Califronia Lawyers' Association and the Inner Temple

Model Moot Court

In the Matter of

Thomas Thaddeus Simmons

(A Child)

COURT BUNDLE

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A. Introduction

CALIFORNIA LAWYERS ASSOCIATION AND INNER TEMPLE

London, October 2022

MOOT BACKROUND

1. In 2005, Jennie Smyth met Roger Simmons in London while each was studying at the London School of Economics. In 2006, Jennie became pregnant. She and Roger separated and Jennie returned to her hometown, Newport Beach, California and gave birth to their son on October 17, 2006. She named him Thomas Thaddeus "Thad" Simmons. She listed Roger as the father of Thad.
2. In 2007, Roger retained counsel in California, and filed a Petition to Determine Parental Relationship. In the resulting Judgment which followed, Jennie and Roger agreed to share joint legal and physical custody and Thad would live with Jennie in California during the school year and spent every holiday and the entire summer with Roger.
3. In 2017, when Thad was 11, he started using illegal drugs, including speed and cocaine, as a result of developing an addiction to Adderall, taken for his ADHD condition.
4. Jennie contacted Roger for assistance and they agreed that Thad would move to London to attend a private school and visit Jennie every holiday and the entire summer. Roger assured Jennie that he would closely monitor Thad and ensure that there was no drug use.
5. The parties modified the California Judgment to include this new parenting schedule and agreed that Roger would register the Judgment with the Family Division of the High Court in London to allow Roger to enroll Thad in school. Jennie also agreed to cooperate with Roger to allow him to apply for dual citizenship for Thad and he became a UK citizen and was issued with a UK passport.
6. When Thad was 15, he returned to California for six weeks as his grandmother had a stroke and was hospitalized. Thad and Jennie visited her most days. She was ventilated and was doing very poorly. Jennie and Thad had many conversations by the bedside about Thad's grandmother's dignity and treatment. Jennie was unclear what should happen as she was worried her mother was frail and would not want to be treated by so many strangers. Jennie recalls Thad told her he thought his grandmother would want to fight for every day of life; that she was a fighter and not a quitter. Jennie says Thad told her every day of life was precious and he was realizing that now as he was getting older. Thad was

fascinated and full of respect for the doctors that treated his grandmother and made her better. Jennie says Thad wrote to the lead clinician after his grandmother recovered and was discharged telling him he was an angel and modern medicine was an extraordinary thing for saving his grandmother.

7. On his return to London, Thad continued to abuse drugs and while celebrating his 16th birthday with friends, he mixed Adderall with a cocktail of drugs that included Fentanyl and alcohol. Thad's friends dumped him at the front door of the London flat he shared with his father and when Roger returned home, he found Thad un-responsive.
8. An ambulance was called and Thad was found to be in cardiac arrest. They administered Narcan, initially with no success. Thad was not breathing. At first, they could not find that he had any pulse, but soon a pulse was located. However, Thad did not regain consciousness. He was admitted to the ICU ward at Royal London Hospital, where he remained, never regaining consciousness. A consultant intensivist had assessed Thad on the evening of his admission and then at length the following day. The intensivist concluded that Thad had suffered both: (i) pulmonary aspiration by inhalation of vomit into the lungs directly blocks the flow of oxygen; and (ii) asphyxiation by overdose of a drug (likely to be heroin) which caused Thad's respiration to drop to a level where life could no longer be sustained. Respiratory depression (hypoventilation) became respiratory arrest (the complete termination of breathing) and the intensivist team was clear Thad had suffered a devasting brain injury from which he unlikely ever to recover.
9. Roger contacted Jennie, who immediately flew to London to be with Thad. Jennie was furious that Roger had allowed Thad to continue to use drugs and hang out with the "drug crowd" at the prestigious school he was attending. Jennie had agreed to share the cost of the school with Roger because she believed that Thad would be safer than in his public school in California.
10. Roger and Jennie met with Thad's team of doctors who took the view a period of intensive observation was necessary. Jennie took the decision to remain in London and Thad's parents visited him daily.
11. After six months of observations and tests, the multi-disciplinary team concluded that Thad was brain dead, and he has remained at the hospital in a persistent vegetative state. The lead paediatric neurologist diagnosed Thad was suffering from a severe generalised hypoxic ischaemic brain injury affecting the entire brain. She was clear there was no detectable responses from Thad and that he was unresponsive with absent pupillary, cough, gag, corneal and ocular-vestibular reflexes.
12. Thad was being kept alive by a ventilator and fed via a feeding tube. The doctors asked Roger and Jennie whether they wanted Thad kept alive in this manner, or

whether they should discontinue life-saving modalities. It was their opinion that Thad could not survive without a ventilator.

13. The multi-disciplinary team were less unclear whether Thad experienced pain. Some clinicians felt there were indicators of pain when Thad was being suctioned to clear secretions. Other doctors took the view that his brain injury was so severe that he had no capacity to feel any pain.
14. Jennie was adamant that no matter how long it took, she wanted Thad to be kept on the ventilator in the hope that he would someday "wake up." Roger initially supported that notion, but upon staying by Thad's bedside for five consecutive days and nights, he came to the conclusion that Thad would never want to live in the manner in which he presently existed with no real hope of coming out of his coma.
15. The National Health Service in the form of the Trust responsible for the Royal London Hospital evaluated the situation. Thad's treatment was costing upwards of £35,000 per day. It filed an application to the Family Division of the High Court in London seeking directions and declarations as to whether continued treatment was or was not in Thad's best interests. The Trust's position was that continued medical treatment by way of artificial hydration and nutrition and mechanical ventilation were no longer in Thad's best interests and he should be offered palliative treatment.
16. The High Court of England and Wales had to consider two principal questions: (1) whether or not Thad was habitually resident in England and Wales in order for the court to exercise jurisdiction; and (2) whether it was in Thad's best interests to continue life sustaining treatment.
17. Jennie and Roger were separately served and each retained counsel to respond to the application. In the High Court, evidence was taken, particularly focusing on Jennie and Roger's divergent views on the subject. After taking the matter under submission, the High Court issued a Judgment in which Mr Justice Smith concluded:
    a. Thad was habitually resident in England and Wales and the English courts had jurisdiction to makes decisions in respect of his medical treatment.
    b. The judge concluded on the facts it was not clear whether Thad felt pain.
    c. The judge determined that it was not in Thad's best interests to continue to receive medical treatment by way of artificial hydration and nutrition or mechanical ventilation and it was in his best interests to be palliated.
18. Jennie's counsel immediately appealed, and a stay of the order of the High Court was granted. The matter is now before the Court of Appeal for decision. Three judges will hear oral argument. Roger will be represented by barristers from the Bar of England and Wales: John McKendrick KC of Outer Temple and Edward Devereux KC of Harcourt Chambers. Jennie will be represented by California attorneys, Jeremy Dzubay of Monterey and Alex Orlofsky of San Francisco, who

have been determined to be entitled to temporary rights of audience before the courts of England Wales.[1]

19. Jennie's counsel has filed a separate application with the High Court, citing Thad's American citizenship and requesting that the High Court permit Jennie to arrange to transport Thad back to California where he can be maintained on life support in a hospital that has agreed to do so. Jennie argues that Thad is not brain dead, but instead he is severely disabled as a result of his drug overdose and subsequent cardiac arrest.
20. Jennie's legal team's grounds of appeals are that Smith J's orders and declarations are wrong because the learned judge below erred as follows:
    a. By determining that Thad is habitually resident in England and Wales, and erred by failing to conclude Thad had not lost his US habitual residence and therefore the US courts only have jurisdiction to determine his medical treatment (and the outcome under California law would be materially different).
    b. By failing to determine whether or not Thad was in pain and by failing to determine this issue, the judge failed to resolve a necessary and highly material factors in the best interests analysis either under the Children Act 1989.
    c. Failed to carry out a detailed best interests analysis, failed to give proper regard to the sanctity of life and failed to properly consider Thad's dignity.
21. The appeal court constitution will be presided over by the Honourable Mrs Justice Arbuthnot.

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[1] You should assume the NHS Trust is also a party but plays no part in the moot.

B. England and Wales Authorities

Neutral Citation Number: [2020] EWCA Civ 1105

Case No: B4/2020/0592

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
FAMILY DIVISION
HHJ WALLWORK
FD19P00499

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/08/2020

Before:

LORD JUSTICE MOYLAN
LADY JUSTICE SIMLER
and
SIR STEPHEN RICHARDS

- -

M (Children) (Habitual Residence: 1980 Hague Child Abduction Convention)

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Mr J Turner QC and Miss K Chokowry (instructed by **The International Family Law Group LLP**) for the **Appellant mother**
Mr H Setright QC and Mr M Gration (instructed by **Sills and Betteridge LLP**) for the **Respondent Father**

Hearing date: 16th June 2020

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Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 10:30am 25th August 2020.

Lord Justice Moylan:

1. The mother appeals from a return order made under the 1980 Hague Child Convention ("the 1980 Convention") on 21 February 2020 by His Honour Judge Wallwork, sitting as a Deputy High Court Judge. She contends, principally, that the judge was: (a) wrong to decide that the children were habitually resident in Germany at the date of their wrongful retention by the mother in England at the end of July 2019 and should have decided that they were habitually resident in England at that date; and (b) wrong to decide that the mother had not established the exception under Article 13(b).

Background

2. In this section, quotations are from HHJ Wallwork's judgment.

3. The children who are the subject of the application are aged 6 and 8. They and their parents were all born in Germany. One of the children (who, for the purposes of anonymisation, I will call T) has significant additional care requirements. The parents married in 2014 and separated in 2017. The father has always lived and continues to live in Germany. For ease of reference I will call the place in which he lives, Stadt. The mother and the children remained living in Germany until July 2018 when they moved to live in England. The judge described the mother as having been the children's "primary carer throughout their lives".

4. In July 2018 the mother wanted to move with the children to England and sought the father's agreement to this. This was "envisaged to be for 12 months or so". The mother "was in a serious relationship and … intended to live, together with [the children], at the home of her then boyfriend". The mother had obtained a contract "to work on a particular project" in the same town where her partner lived. They have since married and have a child born in 2020.

5. The parents mediated and signed a "letter of intent". It was agreed that the children would come to live in England with the mother and her partner. It was also agreed that they would stay in England "until approximately 2019" and that, in December 2018, the parents would "evaluate the situation regarding the rotation between [the mother's home] and [the father's home] and will adjust the current situation and implement improvements". The children were to spend "nearly equal" time with each parent. In addition, the letter said, baldly, that the "children's home will remain in [Stadt]".

6. The children began attending school in England in September and, as set out in the judgment below, "settled quickly". They had "previously stayed there on holiday and loved" the local environment. T received additional support at school. The children were also registered at a local GP practice and the mother ensured that T's medical needs were met through a local paediatrician and other medical services as required.

7. The parents did not agree about the amount of time the children spent with the father in Germany after they moved here in July 2018. The father produced a table which suggested that, over a 12 month period (I assume from July 2018) they had spent 111 days with him in Germany. The mother produced a table which suggested that, over the same period, they had spent 96/97 days with the father. The judge was not in a

position to resolve this difference but, in either event, it is clear that the children were predominantly living in England between July 2018 and July 2019.

8. In December 2018 the parents, as had been agreed, reviewed the situation through mediation. The judge records that they disagreed what precisely had been agreed but "the main thrust" was that the children would return to Germany with the mother at "some point in the summer" of 2019. The judge rejected the father's case that the mother had been disingenuous at that time and had not intended to abide by this agreement. He was not persuaded that the mother "had been acting in bad faith".

9. In July 2019, the mother found out that she was pregnant. This led her to "consider the arrangements that the parents had made" and to decide that she would not return to Germany. She sent an email to the father saying that "she intended to remain with the [children] in England".

Judgment

10. The judge found that the mother had retained the children, in breach of the agreement between the parents, at the end of July 2019. The father had contended, alternatively, that the wrongful retention had occurred in September 2018 but this was rejected by the judge.

11. The principal issues the judge had to decide were: (i) where were the children habitually resident at the end of July 2019, for the purposes of determining whether their retention was or was not wrongful; and (ii) had the mother established the Article 13(b) exception. He decided that the children had not "lost" their habitual residence in Germany by July 2019 so remained habitually resident there. He also decided that it would not be intolerable for the children to return to Germany. Accordingly, he made an order that the children should be returned to Germany on a date in April 2020.

12. On the issue of habitual residence, the judge correctly identified the, non-contentious, starting point that before the children came to England in July 2018 they were habitually resident in Germany. The judge also referred to the fact that they had always lived in Germany and that members of their extended family were in Germany.

