Neutral Citation Number: [2025] EWHC 2247 (Fam)

Case No: FD25P00518

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice Strand, London, WC2A 2LL

Date: 29/08/2025

Before :

THE HONOURABLE MR JUSTICE MCKENDRICK

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Between :

AN NHS FOUNDATION TRUST **Applicant**
\- and -
(1) J (by his Children's Guardian) **Respondent**
(2) A Council
(3) FO (by her litigation friend, the Official Solicitor)

Re J (A Child) (Withdrawal of Ventilation)

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Mr Conrad Hallin (instructed by [a firm]) **for the Applicant**
Ms Susannah Johnson KC (instructed by [a firm]) **for the First Respondent**
Mr Anthony Hand (instructed by local authority solicitor) **for the Second Respondent**
Mr Steven Howard (instructed by [a firm]) **for the Third Respondent**

Hearing date: 28 August 2025

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Approved Judgment

This judgment was handed down remotely at 10.30am on 29 August 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HONOURABLE MR JUSTICE MCKENDRICK

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.

McKendrick J :

Introduction

1. The question with which this judgment is concerned is whether or not it is in the best interests of a baby boy to continue to receive mechanical ventilation and intensive care. He was born on [a date] 2025. He is anonymised in this judgment as Baby J. His best interests are the court's paramount consideration and I have focused almost exclusively on him in these difficult proceedings. The Applicant is the NHS Trust that provides care to him. The second respondent is the relevant local authority which exercises safeguarding responsibilities to him. The third respondent is his mother, who lacks capacity to conduct these proceedings and to make a decision in the exercise of her parental responsibility as to whether or not Baby J should continue to receive mechanical ventilation. The father is unknown.

2. I directed the hearing today should be fully attended and required the clinicians to attend in person. The issues are of such importance that the distraction of remote hearings is unhelpful. At the hearing, the court heard the evidence from Baby J's treating clinician Dr G; and the second opinion doctor from a separate Trust, Dr R.

3. After having heard and read the evidence and received short submissions from the parties, I have determined, with profound sadness, to accede to the Trust's application and I make a declaration that mechanical ventilation and intensive care is not in Baby J's best interests.

The Background

4. On [a date] 2025 Baby J's mother suffered a cardiac arrest after a choking incident and cocaine use. She suffered hypoxic brain damage. She spent forty minutes without a heartbeat. Baby J was born at 8.46 am on [a date] 2025 by emergency C section at hospital at 32 weeks and 5 days of gestational age. His birth weight was 2.150 kg which is on the 75th centile. Baby J's cord blood gases show severe acidosis, indicating that the oxygen supply to him via the placenta has been significantly diminished for a period of time, and as a result he has severe Hypoxic-Ischaemic Encephalopathy (HIE grade 3). The clinical position is that it would be unethical, being futile and contrary to his best interests, to continue intensive care and ventilatory support. With extubation it is very likely that he will not be able to breath independently (with or without non-invasive ventilatory support), and that he would require palliative care. In the unlikely event that he was able to breathe without invasive ventilatory support, and stabilised, he would be provided with non-invasive ventilatory support, and all other support to stabilise, and ceilings of care would not be imposed without further consideration or order.

5. A factor in this case is that as a result of hypoxic brain damage sustained during the cardiac arrest, the mother has had reduced awareness with little meaningful interaction and does not

currently have capacity for any kind of medical decisionmaking or ability to partake in court proceedings.

6. At the first hearing of this matter before me on 22 August 2025 the parties initially agreed the matter should be adjourned to a final hearing on or around 8 September

2025. This was to permit the Guardian time to consider the proceedings and to obtain Baby J's records. More importantly, the parties considered two weeks or so were required to permit the mother's presentation to improve to permit her to meaningfully engage in the proceedings. Notwithstanding the agreed position of the parties at the outset, the clinical evidence was clear (to which I will return below) that mechanical ventilation was not in Baby J's best interest on 22 August 2025. Furthermore the evidence stated that it was inappropriate to await improvements in the mother's functioning. It was noted that Baby J had recently been prescribed morphine for pain relief. I refused to adjourn the case for fourteen days, as I considered there was no certainty about the mother's condition improving sufficiently and more fundamentally I did not consider it appropriate to subject Baby J to a further two weeks of treatment his treating clinicians had already concluded was no longer in his best interests. I gave an *ex tempore* ruling explaining my case management decision.

7. Further directions were made to the final hearing, principally:

   a. to allow a short window of opportunity to see if the mother could recover sufficiently from her hypoxic event to participate meaningfully in the proceedings, and for evidence to be provided from Dr N, the mother's treating clinician, for this purpose and crucially to determine her prognosis;
   b. for a second opinion to be obtained in respect of Baby J's prognosis and treatment;
   c. for the local authority to provide evidence on the mother's family circumstances and background to be better understood;
   d. for other family members to participate, if they wished to do so;
   e. for Dr G, Baby J's treating neonatologist, to provide updating evidence as to his best interests;
   f. to allow the other parties to file evidence if so advised.

