. isoelectric trace (no brain electrical activity);
    ii. severe burst suppression (isoelectric baseline with infrequent spikes of abnormal electrical activity) and;
    iii. burst suppression with additional electrical seizures.

13. The lack of recovery of brain electrical activity, more than 48 hours after the precipitating event was impressed upon me as a very strong indicator of a poor prognosis in infants with HIE. For completeness, I note that Dr A made the following observations in his statement:

> *"It is recognised that hypothermia and administration of neuroactive drugs for sedation or seizure control may impact on the interpretation of neurological examination. DG's neurological examination and CFM remained profoundly abnormal after rewarming to normal body temperature, and more than 72 hours since his last dose of morphine. He has had phenobarbitone during this time to treat seizures, but blood levels are modest and not at a level which could explain his neurological status."*

14. On 21st January 2021, Danny had an MRI scan of his brain. The MRI scan was reviewed by a specialist Consultant Paediatric Neuroradiologist. Those scans revealed what are described as "widespread restricted diffusion, affecting deep grey structures, cortex, hippocampi and vermis". These are all different areas of the brain that process functioning and responses e.g. memory, posture, movement etc. What was also noticed was "a loss of white and grey differentiation involving the deep grey structures". In simple terms, what that indicated was a near-total deprivation of blood and oxygen. Although it was not possible to be conclusive, the neuroradiologist also saw some abnormal features within the brain stem. That is a very serious neurological sign. It suggests that not only was the deprivation of oxygen and blood near-total, but that it was also prolonged.

15. The MRI findings were as poor as they could be, and all indicative of a very poor prognosis for Danny. The structural injury to his brain is static; there is no further treatment that can be given that will reduce the severity of his injury. He is dependent on mechanical ventilation through endotracheal tube and has shown no sign of consciousness or any meaningful neurological activity.

16. Dr A gave his evidence, if I may say so, in a sensitive and reflective way. He told me that the clinical signs point to further treatment for Danny having become "futile". He settled upon that term in response to a question by Miss Gollop and no doubt had in mind the Royal College of Paediatrics and World Health Guidance:

> *"Lack of ability to benefit; the severity of the child's condition is such that it is difficult or impossible for them to derive benefit from continued life."*

Dr A told me that his objectives were to try and minimise any pain that Danny might suffer, and to preserve his dignity. Dr A agreed that it is very difficult to assess pain in infants in Danny's condition.

17. Dignity can be an elusive concept, at least when one discusses it in the artificiality of the court room. But in the hospital, in paediatric intensive care, in particular, it is far more tangible and much easier to capture. As I have observed now, in a number of cases, one of the advantages of "sitting remotely" via video conferencing platforms, is that it is possible for the judge to meet with patients and families in circumstances which seem a long way from the formality of a court room. In the course of the pandemic I have found myself in people's kitchens, living rooms, in care homes and by hospital beds. This unanticipated advantage has permitted greater access to the court. Today, it has enabled me to visit Danny in the hospital. I met his nurse, I met with his grandparents and I was able to see him in his intensive care bed. He was

wearing a delightful and striking striped romper suit, which had been brought by family members, and which they had put him in. The family visit daily, often for long periods and they participate in Danny's practical care. He is surrounded by toys. There was a large Winnie the Pooh, there is a monkey, there is a small traditional teddy bear with a big bow. Most movingly, there is a white fluffy bear which belonged to Danny's mother. It looked almost new, and it brought home to me, with powerful force, how very young his mum was when she died.

18. There was also a little piece of cloth with a bobble on, I was told it is called a 'mini boo'. It is provided by a charity called Cots for Tots. There are two per family. The mini boo are exchanged between family and baby intending to communicate their respective scent or smell and to reassure each. It is not clear whether Danny has the capacity to enjoy these. Many of those who work with very seriously unwell infants have told me that they believe that notwithstanding enormous damage to the brain, they see some surviving kinaesthetic connection or bond between family, parent and child, which appears to endure and perhaps goes beyond medical understanding. As the family are listening to this ex tempore judgment, I pass this on in the hope that it offers some consolation. In any event, what was utterly clear to me, is that Danny, in his present circumstances, in the most tragic of situations, is nonetheless suffused by the love of his family on both sides. Their grief and their distress has not inhibited them from communicating their love to their grandson and son. It is easy to see that they have preserved and guarded his dignity.

19. It is, in my judgment, a great tribute to them, that they perceive an emerging conflict, between the preservation of Danny's dignity, and their understandable wish for him to live. Each of them, and perhaps for different reasons and beliefs, has come to the conclusion that the approach recommended by the Trust is the right one for Danny. It is obvious that each family member is putting his best interests at the centre of this challenging decision.

20. Miss Khalique, providing a voice for Danny today, via the Official Solicitor, supports the Trust's application. There is compelling evidence that Danny will not experience recovery of the brain. It is unlikely that following the removal of the ventilator, he will be able to breathe sustainably. But even if he were, he would never have any meaningful interaction with the outside world.

21. It is, as Dr A has described in his evidence, possible that there would be sufficient brain function remaining to support the most basic functions. It may be that on withdrawal from the ventilator breathing may recover spontaneously. This would have no impact on the functioning of the brain, nor would it render further active treatment any less futile. It would permit of no pleasure or interaction or engagement of any kind. He would be at risk of suffering, perhaps due to aspiration, but also in consequence of a range of invasive interventions that might be required even palliatively.