13. The judge's focus, in that part of his judgment in which he dealt with the issue of habitual residence, was significantly on the children's continuing connections with Germany. This was because, as referred to below, he considered that the question he had to answer, when determining where the children were habitually resident, was "have they lost their German habitual residence". He identified that they "were spending regular periods of time in Germany with" the father and went through the dates on which they were in Germany. They had attended kindergarten in Germany for "part of the time they were there". This was part of the "overall network" which included staying with their paternal grandparents and which "one has to consider when considering the position of the children and the extent to which they may or may not be integrated in a particular society".

14. The judge referred to parental intention as being "relevant … but not determinative". In that respect, he noted, and clearly placed significant weight on, the fact that the

mother had still been intending to return to Germany until she changed her mind in July 2019.

15. There is a key section in the judgment which, in my view, shows the approach taken by the judge when determining the issue of habitual residence. It starts with the following paragraphs:

> "[39] The degree of connection which a child has with a particular environment is clearly something that has to be weighed. In relation to that, in para.viii of the summary, [in *Re B (A Child: Custody Rights, Habitual Residence)* [2016] EWHC 2174 (Fam) and [2016] 4 WLR 156] Hayden J records:
>
> > 'In assessing whether a child has lost a pre-existing habitual residence and gained a new one, the court must weigh up the degree of connection which the child had with the state in which he resided before the move.'
>
> [40] In relation to that matter - and I will come to Lord Wilson's very visual and vivid description of the see-saw - there cannot be two habitual residences. If habitual residence is gained in one location, it will be lost in another, and the question in this particular case, which is of considerable relevance - and it is perhaps unusual and not something that one sees in many cases - is that it is undoubtedly the case that the children were developing relationships in this country, they were learning the language, they were having a life here, but had those factors displaced the fact that they had the connection with Germany, the relationship with their family there, the life that they had in that jurisdiction, and so on?
>
> [41] What one sometimes sees is there is a complete severance of the relationship that a child has in one location and an adoption of a completely new life. To take a rather extreme example: if a child is removed, for example, from here to Australia, then there is rarely the opportunity to keep alive the life that one had at such a distance. In this case, what we have is a situation where the children have one life, the life that they had always had in Germany, and a new life which is developing elsewhere, and the difficult task for this court is to evaluate whether they had lost that connection with Germany as they gained the position in the United Kingdom, and as I say, if it is a question of intention, the application before this court came hard on the heels of the email from the mother in which she said at that point that she did not intend to abide by the original agreement. In short, until the end of July – if I accept the mother's evidence - it was the position that she was adhering to the agreement but that at the end of July, that position had changed."

16. The judge then again referred to the fact that, until July 2019, the parents' intention had been that the children would return to Germany. Adding that, "in any event … they had spent time in Germany … so their links in Germany were still being kept alive" and were still "very much ongoing".

17. The judge continued his assessment of habitual residence in the following paragraphs:

> "[43] The degree of connection, as I have indicated, is another matter for the court to consider, but the degree of connection with Germany was ongoing and whilst the shared arrangement between the parents - one speaks of qualitative and quantitative differences - the quantity is not as significant as the quality, and if there was a good quality time spent with their father in Germany then *the question of whether they had lost their habitual residence with the father arises*. It is the stability of a child's residence, as opposed to its permanence, which is relevant, and as I have just said, it is qualitative, not quantitative, in the sense that it is the integration of the child into the environment rather than a mere measurement of the time the child spends there.
>
> [44] It is said that the relevant question is whether a child has achieved some degree of integration in social and family life. It is not necessary for the child to be fully integrated before becoming habitually resident. This has been a particularly difficult case for this court to determine. There is little doubt that the boys have clearly developed a new aspect to their life, that they seem to have become very popular in their school, and I accept what I have read in the mother's statement that they were popular within the school, they were having sleepovers. She feels that [T] was accepted in the school, which was one that is particularly suited to his needs, and which had not been the case previously, and that the boys were clearly very happy there. They are living in an environment where there is perhaps more fresh air than in [Stadt], that they go out, they go bird-watching, they love the beach. In many ways the description of their life here is one that is most attractive and one where I am satisfied that what the mother has to say is that they are happy, but, as I have indicated, although there is a degree of integration, certainly something that is happening for them, *the question is have they lost their German habitual residence*? That is where one has to consider the see-saw with which Lord Wilson so graphically illustrated the question which the court has to determine. As the children lose their connection with the place of origin and their initial habitual residence, that will happen as they gain habitual residence elsewhere, and so the see-saw tips, the balance tips in one direction and as it tips towards their new location, they lose the connection with the other location." (my emphasis)

18. The judge concluded, "with some degree of sadness", that the children's habitual residence had "not shifted to England" but remained in Germany. He referred to that fact that "in June, that intention [that the children would return to Germany] was still being expressed as the intention of both parents". He then, at [46], summarised his conclusion as follows: "given that those intentions were still alive in June 2019, given that [the children] were still spending time with family in Germany in July [and] that they still had a life there … I have concluded that the habitual residence has not shifted to England"; "The position in Germany having kept alive throughout that period, they have therefore not lost that, and in those circumstances they had not gained habitual residence in this country".

19. The judge's regret at having to reach this conclusion can be seen from his observation that the children "remained habitually resident in Germany despite the obvious time that they were spending in England and the very many benefits that were accruing to them" here. He returned to the latter point later in his judgment when he said, at [52], that he "was impressed with what the mother had to say about the way in which [the children] related to friends at school; [and] the matters that have been raised in terms of their life here".

20. However, despite his regret the judge clearly felt compelled to decide that the children's habitual residence had not "shifted" to England because, I repeat, the "position in Germany having been kept alive throughout that period, they have therefore not *lost* that, and in those circumstances they had not gained habitual residence in this country" (my emphasis). The judge's approach to this issue can also be seen from his subsequent observation that, if the children "had had no contact with their father during the intervening period, then it may be that a change in terms of their integration and their habitual residence would have been found by this court, I cannot say".

21. It is clear from the above that the judge's key focus was on whether the children had lost their habitual residence in Germany. This can be seen, for example, from his saying, at [42], that the question arose of "whether they had lost their habitual residence with the father"; and, at [44], that "although there is a degree of integration [in England] …, the question is have they lost their German habitual residence". This led him, in turn, to focus on the extent to which the children had lost or maintained their connections with Germany and whether those connections had been "displaced". The judge's perspective was clearly driven by, or based on, his understanding of the need to apply Lord Wilson's "see-saw" analogy from the case of *In re B (A Child) (Reunite International Child Abduction Centre and others intervening)* [2016] AC 606, at [45].

22. The judge also decided that Article 13(b) was not established. He accepted that returning to Germany would "create very considerable difficulties for the mother" especially as she was about to give birth and also because she had no accommodation there. He also had "no doubt that there will be considerable disruption for the" children. He concluded as follows: "In terms of the position, however, as to whether it would be intolerable for the boys, I bear in mind that the boys spend regular periods in Germany with their father and that although the position may be that they will be there for longer than is usual, nonetheless, going to their father is not something that is strange or unusual for them, and so I cannot see that that in itself is something that would be intolerable".

Submissions

23. On behalf of the mother, Mr Turner QC and Ms Chokowry made three broad submissions: (a) that the judge failed properly to analyse the issue of habitual residence and, if he had, he would have concluded that the children were habitually resident in England at the end of July 2019; (b) that the judge was wrong to find that returning the children to Germany would not place them in an intolerable situation; and (c) that, if neither (a) nor (b) succeeded, then, exceptionally, the implementation of the return order should be postponed to enable the mother to make a relocation application in Germany.

24. Mr Turner started his submissions by pointing to the fact that, as referred to in the judgment, the mother has been the children's primary carer throughout their lives. He also reflected on the unhappy consequences of the proceedings in that, prior to their commencement, the children had been having extensive contact with the father but that, since then, contact has been far more limited with significantly less direct contact.

25. (a) In respect of habitual residence, Mr Turner submitted that the judge's approach was legally flawed in that he did not apply the approach approved in *A v A and another (Children: Habitual Residence) (Reunite International Child Abduction Centre and others intervening)* [2014] AC 1. This was because the judge appeared to have been misled by Lord Wilson's see-saw analogy from *In re B* into taking the key question as being whether the children had lost their habitual residence in Germany. He submitted that the latter decision had not changed the principles applicable to the determination of habitual residence in that Lord Wilson was not saying, as the judge seemed to consider, that continuing links on the part of a child with the "old" country would prevent that child from acquiring habitual residence in the "new" country, even if an appropriate degree of integration and stability of life in the new country had been acquired.

26. Mr Turner also submitted that the judge's approach was not consistent with the important policy objective of the 1980 Convention. The Convention is designed to achieve the prompt "reinstatement of the status quo ante" for children because it is presumed to be in their best interests to be returned to the state where they are habitually resident. In the present case, a return would not effect a rapid "reinstatement" because, Mr Turner submitted, the children were integrated in England by July 2019.

27. The judge's apparent misunderstanding of *In re B* led him to focus on whether the children had lost their habitual residence in Germany, based on their continuing links with Germany, rather than on the relevant question of whether their residence in England had acquired the requisite degree of integration and stability. This had also meant that the judge had given inadequate consideration to whether, and the extent to which, the children were integrated in England. There was, Mr Turner submitted, little analysis of this highly relevant factor.

28. Mr Turner pointed to passages in the judgment which supported his submission that the judge had failed properly to apply the approach set out in *A v A*. He emphasised that, as set out in the authorities, all that is required for the purposes of habitual residence is "some" degree of integration in the new state. He also referred to Lord

Hughes' observation, at [12], in *In re C and another (Children) (International Centre for Family Law, Policy and Practice Intervening)* [2019] AC 1, when reflecting on whether a child might have become habitually resident in the "destination State" by the date of the wrongful removal or retention:

> "It is perhaps improbable in the case of removal, but it is not in the case of retention. It may particularly happen if the stay in the destination State is more than just a holiday and lasts long enough for the child to become integrated into the destination State."

29. Mr Turner also submitted that the judge's approach to the parents' intentions was flawed. The judge referred on a number of occasions to the parties' initial agreement and their continuing intention that the children and the mother would return to Germany. Intention is a relevant factor but the judge, he submitted, also elevated this above the more important factor of the children's integration in England.

30. If the judge had asked whether the children, who were not just visiting but were living in England with their primary carer, had achieved the requisite degree of integration in England to be habitually resident here, he would have inevitably have determined that they had and, as a result, it would also inevitably follow that they had lost their habitual residence in Germany.

31. (b) As to Article 13(b), Mr Turner submitted that, as set out in the Grounds of Appeal, the judge's reasoning was flawed and/or his analysis was unduly superficial. He had failed to consider, in particular, the complex needs of T and the likely effect on him of moving to live in Germany with the inevitable disruption to his healthcare and to his education. Nor, he submitted, had the judge considered the extent to which the children and the mother were settled in England and, as a result, the likely detrimental impact on them of being required to move to Germany. In addition, he submitted that the judge had failed to look at the mother's and the children's situation at the date of the hearing. He pointed to the judge referring, again, to the fact that in June 2019 the mother had said that she intended to return to Germany.

32. (c) As very much a fall-back position, Mr Turner submitted that, having regard to the length of time the children have been living in England, to the extent to which they are settled here and to the likely disruptive effect of a return to Germany, the implementation of any return order should be delayed to enable the mother to make an application to the German courts for permission to remain in England.

33. In response, Mr Setright QC and Mr Gration submitted that the judge directed himself correctly as to the relevant law and had reached a decision that was open to him both as to the children's habitual residence and as to Article 13(b).

34. (a) In respect of habitual residence, Mr Setright submitted that there is no basis for this court interfering with the judge's decision. He relied on Lord Reed's observation as to the "limited function of an appellate court in relation to a lower court's finding as to habitual residence", at [18], in *In re R (Children) (Reunite International Child Abduction Centre and others intervening)* [2016] AC 76.

35. The judge in the present case had not fallen into error as suggested by Mr Turner but had applied the correct legal principles. He had been correct to focus on Lord Wilson's judgment in *In re B* in part because both counsel had invited him to treat that decision as being of particular relevance to this case and in part because the question the judge had to decide was whether the children had lost their habitual residence in Germany and acquired one in England.

36. The task for the judge was to consider the integration that the children had in Germany against the integration that they had begun to acquire in England and determine whether, and if so when, the balance had tipped so that their integration in England outweighed their integration in Germany. This, Mr Setright submitted, was the effect of Lord Wilson's see-saw analogy which requires a comparative analysis as referred to in *Re G-E (Children) (Hague Convention 1980: Repudiatory Retention and Habitual Residence)* [2019] 2 FLR 17, at [59].