8. Happily, these directions have been complied with.

The Evidence

Doctor N

9. Doctor N is a consultant in rehabilitative medicine. She provided helpful witness statements on 20 and 26 August 2025. She has met the mother several times to assess her. More recently the mother has been assessed jointly by Dr N and Dr G as not having capacity to make decisions about Baby J's treatment, including extubation. Attempts have been made to inform the mother of Baby J's circumstances. Dr N concludes that the mother is suffering from post-traumatic amnesia ("PTA"). She does not appear to retain information about Baby J. She has a short attention span and needs frequent prompts to focus on the question or task request. I quote some material parts of Dr N's evidence.

a. "*Dr G told the mother that as she had a heart attack her heart did not function for 40 minutes and blood to Baby J was reduced causing severe brain injury. The mother did not respond. Dr G told the mother that Baby J was very unwell and the likely would not survive. The mother said "Ok I am sorry. Can*

he like not go somewhere and leave it there." The mother said "I don't want to be involved in it all." Dr G explained that they were thinking to take the tube out and Baby J might survive. The mother said "Ok. I don't know what to say. How many kids have I got?" Her partner responded "seven." The mother said "how is it seven? It isn't my 7th child wait" then the mother tried to name her children. She was able to name two of her children and then kept repeating the first name she had given. She was asked if she could remember the baby's name and she replied "I don't know his name." The mother then became distracted. I asked her what we had just discussed immediately following the above conversation and she said "I don't know." I asked her if we had been talking about a baby and she said no."

b. In relation to a further conversation between the mother and Dr N which took place on 26 August 2025 it is noted: "*I attempted to discuss Baby J more and explained that he is not well. I told the mother that she had been admitted with collapse and a heart problem and that she needed a c-section. The mother said "I don't know. Why is that?" she was distracted when we told her the baby was not well and then a tangential discussion occurred where she was not on topic or responding to discussion regarding the baby, but said "the rest have all been alright." I told her that she was muddled and confused at present and not able to make decisions regarding the baby in my opinion, and asked her if it was ok to speak to her mother and partner regarding her wishes. She gave the impression that this was ok, albeit she did not directly answer the question.*"

c. Dr N recounts another conversation at 13:30 the same day in her updating evidence: "*I visited the mother again at 13:30pm today and showed her pictures of Baby J. The mother took the pictures and looked at them. She said "when will he be better". Her friend was present and we explained that we did not think that Baby J would get better and she said "it is so sad." The mother's friend asked her if she would like to see Baby J and she said "maybe". We explained he had a breathing tube in place and the mother said "it is horrible". She didn't recall being in hospital and said there is not much she can do. She then said "the only thing you could do" and then was unable to finish the sentence. I explained that Baby J is only alive due to the pipe helping him breathe. The mother said "I thought he was alright. Never? How do you know?" I explained that Baby J has brain problems that are not curable. She said "ok" and then became distracted.*"

10. Dr N's evidence is that the mother cannot currently understand, retain or weigh information relevant to Baby J's medical treatment, and is evidently not able to express any clear or

consistent wishes in this regard. As to the prospects for further recovery, Dr N describes the mother's communication as "*improving but remains impaired*". The conclusion is that at present she remains in PTA and is presenting with significant cognitive communication issues and possible expressive and receptive aphasia. Dr N's evidence is that she cannot provide an accurate indication of prognosis overall from the mother's brain injury whilst she remains in PTA. Whilst it remains possible that she could emerge from PTA over the next week, Dr N confirms that it could last for longer, and she does not know what the mother's condition will be when she does emerge from PTA.

Dr G

11. Dr G is Baby J's treating clinician. He is a consultant neonatologist and has been for nine years. He has filed three witness statements. In his first statement dated 20 August 2025, he sets out the background to Baby J's admission and states a breathing tube was inserted into Baby J's windpipe and he was started on mechanical breathing as his own was not effective enough. He notes the majority of babies born at 32 weeks gestational age would not require intubation and mechanical ventilation. Baby J was transferred to the neonatal unit at the hospital, it is a level two neonatal unit with highly experienced doctors and nurses.

12. Baby J's cord blood gases show severe acidosis which demonstrates that the oxygen supply to Baby J via the placenta was significantly diminished for a period of time. He has started having seizures from twenty eight hours of age. On 12 August he was transferred to the neonatal intensive care unit at a neighbouring hospital. His diagnosis is severe Hypoxic-Ischaemic Encephalopathy (HIE grade 3). This is a severe brain injury and babies with this condition often have kidney, liver and sometimes cardiovascular disfunction.

13. Baby J had a 12 lead Electroencephalogram (EEG) and the results were studied by a consultant neuroradiologist and his report concluded: "The background is of very low amplitude with no convincing cerebral cortical activity seen. Occasional higher amplitude slow component is seen with some superimposed faster rhythms; these might be artefactual/ at times related to muscle activity observed. There are no epileptiform abnormalities, and no electrographic seizures are recorded. These findings are in keeping with severe diffuse encephalopathy and in the clinical context most likely due to severe hypoxic brain injury although the ongoing sedation with the prematurity could be contributing to this depressed EEG." The following day he had a MRI scan which concluded: "Extensive diffusion restriction throughout both cerebral hemispheres (predominantly white matter but some cortex also), deep grey nuclei and brainstem is consistent with a severe, profound pattern of hypoxic-ischaemic injury."

14. On the same day a multidisciplinary team meeting took place on 13 August 2025 which included five neonatologists. The team reached a consensus that if the MRI supported the EEG results (the MRI was being carried out when the MDT met) Baby J is "likely to have

severe and global neurological impairment with a very poor quality of life if he does survive and the evidence is that he would be unlikely to have enough respiratory drive off the ventilator to support long term survival. The group supports a redirection towards comfort care."