22. It is important that I re-emphasise, in this judgment, that the consultant, Dr A, has taken great care to consult with other experienced neonatal experts. All have concluded that the prognosis is bleak with a very high likelihood of death, and an inevitability of profound disability to the degree that it would be impossible for him to derive benefit from continued life. The current clinical plan is to provide ongoing mechanical ventilation, intravenous hydration, treat seizures and to prevent any

discomfort for Danny. It follows but, needs to be said in these extremely difficult times, that Danny has a need for privacy. And for his family to be around him. The hospital has been able to facilitate this. If Danny somehow manages to breath independently, following the withdrawal of ventilatory support, milk feeds will then be provided on an ongoing basis, accompanied by pain relief. Danny's best interests will continue to be reviewed.

23. If Danny is unable to sustain adequate independent breathing or if he suffers cardiac or respiratory arrest, then the family and the doctors believe that he should be permitted to die a natural death supported palliatively by care and pain relief.

24. As Dr A identified in his evidence, until the ventilator is actually disconnected, it is impossible to be sure what the response will be. It may be that Danny will die very quickly, but it is possible that he may sustain independent breathing. This is a traumatic dilemma for his family. As Dr A recognised, there are circumstances, where a brain has been profoundly compromised but can sometimes reorganise its function so that different parts of the brain take on duties that might not otherwise have been required from them. It might be possible, Dr A tells me, for Danny to survive even as long as 12 months, though he was not of the view that this was very likely. If he were to survive after the withdrawal of ventilatory support, Dr A considered carefully the question of whether nutrition and hydration would be appropriate at all. As he discussed this issue, it was plain to me that he found it to be a very difficult and delicately balanced one. Nutrition and hydration constitute 'treatment'. Dr A's conclusion is that Danny cannot benefit from active treatment. It is not obviously logical therefore, to continue nutrition and hydration in circumstances which are a form of active treatment. Dr A recognised this as a paradox.

25. Dr A frankly acknowledged that he found this aspect of the care plan to be extremely difficult. However, ultimately, he came to the conclusion that the continuation of nutrition and hydration, whilst it might prolong Danny's death, had the countervailing impact of preserving his dignity. One option opened by this potential outcome is that it might conceivably be possible for Danny to go home to his family. Freed from the ventilator, less awkward and greater spontaneity of interaction becomes a possibility. It may only mean that Danny can die at home, in privacy and in the arms of his family. That is no small consideration, provided that it is driven by Danny's needs alone. Whilst I too find this a delicate balance, I consider that the family and the treating clinicians have thought long and anxiously about it. I am persuaded that the care plan as drafted reflects Danny's best interests.

26. There is no way to predict the outcome, but what is clear and certain is that Danny is surrounded by a loving family and a highly dedicated team of professionals who I am confident will respond to his evolving needs. I am fortified in my analysis by the fact that the team acting for the Official Solicitor have also concluded that the care plan advanced by the trust is in Danny's best interests.

27. The legal framework is now relatively easy to state though always difficult to apply in applications as sensitive and fact specific as this. I do not consider that an exegesis of the applicable Law is required here, indeed the risk is that to do so might eclipse the lode star which guides the Court's approach i.e. "the best interests of the child".

28. The test is perhaps best encapsulated by Baroness Hale in **Aintree University Hospital NHS Trust v James [2013] UKSC 67**, namely:

> *"[22] Hence the focus is 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 toward the patient if they withhold or withdraw it." ...*
> *"[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 widest 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."*

29. In **Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust [2017] EWCA Civ 410**, McFarlane LJ observed:

> *"As the authorities to which I have already made reference underline again and again, the sole principle is that the best interests of the child must prevail and that must apply even to cases where parents, for the best of motives, hold on to some alternative view."*

30. MacDonald J reviewed the authorities and distilled the principles to be applied in **Kings College Hospital Foundation Trust v Haastrup [2018] EWHC 127 (Fam)**. Though extremely helpful, it is unnecessary for me to reprise that exercise here.

31. Having regard therefore both to the legal framework and to the sensitive medical analysis, I have concluded that it is in Danny's best interests to make the declarations sought.

32. There is one further issue which relates to Danny's birth certificate. It was not possible to register Ozzy Godfrey as the father. I was told that the Registrar considered that there were technical difficulties arising from the fact that Mr Godfrey and the mother, Miss Jones, were not married and that she had been unable to signal her consent to Mr Godfrey being named as the father on the birth certificate.

33. Section 14A of the Births and Deaths Registration Act 1953 authorises the Registrar to re-register a birth if he receives a declaration of parentage made pursuant to Section

55A or Section 56 (4) of the Family Law Act 1986 and it appears that the birth should be re-registered.

34. It is also possible to make a declaration of parentage pursuant to Section 55A in respect of a deceased child, see Re: **E (A Child: Burial Arrangements) 2019 EWHC 3639 (Fam)**. It is, in my view, a facet of Danny's Article 8 rights, that his birth register should reflect his parentage on both sides, if it is at all possible. Accordingly, I have permitted, and deemed to have been made, applications pursuant to s 58 of the Family Law Act 1996 and section 20 of the Family Law Reform Act 1969.

35. I am grateful to Dr A and to Miss Gollop for expediting the relevant blood tests to establish paternity, and I hope that it will be possible to rectify the birth certificate.

36. These are profoundly difficult applications but for the judge, the burden is lessened by the assistance of experienced advocates. In this case my task has also been lightened by the careful thought and sensitive planning undertaken by a kind and experienced clinical team and, perhaps most of all, a family that has shown itself unwaveringly able to fight down their own grief and put Danny as their primary consideration.