37. Mr Setright submitted that the court's determination as to whether there has been a transfer of habitual residence will depend on the following: (a) the extent of the roots put down in the country of physical presence; (b) in the context of the time spent there; (c) also in the context of the stability of the arrangements and the intention of those who have made them including the parent or parents with care of the child; (d) the extent of the continuing roots in the country of habitual residence before the physical move; (e) the extent to which those roots have been sustained; (f) a comparative/balancing exercise determining whether the roots in the latter country are sufficiently displaced by the acquisition of roots in the other country. The degree of integration in the new country has to be sufficient - to a "requisite degree" - to displace the previous habitual residence. In his submission, the judge had sufficiently analysed these factors and had undertaken a sufficient balancing exercise to support his conclusion that the children were habitually resident in Germany.

38. Mr Setright specifically addressed the judge's comment, at [44], that "although there is a degree of integration [in England] … the question is have they lost their German Habitual residence?". In his submission, what the judge meant by this was whether the degree of integration in England was sufficient in comparative terms. The judge accepted that there was integration in England but determined that this was not sufficient, or not to the requisite degree, to displace their integration in Germany

39. Accordingly, Mr Setright submitted that the judge had balanced the factors which demonstrated the children's continuing connection with Germany with those demonstrating their integration in England. The fact that the children returned to Germany "frequently and for long periods" was of "great significance" in the balancing exercise. The judge was also, Mr Setright submitted, entitled to treat as a significant factor the joint parental intention that the children would return to Germany in July/August 2019. The judge had taken into account the children's integration in England and, he submitted, had not "underplayed" their lives in England. Based on this assessment, the judge had reached the decision that the see-saw had not tipped and that, as a result, the children remained habitually resident in Germany.

40. (b) As for Article 13(b), Mr Setright submitted that the judge was plainly entitled to decide that this exception had not been established. It was relevant that the mother was still intending to return in June 2019 because, even at that late stage, she must

have considered that any disruption for her and the children was manageable. Mr Setright also referred to the fact that T had continued to receive some of his medical care in Germany and that arrangements had been made for the children's return in terms of schooling.

41. (c) In respect of the submission that the implementation of any return order should be stayed, Mr Setright accepted that there were "a very limited number" of first instance authorities which supported the existence of such a power, it was a power which should only be exercised in exceptional circumstances, which did not exist in this case.

Law

42. Habitual residence has been debated in a number of cases, including five, or perhaps more, in the Supreme Court. In some respects this is surprising given that it is an issue of fact and one which it has been said "should not be glossed with legal concepts which would produce a different result from that which the factual inquiry would produce": Lady Hale, at [54], in *A v A*. This probably reflects the importance of the concept not only because it is "the main connecting factor in all the modern Hague Children's Conventions" (*Note on Habitual Residence and the Scope of the 1993 Hague Convention on Protection of Children and Co-operation in respect of Intercountry Adoption*, 2018, The Hague Conference on Private International Law, Permanent Bureau, at [5]); but also because: "A child's habitual residence in a state is the internationally recognised threshold to the vesting in the courts of that state of jurisdiction to determine issues in relation to him (or her)", Lord Wilson, at [27], *In re B*.

43. However, there is clearly a risk that the number of decisions available to be deployed by parties might by itself distract the court from the essential factual enquiry. It must also be remembered that the situations being considered by the court will vary enormously so that general observations made in these decisions have to be applied with care. They have to be applied with care to ensure that, as Lady Hale said (and I repeat), legal concepts or glosses do not lead the court to make a different decision to that which the "factual enquiry" would have produced.

44. Bearing these preliminary observations in mind, I do not want to add to the existing jurisprudence because, in my view, there is no need further to elaborate on what habitual residence means. However, in order to address the central submission advanced on behalf of the mother, namely that the judge did not undertake the required factual enquiry and that, if he had, he would necessarily have concluded that the children were habitually resident in England at the end of July 2019, I must deal with the law in some detail in part to put Lord Wilson's see-saw analogy in *In re B*, which it appears the judge sought to apply, in context.

45. It has been established for some time that the correct approach to the issue of habitual residence is the same as that adopted by the Court of Justice of the European Union ("CJEU"). Accordingly, in *A v A*, at [48], Lady Hale quoted from the operative part of the CJEU's judgment in *Proceedings brought by A* [2010] Fam 42, at p.69:

> "2. The concept of 'habitual residence' under article 8(1) of Council Regulation (EC) No 2201/2003 must be interpreted as

> meaning that it corresponds to the place which reflects some degree of integration by the child in a social and family environment. To that end, in particular the duration, regularity, conditions and reasons for the stay on the territory of a member state and the family's move to that state, the child's nationality, the place and conditions of attendance at school, linguistic knowledge and the family and social relationships of the child in that state must be taken into consideration. It is for the national court to establish the habitual residence of the child, taking account of all the circumstances specific to each individual case."

46. It is also relevant to note that the factors listed in paragraph 2 (quoted above) were taken verbatim from the judgment, at [39]. Their purpose or objective appears from the preceding paragraph:

> "[38] In addition to the physical presence of the child in a member state, other factors must be chosen which are capable of showing that that presence is not in any way temporary or intermittent and that the residence of the child reflects some degree of integration in a social and family environment."

The need for some degree of integration (as again referred to in *A v A*, drawing on Sir Peter Singer's analysis of the CJEU's decision in *Mercredi v Chaffe* (Case C-497/10 PPU) [2012] Fam 22) is, therefore, to distinguish habitual residence from temporary or intermittent presence. It is for the purposes of assessing what Lord Wilson described in *In re LC (Children) (Reunite International Child Abduction Centre intervening)* [2014] AC 1038 at [1] as, "the nature and quality of that residence". Another expression used, again derived from the European authorities, is the "stability" of the residence.

47. Accordingly, as summarised by Lord Wilson in *In re LC*, at [1], "it is clear that the test for determining whether a child was habitually resident in a place is whether there was some degree of integration by her (or him) in a social and family environment".

48. What is meant by "some degree" of integration? As Lord Wilson said in *In re B*, at [39], there does not have to be "full integration in the environment of the new state … only a degree of it". He also said: "It is clear that in certain circumstances the requisite degree of integration can occur quickly". In *In re LC*, Lady Hale, at [60], referred to the "essential question" as being "whether the child has achieved a sufficient degree of integration into a social and family environment in the country in question for his or her residence there to be termed 'habitual'".

49. As referred to above, another relevant factor when analysing the nature and quality of the residence is its "stability". This can be seen from *In re R* in which Lord Reed referred to both the degree of integration and the stability of the residence. In that case the mother (who was Scottish) and the children, with the father's agreement, had moved from their home in France (the father was French) to live in Scotland for a year. The issue was whether, having arrived in Scotland in July 2013, the children were habitually resident in France or Scotland in November 2013. At first instance

they were found still to be habitually resident in France. On appeal, this decision was overturned and they were found to be habitually resident in Scotland.

50. As explained by Lord Reed, at [9], an Extra Division of the Inner House of the Court of Session had overturned the lower court's determination because the judge had treated "a shared parental intention to move permanently to Scotland as an essential element" when considering whether the children were habitually resident in Scotland. This decision was upheld by the Supreme Court because, applying *A v A*, it was "the stability of the residence that is important, not whether it is of a permanent character", at [16]. There was "no requirement that the child should have been resident in the country in question for a particular period of time" nor was there any requirement "that there should be an intention on the part of one or both parents to reside there permanently or indefinitely".

51. Lord Reed summarised, at [17], what Lady Hale had said in *A v A*, at [54], emphasising that: (i) habitual residence is a question of fact which requires an evaluation of all relevant circumstances; (ii) the focus is on the child's situation with the "purposes and intentions of the parents being merely among the relevant factors"; (iii) "it is necessary to assess the degree of integration of the child into a social and family environment in the country in question"; (iv) the younger the child, the more their social and family environment will be shared with those on whom the child is dependent, giving increased significance to the degree of integration of that person or persons.

52. Later in his judgment, at [21], again applying *A v A*, Lord Reed referred to the important question as being "whether the residence has the necessary quality of stability, not whether it is necessarily intended to be permanent". The judge at first instance, by focusing on the parents' intentions, had failed "to consider in his judgment the abundant evidence relating to the stability of the mother's and the children's lives in Scotland, and their integration into their social and family environment there".

53. It is also interesting to note the way in which Lord Reed rejected the father's case, at [22], that the Extra Division "had erroneously focused only on the children's circumstances in Scotland, and had left out of account the agreement between their parents as to the limited duration of the stay in Scotland, and their parents' intentions". He said:

> "[23] I do not find that submission persuasive. The Extra Division … proceeded on the basis that the stay in Scotland was originally intended to be for the 12 months' maternity leave, that much being uncontroversial. They therefore assumed, in the father's favour, that the stay in Scotland was originally intended to be of limited duration. Their remark that the real issue was whether there was a need for a longer period than four months in Scotland, before it could be held that the children's habitual residence had changed, followed immediately on their statement, at para 14:
>
> 'If the salient facts of the present case are approached in accordance with the guidance summarised earlier, the key

> finding of the Lord Ordinary is that the children came to live in Scotland.'
>
> "In other words, following the children's move with their mother to Scotland, that was where they lived, albeit for what was intended to be a period of 12 months. Their life there had the necessary quality of stability. For the time being, their home was in Scotland. Their social life was there. Their family life was predominantly there. The longer time went on, the more deeply integrated they had become into their environment in Scotland. In that context, the question the Extra Division asked themselves did not indicate any error of approach."

54. I now turn to consider *In re B*. In that case one parent had clandestinely removed the child from England to Pakistan on 3 February 2014. The court had to determine whether the child remained habitually resident in England on 13 February 2014, being the date on which the other parent had commenced proceedings under the Children Act 1989. Hogg J found that the child had lost her habitual residence in England although she had probably not become habitually resident in Pakistan. This decision was upheld by the Court of Appeal but overturned by the Supreme Court which decided, by a majority, that the child remained habitually resident in England on 13 February 2014.

55. As described by Lord Wilson, who gave the majority judgment, at [32], the central issue in the case concerned "a third aspect of the concept of habitual residence, namely the circumstances in which [a child] loses" his or her habitual residence and, in particular, "whether the longstanding domestic analysis of those circumstances, yet again heavily dependent on parental intention, is consonant with the modern international concept". This analysis derived from Lord Brandon's speech in *In re J (A Minor) (Abduction: Custody Rights)* [1990] 2 AC 562 in which he made a third preliminary point, at p 578H, namely that "there is a significant difference between a person ceasing to be habitually resident in country A and his subsequently becoming habitually resident in country B". For reasons set out in his judgment, Lord Wilson concluded, at [47], that this point "should no longer be regarded as correct".

56. In arriving at this conclusion, Lord Wilson made clear, at [32], that "the interpretation of habitual residence should be consonant with its international interpretation". He set out, what is now, the established approach to the determination of habitual residence derived from *Proceedings brought by A*, *Mercredi v Chaffe* and *A v A*. He summarised the effect of *A v A* as being, at [38], that:

> "… this court held that the criterion articulated in the two European authorities ("some degree of integration by the child in a social and family environment"), together with the non-exhaustive identification of considerations there held to be relevant to it, governed the concept of habitual residence in the law of England and Wales: para 54(iii)(v) of Baroness Hale of Richmond DPSC's judgment, with which all the members of the court (including Lord Hughes JSC, at para 81) agreed. Baroness Hale DPSC said at para 54(v) that the European approach was preferable to the earlier English approach

> because it was "focussed on the situation of the child, with the purposes and intentions of the parents being merely one of the relevant factors".
> "

He then added (part of which I have quoted above):

> "[39] It is worthwhile to note that the new criterion requires not the child's full integration in the environment of the new state but only a degree of it. It is clear that in certain circumstances the requisite degree of integration can occur quickly. For example, article 9 of Regulation B2R, the detail of which is irrelevant, expressly envisages a child's acquisition of a fresh habitual residence within three months of his move. In the *J* case, cited above, Lord Brandon suggested that the passage of an "appreciable" period of the time was required before a fresh habitual residence could be acquired. In *Marinos v Marinos* [2007] 1 FLR 1018, para 31, Munby J doubted whether Lord Brandon's suggestion was consonant with the modern European law; and it must now be regarded as too absolute. In *A v A*, cited above, at para 44, Baroness Hale DPSC declined to accept that it was impossible to become habitually resident in a single day."