15. Following these investigations and the MDT, Baby J was transferred back to his original hospital with a plan to be extubated (taken off mechanical ventilation) and for the withdrawal of intensive care. He was considered to be for: "Do Not Attempt Resuscitation" and "no cardiopulmonary resuscitation". The second respondent local authority who had obtained an interim care order in respect of Baby J, confirmed they would not consent to the extubation plan and it was agreed an application to court was needed. Dr G then sets out his evidence why Baby J should receive comfort care rather than intensive care and mechanical ventilation.

16. In his second witness statement, dated 21 August 2025, he remained of the view Baby J will, highly likely, stop breathing if mechanical ventilation is removed. The consultant involved in the MDT meeting at the other hospital, confirmed her views that:

> "Babies with significant neurological injury may show some improvement with time as cerebral oedema (swelling of the brain) resolves. This explains why Baby J now shows more breathing efforts and more movement than previously. However the degree of neurological impact on MRI and EEG would still result in significant and profound impairment in the longer term. There is a risk that by delaying extubation, his respiratory centre improves to the point that he survives indefinitely (with a poor quality of life and significant burden of suffering). For this reason, we would not support delaying redirection of care whilst waiting for improvement in maternal capacity to consent."

17. He then considered academic literature on the issue of whether Baby J's ability to breathe independently may improve if his extubation is delayed. He quotes some academic articles. He concludes it is not possible to quantify the likelihood of Baby J breathing independently if his mechanical ventilation is continued for another two weeks. He states: "It remains my view that it is in Baby J's best interests to withdraw intensive care including ventilation as soon as possible for the reasons set out in my previous statement. By this treatment continuing Baby J is subject to ongoing burdens and risks with no prospect of the treatment benefitting him."

18. His third witness statement is dated 26 August 2025. He confirms that he has been responsible for Baby J's overall care since 15 August and examined him on 25 and 26 August 2025. He remains ventilated and has been started on a low dose of Morphine in order to comfort him. This was begun because Baby J was showing movement and there was a concern he was uncomfortable. He has oral secretions for which he needs frequent

suctioning that is almost every two hours and during this procedure he "shows signs of discomfort by moving his limbs and trunk slightly." He is taking more breaths than he did on 22 August and Dr G is unable to be certain if he will be able to breathe independently for a prolonged period after being extubated.

19. Baby J tolerates preterm formula milk given by nasogastric tube. However feeds have been reduced as he shows signs of gastro-oesophageal reflux. He opens his bowels and passes urine normally. Neurologically he is becoming more awake and opens his eyes spontaneously. His pupils react to light and he has increased tone. The stiffness in his lower limbs is a symptom of the significant brain injury. "Baby J is able to feel pain and discomfort. He is showing that by, for example, moving his foot away on gentle squeeze of his heel and when having blood samples taken."

20. He did not think Baby J's overall prognosis had changed since 21 August 2025 albeit he was breathing a little more. He states: "…if Baby J is able to breathe and survive, it is still highly likely that he will survive with severe disabilities. He might not be able to see or hear, he might not be able to swallow or manage his secretions. He might be dependent on gastrostomy feeds for his nutrition. He might not be able to walk or talk…"

21. He continues: "My professional view remains that it is not in Baby J's best interests to continue his intubation and ventilation (intensive care). I do not think this is providing any benefit to him when at the same time it is exposing him to the burdens of intensive care. These burdens include discomfort of having a breathing tube in the windpipe, frequent blood tests that are needed to manage his ventilation and frequent suctioning (almost two hourly). He is also exposed to risks associated with ventilation such as pneumothorax (air leaks from the lungs to the chest cavity which might require draining if concerning enough) and infection. Having a long line in place also increases the risk of infection and extravasation (infusion fluids leaking to outside veins) injury."

22. His evidence has regard to the relevant Royal College Guidelines. He states:

> "I based my view in accordance with the Royal College of Paediatrics and Child Health (RCPCH) guidance document titled: *Making decisions to limit treatment in life-limiting and life threatening conditions in children: a framework for practice*. In my view, Baby J's condition might come under the following categories of the framework:
>
> a. Category 1C : "Inevitable death, where death is not immediately imminent but will follow and where prolongation of life by LST confers no overall benefit". My view is that Baby J's life is being prolonged unnecessarily by the intubation and ventilation

at the moment. If he is extubated it is highly likely that he will not survive more than days and weeks.

b. If he survives however, it is highly likely that he will survive with severe disabilities. In this situation, my opinion is that category 2C will apply. Category 2C: "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".

23. Dr G gave oral evidence. He was a measured and composed witness. He was very careful when answering questions. He said that as of last night, there have been no material changes in Baby J's condition. On 25 August 2025, the senior nurse on shift that night doubled Baby J's dose of morphine because she considered from observation and the charts he was in discomfort or pain. His oxygen saturation levels had gone down to 60, when previously they were normally at 95 and above. He had oral secretions. He was agitated at that point and for that reason his morphine was doubled. He has since settled.

24. Baby J has been agitated and in discomfort and this is caused by his breathing tube. He gave evidence that the clinical team can tell if baby J is in pain or discomfort, as he arches his body and moves his legs. One can see he is not "happy" and his oxygen levels drop. His evidence is that Baby J is obviously showing discomfort. With his maturity increasing, Baby J is reacting more to pain and discomfort. Dr G did not consider the fact Baby J's eyes opened demonstrated brain function but was simply a consequence of muscle growth. He said Baby J may never have sensory experiences. He needs one to two minutes of suctioning every two hours and this is a discomfort.

25. He said he had reviewed the second opinion report and agreed with it. His evidence was that ventilation remains futile and causes discomfort. He said there was no other means to provide the ventilatory support. He said the plastic tube in Baby J's windpipe causes discomfort, as his windpipe is soft and the tube is tough plastic. He gave evidence that Baby J will not recover and that clinicians cannot restore his health, rather they can only prolong life. It is highly likely the windpipe pain will increase as he matures and becomes bigger and he will continue to feel pain. There is a high likelihood that morphine will need to be increased.

26. He confirmed Baby J has suffered a catastrophic and irreversible injury and that very few babies with this type of injury will survive. Baby J was very likely to have an unsafe swallow and was at risk of aspiration and whilst milk can be provided by a nasogastric tube he would require a gastrostomy or a PEG to be fed. When asked if his open eyes meant progress in brain function, Dr G said this was not the case and this is because of gestational changes, not brain recovery.

Dr R

27. Dr R is at a separate Trust. He has provided a detailed second opinion. He spent the morning with Baby J and staff on 24 August 2025. Of particular significance, he says:

> "The severity and location of Baby J's brain injury — notably involving the basal ganglia, thalami, and brainstem — are associated with very poor prognosis. In studies of neonatal HIE with similar patterns, around 89% of infants suffer death or severe neurodevelopmental impairment, and one cohort showed 95% had a grave outcome or died. Among survivors of severe HIE, up to 80% develop major disabilities, with the remainder often facing cognitive, motor, and behavioural impairments. These findings indicate an extremely poor prognosis, with no realistic prospect of neurological recovery or awareness.
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> Since repatriation to [X], Baby J's condition has evolved. The acute brain swelling seen earlier has subsided, and he now demonstrates some weak spontaneous breathing above the ventilator. This means that if life-sustaining ventilation were withdrawn, he may continue to breathe for a variable period — ranging from hours to days — although sudden and early death remains possible. Importantly, any survival in this context would not be accompanied by awareness or quality of life, but would represent continued existence in a state of profound neurological injury."

28. He gives the following detailed prognosis:

> "**Short-term**: Baby J is capable of shallow spontaneous breathing, but this was observed with a breathing tube in situ, ensuring airway patency. On extubation, there is a significant risk that his airway will not remain protected. Given his profound hypotonia, absent gag reflex, and copious secretions, there is a high likelihood of airway obstruction (e.g. tongue falling back, pooling of secretions, or possible vocal cord palsy). This may result in apnoea and sudden death soon after withdrawal of ventilation.
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> **Medium-term**: If extubation is tolerated, survival could be variable in duration but would not represent neurological recovery. While some neuronal plasticity is theoretically possible in the developing brain, the extent and distribution of Baby J's injury — affecting both cerebral hemispheres, basal ganglia, thalami, and brainstem — mean that there is no realistic possibility of meaningful recovery. He would remain profoundly impaired and entirely dependent.
>
> **Long-term**: Survival would almost certainly be associated with profound neurological impairment, including severe spastic quadriplegic cerebral palsy, global developmental delay, epilepsy, and lifelong complete dependency. Any reflexive or brainstem-driven activity (e.g. gasping, hiccups, clonus) would not equate to awareness or purposeful interaction."

29. He gives the clear view that: "*Balancing these factors, it is my opinion that it is not in Baby J's best interests for intensive life-sustaining treatment to be continued.*" He also provides a conclusion that:

> "In my independent expert opinion, the medical evidence is consistent and overwhelming: Baby J has sustained a catastrophic hypoxic–ischaemic brain injury, leaving him with no realistic prospect of meaningful recovery. The continuation of invasive intensive care would serve only to prolong his suffering. The course most consistent with his best interests is withdrawal of intensive care and provision of palliative comfort-focused support at [X], in the presence of his family."

30. If Baby J were to survive the extubation, his evidence is that:

> "…his care should remain firmly on a palliative pathway, led by the neonatal and children's palliative care teams at [X]. This would allow him to remain close to his mother, who is herself critically unwell, and his wider family. Should he survive beyond the short term, care should transition to community paediatric palliative services and hospice support. If survival extends unexpectedly into months, referral to Child Development Services could be considered, though in view of the severity of his brain injury he would be expected to have profound, lifelong neurodisability, including severe cerebral palsy, epilepsy, intellectual impairment, and complete dependency."

31. Dr R was a clear and confident witness. He said Baby J has no facial expression and he was not sure if he was in pain, although he accepted Baby J might have been in pain on 25 August. He agreed that ventilation is futile. He gave evidence that this is an extreme case and that the injury is profound. He did not see any hope of recovery. He said Baby J has a tiny bit of brain function but it will not transfer into functional ability. Furthermore, he noted that two weeks on from MRI, Baby J's presentation has not recovered. He accepted it was likely that Baby J could not breathe independently and that continued treatment other than palliation was "unethical."