57. The above summary of the current approach to habitual residence provided the foundation for Lord Wilson's consideration, at [40], of "the object of central relevance to this appeal, namely the point at which habitual residence is lost". Although this was of central relevance in that case, it is clear from his judgment that he did not intend to change or replace the clear guidance given in *A v A* and other cases as to the approach the court should take to the determination of habitual residence.

58. Further, it is also clear that Lord Wilson's analogy and his other observations were directed simply to the expectation that the acquisition of a new habitual residence would be likely to coincide with the loss of the previous habitual residence. He did not intend to alter the key question which, in every case, is: where is the child habitually resident? Even though the acquisition of a new habitual residence can be expected to coincide with the loss of the previous one, hence the see-saw analogy, this issue is not determined by asking simply the question whether a child has lost their habitual residence. In addition to the passages I have quoted above, this is clear from his observation, at [46], that "the identification of a child's habitual residence is overarchingly a question of fact" and from the balancing exercise he undertook, at [49] and [50].

59. Lord Wilson's conclusions were, in full, as follows:

> "[45] I conclude that the modern concept of a child's habitual residence operates in such a way as to make it highly unlikely, albeit conceivable, that a child will be in the limbo in which the courts below have placed B. The concept operates in the expectation that, when a child gains a new habitual residence,

> he loses his old one. Simple analogies are best: consider a see-saw. As, probably quite quickly, he puts down those first roots which represent the requisite degree of integration in the environment of the new state, up will probably come the child's roots in that of the old state to the point at which he achieves the requisite de-integration (or, better, disengagement) from it.
>
> [46] One of the well-judged submissions of Mr Tyler QC on behalf of the respondent is that, were it minded to remove any gloss from the domestic concept of habitual residence (such as, I interpolate, Lord Brandon's third preliminary point in the *J* case [1990] 2 AC 562), the court should strive not to introduce others. A gloss is a purported sub-rule which distorts application of the rule. The identification of a child's habitual residence is overarchingly a question of fact. In making the following three suggestions about the point at which habitual residence might be lost and gained, I offer not sub-rules but expectations which the fact-finder may well find to be unfulfilled in the case before him: (a) the deeper the child's integration in the old state, probably the less fast his achievement of the requisite degree of integration in the new state; (b) the greater the amount of adult pre-planning of the move, including pre-arrangements for the child's day-to-day life in the new state, probably the faster his achievement of that requisite degree; and (c) were all the central members of the child's life in the old state to have moved with him, probably the faster his achievement of it and, conversely, were any of them to have remained behind and thus to represent for him a continuing link with the old state, probably the less fast his achievement of it."

In summary, the "expectations" referred to by Lord Wilson were clearly just that and were expressly not intended to alter the established approach to the determination of the issue of habitual residence. He made clear that they were *not* glosses on the concept of habitual residence nor, as Mr Turner submitted, did they represent an alternative approach to that set out in *A v A*. They were, at most, suggestions of what the "fact-finder may well find" at the conclusion of his factual enquiry and were *not* the objective of the factual enquiry.

60. Finally, we were referred to *Re G-E* in which I noted, at [59], both the global analysis required and the comparative nature of the exercise which may be required when there are two states in which a child may be habitually resident. The latter was demonstrated by the exercise Lord Wilson undertook in *In re B* when he analysed, at [49] and [50], the factors which pointed to the child having "achieved the requisite degree of disengagement from her English environment" and those which pointed to the child having "achieved the requisite degree of integration in the environment in Pakistan".

61. In conclusion on this issue, while Lord Wilson's see-saw analogy can assist the court when deciding the question of habitual residence, it does not replace the core guidance given in *A v A* and other cases to the approach which should be taken to the

determination of the habitual residence. This requires an analysis of the child's situation in and connections with the state or states in which he or she is said to be habitually resident for the purpose of determining in which state he or she has the requisite degree of integration to mean that their residence there is habitual.

62. Further, the analogy needs to be used with caution because if it is applied as though it is the test for habitual residence it can, as in my view is demonstrated by the present case, result in the court's focus being disproportionately on the extent of a child's continuing roots or connections with and/or on an historical analysis of their previous roots or connections rather than focusing, as is required, on the child's *current* situation (at the relevant date). This is not to say continuing or historical connections are not relevant but they are part of, not the primary focus of, the court's analysis when deciding the critical question which is *where* is the child habitually resident and not, simply, *when* was a previous habitual residence lost.

63. In many cases, as in the present case, the parties and the court have used the summary of the law set in by Hayden J in *Re B*, at [17]. I agree that this is a helpful summary save that, for the same reasons given above, what is set out in sub-paragraph (viii) (which I quote below) might distract the court from the essential task of analysing "the situation of the child" *at* the date relevant for the purposes of establishing jurisdiction or, as in the present case, whether a retention was wrongful. Accordingly, in future I would suggest that, if Hayden J's summary is being considered, this sub-paragraph should be omitted so that the court is not diverted from applying a keen focus on the child's situation at the relevant date:

> "(viii) In assessing whether a child has lost a pre-existing habitual residence and gained a new one, the court must weigh up the degree of connection which the child had with the state in which he resided before the move (*In re B* - see in particular the guidance at para 46)."

64. The law on Article 13(b) was not in dispute in this case and I do not need to set out the cases which establish that it has a high threshold because of the need for the risk to be "grave" and for the circumstances for a child to be "intolerable".

65. I also do not propose to deal with the law relating to Mr Turner's third point (c), namely deferring the implementation of a return order because, for the reasons set out below, it does not arise in this case.

Determination

66. It is clear, as submitted by Mr Turner, that the judge considered the question he had to answer was whether the children had *lost* their habitual residence in Germany. I suppose, in some respects, it may not matter how a judge phrases the question he has to ask provided it is clear that he has correctly approached the issue as being, to adopt what Lord Wilson said in *In re B*, the "identification of a child's habitual residence". What is important is whether the way in which the question has been phrased leads to the judge failing to apply the proper approach and, again to adopt what Lord Wilson said, applying a "gloss", namely an approach which "distorts [the] application of" the proper approach to the determination of a child's habitual residence.

67. In my view, to adopt, alternatively, what Lady Hale said in *A v A*, the judge in this case was led to make a different decision to that which a "factual enquiry" would have produced by his focus on the question of whether the children had lost their habitual residence in Germany. It does not matter what led the judge to take this path but it seems likely that it was, what appears to have been, his understanding of some of Lord Wilson's comments in *In re B* and, in particular, the see-saw analogy.

68. As set out above, Lord Wilson's see-saw analogy was not intended to deflect the court from applying the established approach. Habitual residence is, I repeat, a question of fact which requires a global analysis of all the relevant circumstances in order to identify the child's habitual residence *at* the relevant date, namely the date of the wrongful abduction or the wrongful retention. In my view, the judge reached a different decision to that which a factual enquiry would have produced as a result of asking, not where the children were habitually resident as at the end of July 2019 but whether they had by then lost their German habitual residence. This resulted in the judge's analysis having the wrong focus.

69. This can be seen from the following. At [41], the judge identified as the "difficult task" for him as being "to evaluate whether [the children] had lost [their] connection with Germany as they gained the position in" England. As Mr Turner submitted, this gives the impression that the judge considered that the children had to have lost their connection with Germany before they could become habitually resident in England. This can also be seen from the judge's later observation, at [52], that if there had been "no contact with the father … then it may be that a change in terms of their integration and their habitual residence would have been found".

70. In addition, the judge, more than once, phrased the key question he had to answer as being whether the children "had lost their German habitual residence". As Mr Turner acknowledged, the judge had recognised, at [44], that the "relevant question is whether a child has achieved some degree of integration" and did not need to be "fully integrated". However, although the judge did then briefly address some aspects of the children's lives in England, he went back to the same key question: "as I have indicated, although there is a degree of integration, certainly something that is happening for them, the question is have they lost their German habitual residence".

71. I have taken the whole judgment into account, but in my view the judge's approach to the issue of habitual residence is encapsulated in his summary of the key factors, at [46], as being: that the parents' intentions in June 2019 continued to be that the mother and the children would be returning to Germany; and that the children were "still spending time with family in Germany in July and … still had a life there". There is no reference to the fact that they had, at least, some degree of integration in England and whether, as a result, they were habitually resident here.

72. If the judge had asked himself the "essential question" as referred to by Lady Hale in *In re LC*, at [60], namely whether the children, as at the end of July 2019, had achieved a sufficient degree of integration into a social and family environment in England such that their residence here was habitual, I have no doubt that he would have concluded that they had.

73. The children had moved here with their primary carer in July 2018. They established their home here with her. They intended to stay for "12 months or so". They went to

school in England. They "settled quickly" in part because they were familiar with the place to which they had moved and "loved" the local environment. They spent significantly more of the year up to July 2019 in England than they did in Germany. They clearly became integrated not to "some degree" but to a very substantial degree in a social and family environment in this country.

74. In my view, there would have to be some powerful countervailing factors to lead to the conclusion that the children were not habitually resident here by July 2019. The factors relied on by the judge were, in summary, the parents' intentions and the time the children were spending with their father and other family members in Germany thereby maintaining their connections with Germany. These are important factors but, in my view, they do not counterbalance the degree of integration that the children had established in England. I would want to emphasise that this is not to diminish the importance for the children of their continuing connections with Germany. Rather, it is that they are not sufficient to mean that the children were not habitually resident in England because of the powerful factors demonstrating the extent of their integration and the stability of their life with their mother in England.

75. Accordingly, in my view, the appeal must be allowed. Further, because it is clear to me that, on any proper application of the appropriate test, the children were habitually in England at the date of their retention, the father's application under the 1980 Convention must be dismissed.

76. It is not, therefore, necessary for me to address the other issues raised on behalf of the mother. I would simply say that there is some force in Mr Turner's submission that the judge did not sufficiently consider the likely effect on the children of returning to Germany. However, it is not necessary to decide whether this would have been sufficient to overturn the judge's conclusion that Article 13(b) was not established, although I doubt whether it would have been.

Lady Justice Simler:

77. I agree.

Sir Stephen Richards:

78. I also agree.

Neutral Citation Number: [2016] EWHC 2174 (Fam)

Case No: FD16P00352

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/08/2016

Before :

MR JUSTICE HAYDEN

- -

In Re B (a minor) (habitual residence)

- -

- -

Mr M Gration (instructed by **Goodman Ray Solicitors**) for the **Applicant Mother**
Ms K Chokowry (instructed by **Brookman Solicitors**) for the **Respondent Father**

Hearing dates: 22nd & 23rd August 2016

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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.

....

MR JUSTICE HAYDEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. I am concerned here with B (a girl) who was born on 1 March 2013. These proceedings concern an application by B's mother for the summary return of the child to the jurisdiction of New York State, USA. The matter has been listed before me for two days, commencing 22 August 2016, for final determination.

2. The father opposes the application. He asserts that B is habitually resident in England and Wales. In any event, it is submitted on his behalf, that by 1st July 2016 the child was no longer habitually resident in New York. The father contends that the mother consented to the relocation to England or alternatively that she acquiesced in her retention in England in the terms contemplated by Article 13 A. It is also the father's case that a summary return to New York would expose B to a grave risk of harm and/or place her in an intolerable position, within the terms of Article 13 B.

3. The father, aged 33 years, is a French citizen who was born in Senegal. The mother, who is now 24 years of age, is an American citizen. The parties first met when the mother was only 17. The father, who at the time was in his mid-20's, was running a small stall outside his home. The mother visited regularly. Listening to them both in evidence it is plain that there was a spark of attraction between the couple. However, nothing came of it and the father returned to France.

4. In June, 2012, the father was visiting New York on a business trip. He contacted a number of friends and acquaintances whom he had not seen in the intervening years since his return to France. The mother was amongst their number. I think the mother was pleased to be contacted. Though there is some dispute as to the extent of the contact which followed, the impression both gave to me is that they spent a lot of time together over a period of two to three days. The relationship, at least from the mother's perspective, was intense.

5. When the father had returned to France, the mother discovered that she was pregnant. I asked her if she had been taking any contraception. I found her response troubling and naive. She told me that she did not think she would get pregnant and that she took a "holistic" approach to the issue. She has an interest in what she describes as 'holistic medicine'. I did not enquire further. She was 20 years of age at the time of the pregnancy, living in New York City.

6. In July 2012 the mother broke the news of her pregnancy to the father. Both of them strike me as having been, understandably, in a state of shock and confusion at this time. In the months that followed, the father had met somebody else and it was obvious that, from the outset, this relationship was important to him, indeed it continues to endure. The mother and father met in New York in 2012 to try to forge plans for the baby. In her evidence the mother told me that she felt down and dispirited during the course of her labour. This was 'not what she had planned for' herself, it interrupted her education. She felt isolated and alone. Though she did not say so expressly, I sensed that she was disappointed by the fact of the father's new relationship.