The Social Worker

32. A social worker has filed a helpful witness statement, dated 26 August 2025. There is some considerable background. She gives evidence that the mother has seven children (including Baby J). All but one are the subject of Family Court orders of different types (interim care orders, special guardianship orders). It was thought that the mother's current partner/friend was Baby J's father but DNA testing has confirmed he is not. Another man has been identified as a sexual partner of the mother. He has been contacted and the situation was explained to him. He has declined on two occasions to engage in paternity testing. The evidence is that Baby J's father is currently unknown.

33. Importantly, her witness statement sets out conversations that have taken place between family members and a social worker (who is not the author of the witness statement). These views are important and I set them out in full with relevant anonymisation:

> *Baby J's maternal grandmother ("MGM"): she explained that she was aware of the situation with Baby J. I reminded her that what was new was that when he had the respirator removed, he was breathing by himself more. MGM said that she thinks that Baby J needs "closure" and that her view is that the breathing machine is turned off. I confirmed that this would likely lead to him dying and although MGM was visibly upset she confirmed that this would be the best for him as he needs closure.*
> *Maternal Step Grandfather (MSG) - I spoke to MSG who confirmed that he understood what I had told him about Baby J's current position and the court hearings. He is aware that I am taking his view to the court and he said "it has to end for him", MSG was crying but confirmed that this meant he wanted the machine turned off feeling that this would be the best for Baby J as he would have no quality of life. MSG noted that he feels Baby J has not really started his life as his brain has not been working since he was born.*
> *The Maternal Great Grandfather (MGG) - I spoke to MGG. I made MGG aware of the current situation and checked out that he understood what I was saying. MGG said it would be "disaster to let him go on" and that it would be a "shame to carry on". I confirmed that he was saying that the machine is currently breathing for Baby J should be turned off and he nodded and then said yes.*

34. The social worker's evidence is that the mother's partner/friend was contacted on 22 August 2025. He continues to visit Baby J in hospital daily, despite no longer receiving medical updates, as he is not Baby J's biological father. The mother's partner expressed that although Baby J may not be his biological son, he has developed a strong bond and attachment to him and intends to continue seeing him regularly. The mother's partner stated that if Baby J's condition remains unchanged from the initial scans and concerns, he would sadly wish to "lay Baby J to rest." He explained that if Baby J has no future or quality of life, he believes this would be the right decision for him. Although these conversations have not been held directly with the mother, the mother's partner shared his belief that if Baby J were, for example, blind, the mother could manage this. However, if she were fully aware of the severity of Baby J's condition, he is "pretty sure she wouldn't want Baby J to be here in pain and discomfort." He added that he believes both he and the mother would agree that if there is no quality of life, then "we would need to let him go."

The Guardian

35. The Guardian has not filed a report, as was agreed at the last hearing, but her position is set out in her counsel's position statement. Relevant parts of her enquiries state as follows:

> "On 26 August the Guardian spoke to nursing staff who told her that they continued to care for Baby J and that he had been receiving cuddles from both staff and his mother's partner. There has been no response in Baby J to such contact and change in his condition.
>
> On 27 August the Guardian visited Baby J in hospital and spoke with Dr G and with nursing staff. Guardian observed Baby J and was also told that:
>
> - Baby J is breathing, but not sufficiently to breathe independently;
> - if he were to survive following the withdrawal of breathing assistance, in future he would require an operation to assist with his breathing i.e., a tracheostomy, which would be invasive;
> - Baby J is trying to briefly open his eyes more, but is not tracking light or objects;
> - when held, he gives no response and remains floppy;
> - he has been observed to make some movements but these are not purposeful;
> - the Guardian understands that life moving forwards would mean that Baby J would have to be cared for 24 hours a day, seven days a week. He is likely to require further operations, for example on his spine, to enable him to sit straight enough to enable him to use a wheelchair. This would be a complex operation involving the insertion of metal rods into the spine.
>   Such an operation carries a high risk of infection;
> - Baby J would require injections into his muscles and tendons as these would seize up;
> - as a result of his breathing difficulties Baby J would be vulnerable to significant respiratory infections;
> - without the purposeful use of his limbs, Baby J would effectively be quadriplegic;
> - Baby J is struggling with the regular suctioning procedures which are needed to clear his airways of secretions and mucous: his movements indicate that these procedures cause him pain and discomfort, and this is why morphine has been reintroduced;
> - Baby J may never have the use of all of his senses and even if he has the use of some senses, these are unlikely to improve his quality of life, so profound is the damage to his brain. But for this, Baby J might have had some quality of life;
> - Baby J is being moved every three hours.

36. Helpfully, the Guardian has also spoken with the maternal grandmother, who told her that having spoken with the team who care for Baby J, he has only got a "tiny little section" of his brain working. The grandmother reported to the Guardian:

> "*I know for a fact if* [the mother] *had the right state of mind, she would not want him to have this life. We have both done support work, she was a care*

> *coordinator, and she knows her stuff. They were both support workers for adults with additional needs and are aware of implications for Baby J's life. It is not fair for Baby J.*"

The Law

37. The law in the area of serious medical treatment for children is clear and settled and I rely on the summary of the law set out in Mr Hallin's helpful skeleton argument. Where a parent is not willing to exercise parental responsibility to sanction the medical treatment (or its withdrawal), the court has the ultimate power to require treatment to be given, in accordance with a 'best interests' test. In considering such an application the Court must weigh up the advantages and disadvantages of providing or withholding the various treatment options within that plan, and to balance them in order to determine where the child's best interests lie (*Re J (a minor) (wardship: medical treatment)* [1991] 2 WLR 140; 3 All ER 930; [1990] 2 Med LR
67).