7. The discussions in November 2012 have been the focus of much enquiry during this hearing. Both parties have their own recollection of what was agreed but I find that the plans were, perhaps inevitably, nebulous. I am however clear that the mother was

very keen that the father should play an active role in their child's life. Again, though she did not say so in terms, I had a strong sense, from her evidence, that her firm belief that B should have a relationship with her father was rooted in her own childhood experiences.

8. B was born in New York on 1 March 2013. The father was not present at the birth. However uncertain the future may have appeared, it is clear that the mother would very much have liked the father to have been present at the birth. She criticised his failure to be there. Father visited in April 2013 when B was a few weeks old and signed her birth certificates. It is important that I record that the father has not sought to shirk his responsibility to his daughter.

9. On 29 July 2013 there followed an unexpected development. The father was contacted by the maternal grandmother. That came as a great surprise to him as their relationship had been far from cordial. She told him that she thought the mother was 'in danger'. She described her daughter as being "out of her mind" and that she was engaging in prostitution. The mother herself later contacted the father to inform him that she and the baby had been evicted by the grandmother. On 7 February 2014, the mother told the father that the government wanted to 'take her daughter from her'. In her statement filed in these proceedings dated 16th August 2016 the mother described these messages as 'an over reaction' on her part. She contended that the social services were merely asking rudimentary questions regarding a security card. Of her mother's report that she had become involved with prostitution she said that this was motivated by her mother's belief that she and the father were in a continuing relationship and that she was unhappy that her daughter had been seeing another man. I am bound to say I found these explanations rather convoluted in writing but wholly unconvincing in the mother's oral evidence. In her evidence the mother presented as a psychologically fragile personality. It was clear that she found life as a single mother very difficult to cope with.

10. I have found it difficult to unravel the couple's thoughts or plans in the months that followed, but by the autumn it is clear that the mother had resolved to travel to Paris. That the mother should do this, never having been to Europe before, without obvious means of financial support (other than from the father) and with a baby to care for, I consider to be reflective of how unsatisfactory she had come to find life in New York. She purchased a return ticket for herself and the baby. Though her funds were extremely limited she managed to identify a travel company known, somewhat dispiritingly, by the name of Cheapo Airways. The journey involved travelling via Moscow and took mother and child some 16 hours.

11. A particularly strange feature of this plan to move to France, is that by this time the father was living in London. I am satisfied that one of the objectives behind the arrangement was to secure for B a French passport. Though this could have been organised from London the father told me he preferred to make the arrangements in his own town, Amiens, where he was familiar with the system. On 19 December 2014 father and daughter flew back to London where they lived with the father's partner (S). Though the mother accepts that she agreed with this arrangement, she also told me that B was at that point being weaned of breast feeding. The mother plainly contemplated a significant period of separation between her child and herself at this stage. I regret to say I was left with the impression that the mother was not instinctively in tune with the needs of her baby.

12. November 2014 marked the beginning of a very chaotic time for B. Mr Gration, who appears on the half of the mother, has provided a convenient chronology setting out the extent of B's travels. I pause to note that neither the mother nor the father seemed to have any sense that this level of chaos in their child's life might be detrimental to her welfare. Indeed, the mother seems to have believed that the opportunities for travel, before she started school, were a good thing for her daughter. I emphasise that B is, at the time of this hearing, still only 3 ½ years old.

13. Another striking fact of this case is that both parent's call their child by a different name. The father was asked, by Mr Gration, whether he thought that was a bad thing for his daughter. He responded that he had come to realise, during the course of these proceedings, that other people might think this was a bad idea and he volunteered, in future, to call his daughter by the mother's chosen name. Mr Gration submits that this reveals little insight into the needs of a child. In addition I also note that when in her father's care, B has found herself cared for, for quite long periods by babysitters that the father has engaged to look after her and who sometimes have been entirely unknown to her.

14. Mr Gration's chronology, which is agreed, requires to be stated in full:

a) November 2014 – December 2014, to Amiens, France with the mother and the father;

b) 19th December 2014 – 21st January 2015 to London, England with the father;

c) 21st January 2015 – 24th January 2015 to Lille, France with the father;

d) 24th January 2015 – 9th February 2015 to Italy with the father;

e) 9th February 2015 – 16th February 2015 to Paris, France with the father;

f) 16th February 2015 – 18th February 2015 to London with the father;

g) 18th February 2015 in London with the mother;

h) 20th February 2015 – 6th March 2015 to Paris, France with the mother;

i) 6th March 2015 – 28th March 2015 in London with the father;

j) 28th March 2015 – 8th May 2015 to Senegal with the father;

k) 8th May 2015 – 5th June 2015 in London with the father;

l) 5th June 2015 – 22nd July 2015 to Paris, France with the mother;

m) 22nd July 2015 – 29th October 2015 in New York, USA with the mother;

n) 30th October 2015 – 31st October 2015 to Paris, France with the mother;

o) 31st October 2015 – 11th January 2016 in London, at times with the father but also being cared for by others;

p) 11th January 2016 – 13th March 2016 to Senegal with the father.

15. By way of completeness it should be added to the above that between the 13th March 2016 and 22nd April 2016 B was in London with the father.

16. It is obvious from the chronology that B's habitual residence does not reveal itself instantly. Both counsel have, in their respective Skelton Arguments, analysed the evolution of the Supreme Court case law extensively and with characteristic skill. In her document Ms Chokowry distils a number of propositions that she contends can be gleaned from the five Supreme Court judgments, addressing habitual residence, delivered since 2013: **A v A and another (Children: Habitual Residence) (Reunite International Child Abduction Centre and others intervening)** [2013] UKSC 60, [2014] AC 1, sub nom Re A (Children) (Jurisdiction: Return of Child) [2014] 1 FLR 111 ("A v A"); In **re L (A Child) (Custody: Habitual Residence) (Reunite International Child Abduction Centre intervening)** [2013] UKSC 75, [2014] AC 1017, sub nom Re KL (A Child) (Abduction: Habitual Residence: Inherent Jurisdiction) [2014] 1 FLR 772 ("Re KL"); In **re LC (Children) (Reunite International Child Abduction Centre intervening)** [2014] UKSC 1, [2014] AC 1038 sub nom Re LC (Children) (Abduction: Habitual Residence: State of Mind of Child) ("Re LC"); In **re R (Children) (Reunite International Child Abduction Centre and others intervening)** [2015] UKSC 35, [2016] AC 76, sub nom AR v RN (Habitual Residence) [2015] 2 FLR 503 ("Re R"); **Re B (A child) (Habitual Residence: Inherent Jurisdiction)** [2016] UKSC 4, [2016] 2 WLR 557 ("Re B").

17. I think that Ms Chokowry's approach is sensible and, adopt it here, with my own amendments:

    i) The habitual residence of a child corresponds to the place which reflects some degree of integration by the child in a social and family environment (A v A, adopting the European test).

    ii) The test is essentially a factual one which should not be overlaid with legal sub-rules or glosses. It must be emphasised that the factual enquiry must be centred throughout on the circumstances of the child's life that is most likely to illuminate his habitual residence *(A v A, Re KL)*.

    iii) In common with the other rules of jurisdiction in Brussels IIR its meaning is 'shaped in the light of the best interests of the child, in particular on the criterion of proximity'. Proximity in this context means 'the practical connection between the child and the country concerned': A v A (para 80(ii)); Re B (para 42) applying Mercredi v Chaffe at para 46).

    iv) It is possible for a parent unilaterally to cause a child to change habitual residence by removing the child to another jurisdiction without the consent of the other parent (*Re R*);

    v) A child will usually but not necessarily have the same habitual residence as the parent(s) who care for him or her (*Re LC*). The younger the child the more likely the proposition, however, this is not to eclipse the fact that the investigation is child focused. It is the child's habitual residence which is in question and, it follows the child's integration which is under consideration.

vi) Parental intention is relevant to the assessment, but not determinative (*Re KL, Re R* and *Re B*);

vii) It will be highly unusual for a child to have no habitual residence. Usually a child lose a pre-existing habitual residence at the same time as gaining a new one (*Re B*); (emphasis added);

viii) In assessing whether a child has lost a pre-existing habitual residence and gained a new one, the court must weigh up the degree of connection which the child had with the state in which he resided before the move (*Re B – see in particular the guidance at para 46);*

ix) It is the ***stability*** of a child's residence as opposed to its *permanence* which is relevant, though this is qualitative and not quantitative, in the sense that it is the integration of the child into the environment rather than a mere measurement of the time a child spends there *(Re R and earlier in Re KL and Mercredi);*

x) The relevant question is whether a child has achieved ***some degree** of* integration in social and family environment; it is not necessary for a child to be *fully* integrated before becoming habitually resident (*Re R)* (emphasis added);

xi) The requisite degree of integration can, in certain circumstances, develop quite quickly (Art 9 of BIIR envisages within 3 months). It is possible to acquire a new habitual residence in a single day (*A v A; Re B)*. In the latter case Lord Wilson referred (para 45) those '*first roots*' which represent the requisite degree of integration and which a child will '*probably*' put down '*quite quickly*' following a move;

xii) Habitual residence was a question of fact focused upon the situation of the child, with the purposes and intentions of the parents being merely among the relevant factors. It was the stability of the residence that was important, not whether it was of a permanent character. There was no requirement that the child should have been resident in the country in question for a particular period of time, let alone that there should be an intention on the part of one or both parents to reside there permanently or indefinitely (Re R).

xiii) The structure of Brussels IIa, and particularly Recital 12 to the Regulation, demonstrates that it is in a child's best interests to have an habitual residence and accordingly that it would be highly unlikely, albeit possible (or, to use the term adopted in certain parts of the judgment, exceptional), for a child to have no habitual residence; As such, "if interpretation of the concept of habitual residence can reasonably yield both a conclusion that a child has an habitual residence and, alternatively, a conclusion that he lacks any habitual residence, the court should adopt the former" (Re B supra);

18. If there is one clear message emerging both from the European case law and from the Supreme Court, it is that the child is at the centre of the exercise when evaluating his or her habitual residence. This will involve a real and detailed consideration of (inter alia): the child's day to day life and experiences; family environment; interests and

hobbies; friends etc. and an appreciation of which adults are most important to the child. The approach must always be child driven. I emphasise this because all too frequently and this case is no exception, the statements filed focus predominantly on the adult parties. It is all too common for the Court to have to drill deep for information about the child's life and routine. This should have been mined to the surface in the preparation of the case and regarded as the primary objective of the statements. I am bound to say that if the lawyers follow this approach more assiduously, I consider that the very discipline of the preparation is most likely to clarify where the child is habitually resident. I must also say that this exercise, if properly engaged with, should lead to a reduction in these enquiries in the courtroom. Habitual residence is essentially a factual issue, it ought therefore, in the overwhelming majority of cases, to be readily capable of identification by the parties. Thus:

i) The solicitors charged with preparation of the statements must familiarise themselves with the recent case law which emphasises the scope and ambit of the enquiry when assessing habitual residence, (para 17 above maybe a convenient summary);

ii) If the statements do not address the salient issues, counsel, if instructed, should bring the failure to do so to his instructing solicitors attention;

iii) An application should be made expeditiously to the Court for leave to file an amended statement, even though that will inevitably result in a further statement in response;

iv) Lawyers specialising in these international children cases, where the guiding principle is international comity and where the jurisdiction is therefore summary, have become unfamiliar, in my judgement, with the forensic discipline involved in identifying and evaluating the practical realities of children's lives. They must relearn these skills if they are going to be in a position to apply the law as it is now clarified.

The simple message must get through to those who prepare the statements that habitual residence of a child is all about his or her life and not about parental dispute. It is a factual exploration.

19. In my review of the case law I note the observations of Lord Wilson in Re B (a child) (supra):

> *"Simple analogies are best: consider a see-saw. As, probably quite quickly, he puts down those first roots which represent the requisite degree of integration in the environment of the new state, up will probably come the child's roots in that of the old state to the point at which he achieves the requisite de-integration (or, better, disengagement) from it."*

20. Finally, the observation of Mc Farlane LJ in Re R (a child) [2015] EWCA Civ 674 strikes me as important to bear in mind on the facts of this particular case and more generally:

> *"When determining habitual residence there is no requirement that, to be sufficient to support a finding, the individual needs to be happy, well cared for or free from abuse. The 'social and family environment' into which a child might be integrated may include both positive and negative factors. These will not be irrelevant. In the present case the judge took full account, as he was entitled to do, of the negative aspects of the mother's life in Morocco. But in this case, where the judge was entitled to hold that the child's habitual residence was dependant upon determination of the mother's habitual residence, the primary, if not the sole, focus must be on evidence relating to the mother rather than the child. The negative aspects of the child's experience once she arrived here are not, therefore, in point in this context (although they obviously will be given full weight within any care proceedings)."*

21. Both Ms Chokowry and Mr Gration submit that if I find the child was not habitually resident in the USA at the relevant time, I do not need to consider whether the mother consented to or alternatively acquiesced in the child's retention in this jurisdiction. That is plainly right. Nor is it necessary for me to address whether the Article 13 b defence is made out.

22. I do not consider that either parent had a defined or clearly considered plan as to where B would live, long term, following her first visit to Europe in November 2014. It is obvious from the social media messages between the parents, prior to the trip, that the father had general anxieties about his daughter's welfare. He pursued those concerns with the mother in a way that he perceived to be 'diplomatic', to use his term in evidence. In their various exchanges, a sample of which has been filed in the Court bundles, it usually involves the father trying to pin the mother down to clear and structured arrangements. The messages reveal that whilst the father rarely expresses exasperation, the mother nonetheless senses it. When she has had enough she withdraws from the conversation. Thus neither party is being entirely open or candid with the other. This situation is inimical to joint planning.

23. Though she resists the suggestion, it is very clear that this mother has continuingly harboured hopes that she and the father might effect what Ms Chokowry has termed 'a rapprochement'. I hope Ms Chokowry will forgive me for saying so but I do not think that is quite the correct term, in so far as it implies a coming back together. The truth is that, for the father, he and the mother were never anything other than a fleeting, sexual encounter. Though the mother knows this too on some level, she has been highly motivated to provide a family life for her daughter.

24. In his evidence the father told me how, when B first came to Amiens, he had arranged a small party for friends and relatives. He told me that this was, to paraphrase him, a special memory. However, he quickly became aware that the mother was deriving the wrong signals from this simulacrum of family life. Though the father can be dogmatic and defensive I consider that he was sensitive in his approach to the mother and highly attuned to her vulnerability to receiving the wrong messages. He told me that she would sometimes pester him as to why he did not find her attractive. Disparagingly and reflecting her own jealousy, I note that she refers to the father's partner, who is significantly older than her, as 'the whale'.

25. I am satisfied that the mother both permitted and encouraged the development of the relationship between B and her father. I find it informative to consider her underlying reasoning. This I consider to be threefold: the mother was a young woman experiencing European culture for the first time, she visited Marseilles and forged relationships there, the text messages reveal that she was enjoying her freedom and opportunity to socialise; she firmly believes that B is entitled to a relationship with her father and, perhaps most importantly of all it is clear that she considered that the more time she and the father spent in their daughter's orbit, the greater the prospect of her achieving the fantasy of their living together as a family.

26. It is also clear from the text messages that it is the father who tries to keep B's needs in focus. It is he who repeatedly enquires about 'getting her stuff' organised and whether she needs rest between journeys. It is the father who brings up important topics such as educational provision and opportunities for B to socialise. In her evidence the mother construed this as criticism of her parenting, it was not. When the father wanted to take B to meet his parents in Senegal he repeatedly pressed the mother on the need for injections. She largely avoided the father's request. He told me that she did not consider they were necessary, preferring to rely on her holistic medicine. Fortunately for B the father was able to prevail.

27. I have no doubt that the father did not get everything right, he too had no previous experience as a parent. I am sure that Mr Gration is correct to highlight, as he does and as I have alluded to above, some of the father's shortcomings. That said, I was left with the clear impression that the father was far more in tune with his daughter's needs than was the mother. The relevance of this, I find to be, is in evaluating the father's consistently expressed objective to bring 'stability' into his daughter's life. I am satisfied that he tried hard to achieve this. The chronology might, if considered superficially, seem to indicate that the father was not successful. However, the reality is rather more multi faceted.

28. The father plainly wanted his daughter to have a life that was grounded by a sense of family. The trips to Senegal were either designed to or had the tangential benefit of providing an opportunity for B to see her extended paternal family, which both parents appear to agree she enjoyed. The father was also keen to keep on amicable terms with the mother and to promote his daughter's relationship with her. At the same time, like many other parents, he had to work and negotiate child care. All these challenges will be instantly recognisable to many parents. The added complication in this family is that balancing them all required moving between at least four countries.

29. In January 2015 the father had to go to Italy to work. B went with him. A full time babysitter was arranged and B spent most of the day with her as the father worked long hours. I note that the father tried to encourage the mother to have B with her at this period. She gave me no convincing reason why she had been unable to agree to do so.

30. As the evidence progressed it became very clear to me that it was the father who was most consistently identifying B's broad spectrum of needs. I was left with a persistent sense that the mother struggled to understand them. The father I found has given B a real sense of her identity. He told me she speaks English, French and Fullani, his African dialect. He told me that she sings some French songs, though not very many yet. He has lived at the same address in London since B arrived. She has her own

bedroom, decorated as she wishes. The father has also been in a stable relationship which itself will have contributed to B's sense of security. Though S has never tried to be a substitute for the mother, it is plain that she has been able to provide continuity for B and has become a significant person to her. It is of course not the mother's fault that she has not been able to provide this kind of consistency for her daughter, but it is what is happening in B's life that really matters in this enquiry. Also of relevance, on many levels, is that the father and his partner S have just had a baby. I am told and accept that B has welcomed this event and was looking forward to it.

31. Delivering the news of S's pregnancy to the mother was, as I have analysed the case above, inevitably going to cause her to confront the hopelessness of her own wish to be a family with the father. Almost immediately upon hearing the news she decided that the time had come for her to take her daughter back to the USA. It is that decision that has precipitated these proceedings. It is clear to me that the father's initial response was to agree to the mother's suggestion, with the hope that the reality would be that they could negotiate. His approach, as I have outlined above, was never to confront matters directly with the mother, but to address them obliquely. However, it soon became clear that this was not going to be possible.

32. In an otherwise peripatetic life B had, in my judgement, managed to put down secure roots in England with her father and his partner. The simple fact of this emerges quite strikingly from the evidence. To the question, where does B think of as home?, there seems to me to be one obvious answer. Her home is in London with the father.

33. S bought the property, a two bedroom house with a garden, in 2004. S is plainly settled there. She met the father, working together in Senegal, in August 2012. He moved in with her later that year. What is striking is that father immediately told her that he had just found out the mother was pregnant with his child. Their's strikes me as a relationship with a high degree of openness and honesty. It is clear that S is extremely fond of B. Her statement relates how she and father take turns giving her a bath and taking her to bed and reading bedtime stories. She recounts how she takes B to swimming classes once a week and goes swimming a few times during the course of the week. This is apparently because B is so fond of swimming. S relates how excited B has been about the arrival of her 'brother' and her enthusiasm for redecorating to prepare for his arrival. Now that B's French passport has arrived she has been able to get into a nursery that both father and S are very enthusiastic about. There has been much mention of 'Jessica', B's nanny, who has been a consistent figure in the home of this busy professional couple. I also note that at the weekends 'play dates' are arranged at B's home or at her friend's houses and sometimes in local parks. S considers that B is a very sociable child.

34. S's statement is unchallenged. Mr Gration is not in a position to challenge it. The mother knows very little of B's life in London. That may say something about the nature of the mother and daughter relationship, but its primary significance is that it casts into stark relief the fact there is little, if indeed any evidence of competing integration by this child elsewhere. Mr Gration suggests that something of the picture created is a confection constructed by the lawyers to focus, at least to some degree, on the applicable criteria. Thus he suggests that B joining the nursery in April 2016 was crafted to create the impression of a child integrated into the community. Despite its coincidence with the contemplation of proceedings, I am satisfied, on the father's evidence, that the nursery placement was achieved because the French passport had

arrived at the end of March thus permitting her enrolment. So structured is B's life elsewhere in London that I am persuaded that the father has had this nursery in mind for sometime and was anxiously awaiting the passport which would be the key to achieving a place.

35. Accordingly, I have come to the firm conclusion that B is habitually resident in the United Kingdom. Her life here has been, I find, qualitatively more stable and secure than anywhere else. It is in some ways an irony that in her determination to provide a family life for her daughter the mother achieved her goal. Sadly, she was not to be part of that unit. It is not merely that the father has provided a better quality of care for B, it is that the social and family environment he created for her enabled her to integrate into life in London. Perhaps because she has travelled so widely she put down her roots in the only fertile soil available to her.

Neutral Citation Number: [2019] EWHC 2531 (Admin) and [2019] EWHC 2530 (Fam)

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION (ADMINISTRATIVE COURT)
AND FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/10/2019

Before:

THE HONOURABLE MR JUSTICE MACDONALD
(Sitting in Public)

\- -

Case No: CO/2767/2019

Between:

TAFIDA RAQEEB **(By her Litigation Friend XX)**	**Claimant**
-and- **BARTS NHS FOUNDATION TRUST**	**Defendant**
-and- **SHALINA BEGUM and MUHHAMED RAQEEB**	**Interested Parties**

Case No: FD19P00378

Between:

BARTS NHS FOUNDATION TRUST	**Applicant**
- and - **SHALINA BEGUM and MUHHAMED RAQEEB**	**First and Second Respondents**
-and- **TAFIDA RAQEEB** **(By her Children's Guardian)**	**Third Respondent**
-and- **XX**	**Fourth Respondent**

Ms Katie Gollop QC and Mr Eliot Gold (instructed by **Kennedys LLP**) for the **Applicant in FD19P00378 and Defendant in CO/2767/2019**
Mr David Lock QC and Mr Bruno Quintavalle (instructed by **Sinclairs Law**) for the **First and Second Respondents in FD19P00378 and Interested Parties in CO/2767/2019**
Mr Vikram Sachdeva QC, Ms Nicola Kohn and Mr Alan Bates (instructed by **Irwin Mitchell LLP**) for the **Claimant in CO/2767/209 and the Interested Party in FD19P00378**
Mr Michael Gration (instructed by **CAFCASS Legal**) for the **Third Respondent in FD19P00378**

Hearing Dates: 9 to 13 September 2019

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.

Mr Justice MacDonald:

INTRODUCTION

1. The dilemma presented by cases concerning, as this case does, the withdrawal of life sustaining treatment from a child rests on the fact that they address what many see as an appalling present, but a present that for many also remains sanctified morally or as an article of religious faith because life subsists. For the treating doctors involved in such cases, seen through the prism of medical best interests life is at best a barely wakeful shadow burdened by futile medical treatment or, at worst, mere oblivion. For parents, seen through the prism of abiding love and fierce devotion and the amplifying effect on those emotions of the flattering voice of hope, life is still a faded jewel that has not yet been robbed away from the body and one that may yet regain its lustre. Within this context, the decision for this court in these concurrent proceedings is a grave, multifaceted and complex one.

2. I recognise at the outset of this judgment that such cases, touching as they do on the very nature, purpose and value of human life, raise emotive, complex and contentious issues that generate strong feelings on both sides of the litigation and in the wider public and professional sphere. Be that as it may, it is important to state at the beginning that the duty of this court is to decide the applications before it by reference to the law. The court must, and does disregard the urging of media and social-media campaigns, petitions, and pressure groups and the views of informed and uninformed commentators and opinion writers. The court does so not because the views and opinions of those diverse constituencies are in any way unwelcome or invalid, but rather because the decisions of the High Court in these most challenging of cases are determined solely by application of the law, in order to reach a decision on the seminal question of best interests.

3. Within the foregoing context, the court has before it two sets of proceedings concerning Tafida Raqeeb, a little girl born on 10 June 2014 and now aged five years old. The first set of proceedings, issued on 16 July 2019, concerns an application by Tafida for judicial review of what is said to be the decision by the Barts Health NHS Trust (hereafter 'the Trust') not to agree to Tafida being transferred to a hospital in Italy for continued medical treatment pending the determination of an application to the High Court for a declaration regarding her best interests. The second set of proceedings, also issued on 16 July 2019, concerns an application by the Trust for a specific issue order pursuant to s. 8 of the Children Act 1989, and an application for a declaration pursuant to the inherent jurisdiction of the High Court, that it is in Tafida's best interests for her current life-sustaining treatment now to be withdrawn, a course of action that will lead inevitably to her death.