38. The court's approach to the child's best interests will necessarily be highly factspecific and the courts have been slow to set definitive guidance on how to approach the 'best interests' test in this context. For example, in *NHS Trust v MB* [2006] .EWHC. 507 Holman J said at paragraphs 106-107:

> "...this is a very fact specific decision taken in the actual circumstances as they are for this child and today... My sole and intense focus has been this child alone".

39. Macdonald J has provided a helpful summary of the legal principles in *Manchester University NHS Foundation Trust v Fixsler & Ors* [2021] .EWHC. 1426 (Fam):

> "56 The court may grant a declaration declaring that treatment in accordance with the recommendation of the child's doctors can take place, on the grounds that it is in the child's best interests (see *In re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421). The jurisdiction of the court to make such an order arises where a child lacks the capacity to make the decision for him or herself, in the context of a disagreement between those with parental responsibility for the child and those treating the child (*An NHS Trust v MB (A Child Represented by CAFCASS as Guardian Ad Litem)* [2006] .EWHC. 507 (Fam); [2006] 2 FLR 319). The court has no power to require doctors to carry out a medical procedure against their own professional judgment.
>
> 57. As I have observed in previous cases, the legal framework that the court must apply in cases concerning the provision of medical treatment to children who are not "Gillick" competent is well settled. 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 (Official Solicitor intervening)* [2005] .EWCA. 1003; [2006] QB 273 , *An NHS Trust v MB*, *Portsmouth Hospitals NHS Trust v Wyatt* [2005] .EWCA. Civ 1181; [2005] 1 WLR 3995 , *Kirklees Council v RE* [2014] .EWHC. 3182 (Fam); [2015] 1 FLR 1316 and *In re Gard (A Child) (Child on Life Support: Withdrawal of Treatment)* [2017] .EWCA. Civ 410; [2018] 4 WLR 5 :

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 judgment. 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 in a particular case with a view to determining where the final balance lies. Within this context *16 the wise words of Hedley J in *Portsmouth NHS Trust v Wyatt (Southampton NHS Trust intervening)* [2004] .EWHC. 2247 (Fam); [2005] 1 FLR 21 at [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 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 should 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 *In re A (A Child)* [2016] .EWCA. Civ 759; [2016] Med LR 427 at [34] , 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 light of the child's age and understanding."

40. These principles have been reiterated at appellate level. In *In re A (A Child)* [2016] .EWCA. Civ 759; [2016] Med LR 427 the Court of Appeal confirmed once again that, whilst requiring great sensitivity and care of the highest order, the task of the court in cases concerning disputes in respect of the medical treatment of children can be summed up by reference to two paragraphs from the speech of Baroness Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] AC 591 at para 22 , namely:

> "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."

And at para 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."

41. In the case of *Gard*, McFarlane LJ (as he then was) reiterated, at para 112 that:

> "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."

42. Whilst Article 2 of the ECHR is plainly engaged where life and death medical decisions are in question, there is no obligation to provide treatment that is assessed as being futile. In *An NHS Trust A v Mrs M and An NHS Trust B v Mrs H* [2001] 1 All ER 801, it was held by Dame Elizabeth Butler-Sloss, then President of the Family Division, that:
"Article 2… imposes a positive obligation to give life-sustaining treatment in circumstances where, according to responsible medical opinion, such treatment is in the best interests of the patient but does not impose an absolute obligation to treat if such treatment would be futile."

The Parties' Positions

43. The Trust submitted the evidence demonstrates that Baby J would be likely to die if the mechanical ventilation is removed, although this was not certain. The continued mechanical ventilation was futile, as there was no prospect of any recovery from the brain injury. The continued mechanical ventilation was burdensome because of its invasive nature and because it caused pain and discomfort which would increase as Baby J matures. He feels pain

and discomfort. He is at significant risk of having no sensory awareness, being blind, deaf and possibly unaware of even the comfort of a cuddle. He finds it painful to receive suctioning which happens frequently, and being handled and receiving blood tests are painful. He will be very profoundly disabled all his life. The burdens far outweigh the benefits. This is the unanimous view of the treating neonatal team. It is the view of the independent second opinion doctor, Dr R. No family member or friend of Baby J or the mother supports continued treatment. Mr Hallin's position statement concludes:

> "The Court will recall the applicant Trust's position has been (and remains) that long term invasive ventilation is not an option that the applicant is offering in this case, as such treatment would be futile, is not clinically indicated and would in the circumstances be considered unethical. There is now unequivocal and overwhelming evidence from the treating team and the second opinion doctor that it is in Baby J's best interests to be extubated as soon as is practicable, in a planned way, and to receive palliative care..."

44. The local authority neither consents to, nor opposes, the relief sought. It's helpful position statement states:

> "There is a strong presumption in favour of trying to preserve life. Yet the medical evidence seems to all point in one direction. Brain function for this child now and in the future is exceedingly limited. We are told that maintaining ventilation is futile. We are told that Baby J is starting to feel pain, and the Local Authority was asked to agree to an increase in morphine. This is an incredibly unhappy and sad case. The Local Authority has debated at all levels what is best for this baby. The Local Authority does not want suffering for Baby J, we are being told that whatever happens this boy's life is the bleakest."

45. The Official Solicitor on behalf of the mother is also neutral on the application and is not able to either consent to or oppose the relief sought. The Official Solicitor accepts

Dr N's evidence that the mother lacks capacity to make a decision how to treat Baby J. It is also accepted there is unlikely to be sufficient improvement in the mother's functioning. The Official Solicitor recognised there could not be a further adjournment to permit more time for the mother's functioning to improve. The Official Solicitor accepted that the mother's views could never be determinative of the application for relief for Baby J. Her solicitor visited her to elicit views on 27 August 2025. Her wishes and feelings remain unclear. I am reminded the evidence is that the mother wanted a baby and did not intend to cause Baby J intentional injury or harm. Mr Howard's helpful position statement observes the neutrality of the Official Solicitor's position but he submits as follows:

"[T]he touchstones for the Official Solicitor in this difficult decision for the court are:

a. Dr R's 2nd opinion that "In my independent expert opinion, the medical evidence is consistent and overwhelming: Baby J has sustained a catastrophic hypoxic–ischaemic brain injury, leaving him with no realistic prospect of meaningful recovery. The continuation of invasive intensive care would serve only to prolong his suffering. The course most consistent with his best interests is withdrawal of intensive care and provision of palliative comfortfocused support ..."

b. The neurological examinations on 24 August 2025: "Baby J was unresponsive, with eyes closed and no reaction to voice or pain. He was profoundly hypotonic, lying in a frog-like posture. Deep tendon reflexes were absent, with only distinct ankle clonus on stimulation. Palmar grasp was absent and plantar grasp weak on the right only. He showed no facial movements, no gag or rooting reflex, and no protective responses to suction despite copious secretions. Pupils were small and equal; there was no visual fixation or auditory response. Spontaneous activity was limited to reflex withdrawal and abnormal posturing, with occasional lip-smacking, ET tube sucking, hiccups, and clonus. No seizures were observed."

c. That doctor's opinion, based on the neurological examinations he has undertaken, of the severity and location of Baby J's brain injury, involving the basal ganglia and brainstem, being associated with very poor prognosis; of there being no realistic possibility of meaningful neurological recovery; and the burdens on Baby J of the interventions that would be necessary to sustain his life, particularly in the context of the opinion that, "Importantly, any survival in this context would not be accompanied by awareness or quality of life, but would represent continued existence in a state of profound neurological injury."

d. That 2nd opinion being consistent with the opinion of Dr G (a member of the treating clinical team), who opines that "if Baby J is able to breathe and survive, it is still highly likely that he will survive with severe disabilities. He might not be able to see or hear, he might not be able to swallow or manage his secretions. He might be dependent on gastrostomy feeds for his nutrition. He might not be able to walk or talk, in which case he will be wheelchair dependent. He might have some combination of these disabilities in any combination or all of them."

e. The list of burdens of ongoing treatment set out by Dr G.

f. The opinion of Dr G when considering the relevant RCPCH guidance that Baby J might come under Category 1C or if he survives Category 2C.

g. Importantly, in the context of that medical evidence, the views of all family members who have been asked by professionals: all say that Baby J should be relieved of his suffering and his treatment ended."

46. The Guardian's position statement filed on the evening before the hearing began sought an adjournment. It was submitted that:

> "At the same time, given the exceptional nature of this case, the Guardian is concerned that a fundamental and potentially irreversible decision is about to be made about Baby J in very short order: a week. The Guardian has quite properly sought advice from both her CAFCASS service manager and the Service Manager at the High Court CAFCASS Team. Having done so, she is clear that the usual procedure in cases such as these is for a full welfare analysis, including a balancing exercise in favour and against the course proposed by the applicant, including the proposal for what should happen if Baby J were to survive for longer than hours or days. The Guardian has conscientiously carried out some work already, but given the complex nature of the evidence, the Guardian asks for more time to reflect on the evidence, and the literature provided by the medical witnesses: the article relied on by Dr G was not provided (although obtained via counsel) and what appears to be a lengthy set of articles were served this afternoon. The Guardian has simply not had any time to consider these and her view is that all relevant information should be considered by her in order to provide a balanced analysis and ultimately, to assist the Court."

47. On the morning of the hearing Ms Johnson made clear the Guardian no longer sought an adjournment. Her final submission was neither to consent to, nor oppose the relief sought by the Trust.

Analysis

48. As matters have progressed from the hearing on 22 August 2025 to the conclusion of the hearing on 28 August 2025, no party submits that a further adjournment is necessary and no party now seeks to oppose the relief sought by the Trust. I am entirely clear there could be no further delay in decision making for Baby J. What has befallen Baby J and his mother is a tragedy. Whilst it has been necessary to briefly delay decision making for Baby J to permit assessment of his mother's capacity to decide on her son's medical treatment, that could only ever be for a short period. As has been made clear in the case law, the views of parents fall to be considered within the analysis of what is in the child's best interest but they are not determinative.

49. I do not know what Baby J's mother's views are in respect of whether he should continue to receive mechanical ventilation. I have read with interest the helpful evidence gathered from the mother's family and partner/friend. I need not determine whether what they say is correct about her views. Irrespective of what she may previously have said, she may have had a different view when holding Baby J in her arms. I proceed to determine the best interests analysis not knowing what her views are. There is no violation of her Article 8 ECHR right

to respect for family life in circumstances where the court must determine her son's welfare best interests urgently.

50. I am satisfied that the evidence demonstrates the wider family agree with the position taken by the applicant Trust. Rightly they do not want Baby J to suffer.