4. In the application for judicial review Tafida acts through her litigation friend, XX. On 5 September 2019, I dismissed an application by the Trust to remove XX as the litigation friend for Tafida. My reasons for so doing will be set out in a separate judgement. Tafida is represented in the application for judicial review by Mr Vikram Sachdeva, Queen's Counsel, Ms Nicola Kohn and Mr Alan Bates of counsel. The Trust is the defendant to the application for judicial review and is represented by Ms Katie Gollop, Queen's Counsel. Tafida's parents, Shelina Begum and Mohammed Abdul Raqeeb are interested parties in the application for judicial review, represented by Mr David Lock, Queen's Counsel and Mr Bruno Quintavalle of counsel. The

Trust is the applicant in the applications made pursuant to the Children Act 1989 and the inherent jurisdiction and the parents and XX are respondents to those applications, each party with the same legal representation as set out above. Tafida is a party to the application under the inherent jurisdiction and is represented by Mr Michael Gration of counsel through her Children's Guardian, Kay Demery.

5. In this case I have also had the benefit of written representations from the Bangladesh High Commissioner to the United Kingdom (the parents each also being citizens of the People's Republic of Bangladesh), and a *fatwa* (being a ruling on Islamic law given by a recognised authority) from the Islamic Counsel of Europe, obtained and filed and served by the parents. In addition, the parents obtained, and I admitted into evidence with the consent of the parties, a legal opinion authored by Dr Giacomo Rocchi, a Judge of the Italian Supreme Court of Cassation, provided in his capacity as an acknowledge expert in Italy on issues of the type with which this court is concerned. This court extends its gratitude to those who have provided the aforesaid documents, to which it has given careful consideration.

6. In this case Tafida and her parents argue that, before any issue of best interests is considered, Tafida is entitled to what has been termed an "anterior procedural ruling" in the claim for judicial review that the decision of the Trust to refuse her transfer to Italy is unlawful and that, accordingly, the decision of the Trust should be quashed, a mandatory order made requiring the Trust to retake the decision or a mandatory order made requiring the Trust to permit the transfer of Tafida with a declaration that the Trust may not prevent that transfer, following which decision the court would be *functus* as to Tafida's wider best interests. Within this context, with respect to the order of proceedings, over the first two and a half days of the final hearing, I heard the submissions in the application for judicial review. Having been satisfied that it was necessary and appropriate to do so, I then moved to hear the oral evidence of the mother and submissions in the application under the Children Act 1989 and the inherent jurisdiction in respect of Tafida's best interests. Given the gravity, complexity and range of the issues engaged in this case, I thereafter reserved my judgment and now set out the decisions I have made, and the reasons for those decisions, in each set of proceedings before me. Given the court has heard and determined *two* sets of proceedings in one hearing and given the gravity, complexity and range of the issues engaged in each set of proceedings, this judgment is, of regrettable necessity, lengthy.

BACKGROUND

7. Tafida was born on 10 June 2014 and is the daughter of Shelina Begum and Mohammed Abdul Raqeeb. Each parent holds parental responsibility for Tafida. Tafida has a brother and a large extended family, many of whom live on the same street as Tafida and her parents. The parents are committed Muslims and were raising Tafida in the Islamic religious tradition. The applications before the court concerning Tafida arise in what all parties acknowledge is a truly mournful situation. The brevity with which the genesis of that situation can be stated articulates starkly the sudden and devastating manner in which it arose early on the morning of 9 February 2019.

8. Prior to that date, Tafida was a happy, joyful little girl, as is so evident from the description of her provided to me by her parents and relatives and in the videos of Tafida I have seen from before February 2019. She was the helping hand monitor in

her class, her favourite film was 'Frozen', she attended ballet lessons and she was always running everywhere. She was bilingual in English and Bengali, had learnt some verses from the Quran and was due to attend Arabic classes in September 2019. She had already, at her young age, travelled widely across the world. At approximately 5.15am on 9 February Tafida woke her mother and complained of a headache. Shortly afterwards Tafida stopped breathing. The mother immediately summoned an ambulance, which arrived promptly and conveyed Tafida to Newham University Hospital. Examination revealed a large blood clot on Tafida's brain considered to be life threatening and requiring urgent surgical intervention. Some three hours later an operation was carried out at Kings College Hospital. The cause of the bleeding in Tafida's brain was identified as a ruptured arteriovenous malformation (hereafter AVM). This is a rare condition and was undetected and asymptomatic in Tafida. The ruptured AVM has resulted in extensive and irreversible damage to Tafida's brain.

9. Following surgery on 9 February 2019 Tafida was treated in the paediatric intensive care unit of Kings College Hospital for nearly two months before being transferred to the Royal London Hospital on 3 April 2019. I pause to note that in his report of 10 July 2019, Dr H, paediatric neurologist from Kings College Hospital, states as follows (emphasis added):

> "At the nadir of her illness in March 2019, myself, Mr Z and Dr S, consultant in paediatric intensive care and PICU senior nurses jointly spoke to the parents and counselled them that Tafida was extremely unlikely to survive her illness and that if she did she would be profoundly disabled and ventilator dependent, needing permanent intensive care inputs for a short few months ahead. We recommended that Tafida's care was redirected to palliative care and that she was not given invasive treatment inputs that would of no benefit to her on futility grounds. Parents could not bring themselves to withdrawal of treatment *under any circumstances*. They wanted all active treatments for her."

10. Save for a short period of further treatment at Kings College Hospital between 12 and 25 April 2019 to deal with a build-up of fluid on Tafida's brain, Tafida has remained at the Royal London Hospital to date. She is provided with artificial ventilation, which artificial ventilation is keeping her alive. Tafida's mother has demonstrated unerring and conscientious dedication to her care during this time, giving up her career as a solicitor and remaining in the hospital to meet Tafida's day to day care needs, assisted at times by the father, Tafida's nanny and members of the extended family. Whilst there is a dispute about whether a further cerebral insult occurred between 2 and 10 June 2019, which dispute it is not necessary for the court to determine for the purposes of these twin proceedings, all parties accept that Tafida has been left with catastrophic damage to her brain.

11. Within this tragic context, two key issues of fact came into focus during the course of submissions. First, whether the parents at any point prior to this hearing consented to the withdrawal of life sustaining treatment from Tafida (the Trust contending that this question is relevant to the courts assessment of the weight to be accorded to the strength of the religious objections to the withdrawal of treatment in this case). Second, the precise nature of the decision made by the Trust in relation to the question of whether Tafida could be transferred to the Gaslini Hospital in Italy. Whilst the

submissions on each of these issues were extensive, each issue can be dealt with shortly.

12. In relation to the question of whether at any point consented to the withdrawal of life sustaining treatment from Tafida, the answer is plainly 'no' on the Trust's own evidence. In her statement, Dr D, Tafida's treating paediatric intensivist, makes clear that "The family never consented to the withdrawal of treatment and of course we never acted without parental consent." Within the documentation before the court, there is clear evidence that the mother in particular, but also the father stated on more than one occasion that the active withdrawal of treatment from Tafida was against their personal and religious beliefs. There is evidence that in late June 2019 the mother in particular was struggling with the question of the right course of action and agreed that should Tafida deteriorate *whilst on life support*, she should not be resuscitated. However, as Dr D makes clear in her evidence, at no point does the evidence suggest that the parents consented to the withdrawal of the life-sustaining treatment itself. Within this context, I am also satisfied that there was never a point where the Trust intended to withdraw treatment from Tafida without her parents' consent. Within the context of conversations taking place with the parents in late June, and the treating teams firm view that continued life sustaining treatment was not in Tafida's interests, it is apparent that at one point the doctors believed they had reached a consensus with the parents and a date for the withdrawal of treatment was set subject to the outcome of the parents' enquiries of other hospitals. Once again however, it is clear that the parents at no point gave their informed consent and the plans were, accordingly, never enacted. In any event, matters were subsequently overtaken by the outcome of parental enquiries of the Gaslini Hospital.

13. In light of the firm medical opinions being expressed by the treating team in London, the parents commenced contact with a number of hospitals around the world, to see whether they would be in a position to assist Tafida. As part of this process they contacted a team of doctors from the Gaslini Paediatric Hospital in Genoa, Italy (in which hospital the child of a family friend of the parents was being treated). By 5 July 2019 the parents had obtained, and the Gaslini had been provided with, a complete set of medical records for Tafida. The team from the Gaslini Hospital who considered Tafida's case comprised Dr Armando Cama, Professor of Paediatric Neurosurgery, Dr Carlo Minetti, Professor of Child Neurology, Dr Luca Ramenghi, Honorary Professor of Neonatology and Dr Andrea Rossi, Honorary Professor of Neuroradiology. Following the receipt of the report dated 6 July 2019 from these doctors, and in circumstances where the opinion of the experts from the Gaslini Hospital did not state that they believed that Tafida should have all medical care removed, on 7 July 2019 the parents made a request to the Dr Paolo Petralia, Director-General of the Gaslini Hospital, to transfer Tafida from the Royal London Hospital to the Gaslini Hospital for care and treatment. By a letter to the parents dated 7 July 2019, Dr Petralia accepted this request subject to the parents being responsible for all costs associated with Tafida's transfer to and treatment at the Gaslini Hospital.

14. Once again, whilst during the course of submissions the precise nature of the decision made by the Trust in response to the parents' request for the transfer of Tafida to Italy was the subject of some dispute, the position is, again, tolerably clear on the documentary evidence before the court. It is plain from an email sent by the mother on 7 July 2019 to Dr D that on that date that the parents requested that the treating

team in London agree to the transfer of Tafida to the Gaslini Hospital. In her statement of 6 September 2019, Dr D confirmed that she understood the mother, by her email of 7 July 2019, to be asking for this once the necessary transfer arrangements had been put in place. It is further clear from the documentary evidence before the court that by 8 July 2019 the treating team had indicated to the parents that they would *not* agree to the transfer of Tafida to the Gaslini hospital because, in circumstances where the treating team considered that such a transfer would not be in Tafida's best interests, and hence there was a dispute as to best interests between the parents and the doctors, the court would have to decide that issue.

15. On 12 July 2019 two further clinicians from the Gaslini Hospital, Professor Lino Nobili, Chief of Paediatric Neurology and Paediatric Psychiatry at the Gaslini Hospital, and Andrea Moscatelli, Honorary Professor of Paediatric Intensive Care, examined Tafida via a video-link arranged by the Royal London Hospital. Exhibited to Dr D's statement is a record of this video-link which records as follows:

> "The team at Gaslini were asked the purpose of accepting the parents (*sic*) request to take over the care of Tafida. Based on the assessment they were able to make from the documentation sent to them by RLH, they thought it was highly unlikely that they could do anything to treat Tafida and lead to an improvement. They explained however that they would be able to offer palliative care, which would consist of ensuring Tafida was comfortable and not suffering. It may also entail performing a tracheostomy, so that Tafida could go home on long-term ventilation. As Tafida does not fulfil the criteria for brain-stem death, Italian law does not allow active withdrawal of care. The parents had no further questions. Following the call with the Gaslini team, the parents said they would reflect on this, discuss with family and give us their views at a meeting on Monday 15 July."

16. On 15 July 2019, following the examination by the clinical team at the Gaslini Hospital, that team confirmed as follows in a letter to Tafida's parents which is contained in the bundle:

> "This letter aims to corroborate all the points discussed during our video conference last Friday, from 1.30 to 2.30pm, Italian time and the previous email correspondence. We confirm we can take care of Tafida Raqeeb including potential palliative care and without any limitation of length of staying. We also add under Italian laws Tafida does not fulfil the criteria for active withdrawal of care as she cannot be judged as "brain dead".
>
> We have already given our clinical judgment based on the exhaustive clinical documents received from London, nevertheless we cannot exclude that in order to get the best standard of care for Tafida may receive tracheostomy and gastrostomy once Tafida will be under our clinical responsibility. Having consulted the full medical records again, discussed her condition with her treating clinicians and observed the patient's conditions by video link, we can confirm that such transportation can be effected safely without undue risk to the patient as we can guarantee during transport the same level of care that Tafida is currently undergoing in the

> PICU. In conclusion, although we may be not able to cure Tafida, we will take care of her to the best of our abilities."

Within this context, the parents continued to seek Tafeeda's transfer to Italy. On 19 July 2019 the Gaslini Hospital provided a detailed "Transport Plan" for Tafida detailing the Gaslini Critical Care ECMO and Transport Team's proposals for conveying Tafida to the Gaslini Hospital and the medical care that will be made available to her on arrival at that institution, which plan, as I have noted, Dr Playfor considers appropriate. The parents have secured private funding for Tafida's transfer to, and continued treatment at the Gaslini Hospital. It became clear during the course of submissions that the parents will, if it proves possible to move Tafida to a position where she can be maintained on ventilation at home, contemplate a return to this jurisdiction with Tafida in order to care for her at home with family support.