51. Baby J is only twenty days old. He is a tiny, vulnerable baby. He has met his mother only very briefly. He has not met his father. He has not been with his siblings. He has spent some time with his wider family and his mother's partner/friend. He has received some cuddles from them and from the nurses. He has been fed by nasogastric tube. His life has been short. His life has been limited by his profound disabilities. Despite this, my starting point is to weigh heavily in the best interests balance his precious life, however short and however limited. I unhesitatingly agree with Baker J (as he then was) that: "*The principle of the right to life can be simply stated but of the most profound importance. It needs no further elucidation. It carries very great weight in any balancing exercise.*'[1]

52. Baby J's life has been one lived in a noisy and disruptive neonatal intensive care ward. He has been taken between hospitals for necessary examinations and tests. He has an unpleasant nasogastric tube in his nose. He has a painful plastic tube in his delicate, soft chest. It is not clear whether he can see or hear. His awareness is at a very low level.

53. I am satisfied he feels pain and is regularly in pain or discomfort. I accept Dr G's careful evidence that his little body arches in pain. That he feels pain when he receives blood tests. He feels discomfort when handled. That when he is gently pinched he feels it and tries to move his leg away. I conclude he finds the one to two minutes of suctioning every two hours a discomfort. I accept Dr G's evidence that as his body matures, his pain will increase. I accept his morphine doses have had to be doubled already, and he is only twenty days old. Dr G is the treating clinician and observes him regularly. Dr R saw him only once and was mostly guided by Baby J's facial expression. I also note the evidence of the neonatal nurses' distress in respect of the burdens on Baby J of continuing to be ventilated and treated in intensive care. They are highly experienced and they are upset and questioning because they sense and feel Baby J's distress.

54. I therefore accept the Trust's evidence that continued mechanical ventilation is a burden to Baby J.

55. I am also satisfied that the clear evidence from the MRI and EEG combined with the observations over the last twenty days and as interpreted by the two clinical witnesses, points to the fact Baby J will make no improvement in his brain function. His Hypoxic-Ischaemic Encephalopathy (HIE grade 3) has left him with profound disability from which he will not

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[1] W v M [2011] .EWHC. 2443 (Fam) at paragraph 220.

recover. No clinicians gave evidence that there were doubt about this or that further tests or examinations were being necessary before a prognosis could be reached.

56. Whilst the mechanical ventilation is not entirely futile, because it maintains Baby J's life, it is futile as a treatment as Baby J's brain injury cannot improve. The small changes such as opening his eyes, do not represent evidence of improving brain function. They are simply a sign of gestational development. As Dr R put it in oral evidence, Baby J is gaining weight but he cannot gain strength.

57. The evidence before me, is that there is a high risk he will be blind and deaf and possibly without any sensory awareness. He will be physically profoundly disabled and would need extensive and painful operations. He will most likely have an unsafe swallow and would receive nutrition and hydration by artificial means.

58. Given the unchallenged evidence and the prognosis that follows, mechanical ventilation traps Baby J in a life without stimulation or pleasure whilst permitting him to languish in pain and discomfort without the means by which loved ones may comfort him. This is a life devoid of quality. I agree with the Trust the treatment is futile and burdensome. I understand why the doctors say the point has been reached that continued mechanical ventilation is unethical.

59. I have tried hard to apply *Aintree* to Baby J's situation. I have tried to "put [myself] in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be." That is an almost impossible task. There are no loved ones who have known Baby J and who can tell me about him. Seeking out his best interests in the widest sense and going beyond the medical is difficult. Unquestionably and uncontroversially life with disability is dignified. The question for the court is not whether Baby J's life with disability is of value; the question is whether the continued ventilation is or is not in his best interests. The determination of the underlying intensely child specific facts must be checked against the key tests of burdensomeness and futility. This plainly leads to the conclusion that continuing to subject Baby J to his current regime is wholly contrary to his best interests. I reach this conclusion, accepting the evidence that the withdrawal of mechanical ventilation is likely to lead to his death. This outcome is not, as explained above, a violation of Baby J's Article 2 ECHR rights.

60. Mechanical ventilation is futile as it will not improve his catastrophic brain injury which leaves him devoid of meaningful human functions. Mechanical ventilation is burdensome as the ventilator, NG tube, suctioning, blood tests and the whole apparatus of intensive care visit upon him regular pain and discomfort. I can detect little if any evidence of pleasure, positives, benefits other than continuation of life itself. Whilst I value that highly, taking all the factors in account as widely as I am able and looking at the matter as best I can from Baby J's perspectives, mechanical ventilation is not in his best interests.

61. If there was any doubt in my mind, Dr G's evidence that the Royal College Guidance at Category 1C likely applies to Baby J's situation, and if not then category 2C applies provides the wider comfort that what is being proposed is entirely consistent with clinical good practice to treat seriously ill babies. This Guidance comes with a foreword from the then President of the Royal College of Paediatrics and Child Health, Hilary Cass. It has been applied by clinicians for ten years and frequently referenced by this court.

For all these reasons the declaration sought by the applicant Trust must be granted. Continued mechanical ventilation and intensive care is no longer in Baby J's best interests. As a result it is no longer lawful for clinicians to provide him with this medical treatment. Baby J will be extubated on Friday 29 August 2025. Plans are being made for this to happen in a caring and loving way.