17. As noted above, this court has also had additional documentation in the form of a *fatwa* from the Muslim Council of Europe, a legal opinion on authored by Dr Giacomo Rocchi provided in his capacity as an acknowledge expert in Italy on issues of the type with which this court is concerned and a written representation from the Bangladesh High Commissioner to the United Kingdom. No party has sought to press during this hearing the representations from the Bangladesh High Commissioner, in part because it remains unclear whether they are yet in their final form. The essential thrust of the representations is that any Bangladeshi national, including doctors, who consented to, or participated in the withdrawal of treatment from Tafida would be guilty of a criminal offence under the law of Bangladesh and liable to prosecution in that jurisdiction. Whilst grateful to the High Commissioner for this information, I have not held it necessary to investigate these matters further or to place reliance on them in reaching my decision.

THE MEDICAL POSITION

18. In this case the court has the following medical opinions and evidence on Tafida's medical condition and prognosis:

    i) A report dated 1 July 2019 from Dr T, Tafida's treating consultant paediatric neurologist at the Royal London Hospital.

    ii) A report dated 10 July 2019 from Dr H, Tafida's treating paediatric neurologist at Kings College Hospital.

    iii) A report secured by the parents dated 20 August 2019 from Dr Andrea Moscatelli, anaesthesiologist and intensivist paediatrician, Professor Lino Nobili, Professor of Child Neuropsychiatry and Dr Michele Torre, paediatric surgeon, each of the Gaslini Hospital.

    iv) A report dated 21 August 2019 secured by the Litigation Friend in the judicial review proceedings from Dr Stephen Playfor, consultant paediatric intensivist at the Royal Manchester Children's Hospital dealing with the question of transfer.

    v) A report dated 30 August 2019 secured by the Trust from Dr Martin Smith, consultant in paediatric neurology at the Oxford John Radcliffe Hospital.

vi) A note of the experts meeting that took place on 6 September 2019 between Dr D, Dr Martin Smith, Dr Stephen Playfor and Professor Lino Nobilli.

vii) A supplementary medical report dated 8 September 2019 secured by the Litigation Friend in the judicial review proceedings from Dr Stephen Playfor dealing with the question of medical best interests.

Tafida's Overall Medical Condition

19. With respect to Tafida's medical condition, there is no dispute that on 9 February 2019 she suffered a catastrophic rupture of a previously undetected and asymptomatic congenital AVM, resulting in a bleed into the right side of her posterior fossa, causing brain stem compression, displacement of the midline structures of the brain and obstruction in the flow of cerebrospinal fluid. As I have noted, whilst their remains a dispute as to whether Tafida suffered the totality of the damage to her brain on 9 February 2019, or sustained further damage at a point thereafter between 2 and 10 June 2019, it is common ground that the hypoxic ischaemic damage now extends to her right cerebellar hemisphere, vermis, two thirds of her left cerebellar hemisphere, her cerebellar peduncles, midbrain, pons, nearly one third of the medulla, the fronto-parietal, temporal and occipital lobes, caudate nuclei and globus pallidi. No party seeks to dispute that the proposition that, as a result, Tafida has extensive disabilities. Dr Smith considers Tafida's condition to be exceptionally complex.

20. During his examination, Dr Smith was able to elicit ongoing breathing effort by Tafida without mechanical ventilation for a period of 10 minutes maintaining good oxygen saturations but with instances of pauses of nearly 40 seconds, associated with a slowing of her heart rate, a rise in her end tidal CO_2 levels without change in her respiratory rate. The Italian doctors state that, subject to further assessment, they are and were comfortable with an assumption that the motor neurones are activating the respiratory muscles. However, whilst Tafida has regained some breathing after the initial cerebral insult, the consensus of medical opinion is that this is currently insufficient by itself to sustain her breathing independent of the ventilator and she remains ventilator dependent. Tafida does not exhibit episodes of pronounced muscle spasm although she has episodes believed to be epileptic in nature and treated with Levetiracetam. Within this context, it is agreed between the doctors that Tafida is otherwise medically stable.

Level of Awareness

21. With respect to current level of awareness, on 27 June 2019 an EEG demonstrated very severe generalised cerebral dysfunction with no reactivity to external stimulation. Somatosensory evoked potentials the same date showed response in the cervical region to stimulation of the median nerve, but no cortical response. On 1 July 2019 Dr T reported that on neurological examination Tafida had a sleep/wake cycle with eye opening and closing. Dr T reported no brainstem function save for pupillary response and some breathing drive. In their report of 20 August 2019 the Italian team consider that Tafida has a severe alteration in her state of consciousness, that they were unable to verify the parents' reports of motor responses related to verbal stimuli and nor could they themselves elicit any responses that could be unequivocally be interpreted as awareness, although they did note that Tafida opened her eyes spontaneously several times, that her eyes could sometimes be maintained

fixed in axis and she had a direct and consensual pupillary light reflex. Dr Smith concludes that during his assessment he noted no signs of volitional spontaneous movement in Tafida's arms and legs but noted a video (also shown to the court) where Tafida appeared to life her arm and turn it outwards to place rolled up bandage into the hand of her nanny. Dr Smith could identify no evidence of visual function, although in respect of Tafida's "doll's eye response", the absence of which is one of the features of brain stem death, Dr Smith considered the results to be equivocal, he not being confident that a response was entirely absent. With respect to awareness of touch and of voices, Dr Smith records as follows:

> "36. I asked mother to stimulate Tafida by voice and touch whilst positioned on her left side. It appeared to me that Tafida's eyes slowly moved to the left side. I then asked mother to move to the opposite side of the bed and repeat the exercise. Once again it appeared to me that Tafida's eyes moved to the right side where mother was now positioned. Finally I asked mother to return to the left side. On this occasion there was no obvious eye deviation to the left. I repeated this task at the end of the assessment and on the second occasion there was no convincing response in terms of eye deviation to stimulation.
>
> 37. If this was a genuine sign of responsiveness, my instinct is that Tafida was responding to her mother's voice and touch, but was probably not visually aware of her mother."

22. Within the foregoing context, there is a consensus of medical opinion that if Tafida is aware, she is minimally so. During the meeting of doctors on 6 September 2019 Dr D stated that she is "reasonably certain she has no or minimal awareness". At the same meeting Professor Nobili stated they were not able to detect any level of awareness but cannot exclude the possibility of some level of conscious awareness. Dr Playfor considered he had seen no convincing evidence of awareness. Dr Smith repeated the view as set out in his report in which, having noted that distinguishing between a vegetative state (VS) and a minimally conscious state (MCS) is very challenging and, in children, most paediatric neurologists do not attempt the distinction in routine practice, he concludes as follows:

> "54. It is very difficult to accurately state whether Tafida is in a vegetative state or a minimally conscious state. I would be very wary of the risk of misinterpreting the absence of responses in Tafida as VS because of the inevitable limitations on the accuracy with which medical science is able to test for awareness in a child like Tafida who has no useful vision, no speech, impaired or no pain sensation and a sever movement disorder."

And, within this context, and in common with the clinicians at the Gaslini Hospital:

> "59. Bearing in mind the limitations of medical science in assessing and categorising between VS and MCS, I am inclined to adopt the approach advocated by Wade (2017), that the distinction between VS and MCS is somewhat artificial. Whilst I feel Tafida's condition is consistent with VS, I am reluctant to exclude the possibility of some minimal awareness."

Tafida's Ability to Feel Pain

23. With respect to Tafida's ability to feel pain in the context of the possibility that she retains some minimal awareness, in early July 2019 Dr T reported that Tafida "flexes to pain". In his report on 10 July 2019 Dr H relates that Tafida shows no facial grimace to deep pain and does not cough or gag to endotracheal tube suction. On examination, the Italian team likewise noted no facial grimace to pain and only intense pain stimulation elicited flexion of the legs or arms, further noting that no EEG changes after painful stimulation are visible. Within this context, the Italian team concluded that:

> "Tafida does not seem to perceive pain in her resting state and reacts only to intense painful stimulations with flexion. The suggests she feels no pain under her standard condition."

24. In the meeting of doctors held on 6 September 2019 Dr D stated she had not seen a response to pain such as in increase in heart rate or a facial grimace or withdrawal from pain. Dr Smith concurred, having stated in his report as follows:

> "79. Tafida's experience or lack of experience, of pain has to be considered. Accurate and reliable assessment of ability to experience pain, like assessment of awareness, is fraught with difficulty in a patient as severely neurologically impaired as Tafida. We cannot ask her, she cannot speak or communicated, and her ability to move is so impaired that it is difficult to interpret any movement she may make, or an absence of movement, after the application of a stimulus that would cause pain in a child not neurologically impaired. The absent SSEP responses suggest that sensory information from the rest of the body is not perceived within the sensory processing areas of the brain, although this test does not necessarily imply total absence of the ability to feel pain.
>
> 80. There is no evidence that Tafida's everyday life causes her pain. I have not seen any evidence to suggest to me that she does experience pain in painful stimulus is applied. However, as to both her everyday life and response to stimulus it is impossible to prove a negative, and in the same way I cannot exclude some limited awareness I cannot exclude the ability to perceive some pain. It may be that her brain stem damage protects painful stimuli connecting to higher cortical centres that are in any event so damaged that pain could not be experienced in a conventional sense event if the brain stem was intact, but because of the difficulties of testing and interpretation, it is difficult reliably to say more."

Future Options for Treatment and Care

25. With respect to future treatment and care options, there is agreement between all doctors, including the team from the Gaslini Hospital, that Tafida will not substantially recover and cannot, accordingly, be "cured". Within this context, there is consensus that any continued medical intervention will be aimed at sustaining Tafida's life in or very near to her current condition. Two key issues emerge from the medical evidence in this context.

26. First, the question of whether it will, ultimately, be possible to wean Tafida off mechanical ventilation. Whilst there is consensus that Tafida is currently unable to breath without mechanical support, and the doctors in this jurisdiction are sceptical that this position will ever change, the Italian doctors consider that the question of whether Tafida could be weaned off a ventilator following a tracheostomy requires further, detailed evaluation.

27. Second, the question of whether, even if she is required to remain on mechanical ventilation, Tafida could return, and be cared for at home. In this respect the Italian doctors commented in their report on 20 August 2019 that "a possible scenario is to discharge her at home on mechanical ventilation with a tracheostomy, since she is not oxygen dependent" if this was ultimately assessed to be proportionate to her clinical status. They went on to observe that:

> "Tracheostomy could be managed safely at home by well trained family caregivers. In our experience, we have been following plenty of tracheostomised children cared at home by parents with no major accidents (life threatening). The same experience is reported in the medical literature. There are risks related to the management of a child with tracheostomy at home (e.g. obstruction, displacement of the tracheostomy tube) that should be taken into consideration and must be overweighted by the benefits given by the tracheostomy itself. In the case of Tafida, the tracheostomy could be life sustaining, because of the tendency of airway obstruction. Our centre, being the site of tracheal team, is used to train parents to tracheostomy management at home".

28. In their report dated 20 August 2019 the Italian team complete a comprehensive risk analysis regarding a tracheostomy and conclude that the risks are well known and do not contraindicate the procedure in Tafida, albeit they recognise that there is an ethical component in that:

> "Tracheostomy imposes a relevant burden to the family, since a trained caregiver should always look after Tafida 24/7. The life expectancy of Tafida would increase, even if withdrawal of care could always be possible, if indicated, through weaning from mechanical ventilation, and appropriate sedation."

The Italian team also consider that a gastrostomy would be advantageous and that a PEG would improve Tafida's quality of life. Within the foregoing context, in the meeting of doctors on 6 September 2019, Dr D expressed herself to be reasonably confident that, with a care package and training, Tafida will be able to go home. Professor Nobili agreed, as did Dr Playfor and Dr Smith.

29. Within this context I pause to note that, during the course of submissions, the approach to the treatment of other children in this jurisdiction in a similar situation to Tafida was raised in circumstances where both Dr Playfor and Dr Smith deal with that issue in their respective reports. A degree of caution is required in respect of these submissions as the court does not have precise details of the conditions of other such children. However, in his unchallenged report dated 21 August 2019, Dr Playfor notes, in the context of observing that PICU has transitioned from a speciality that

deals with acute illness in the mostly previously well, to one that is part of a multidisciplinary team that cares for children with chronic illness, as follows:

> "[3.10] With these changes, and with the increase in numbers of children dependent on technology to survive living at home, there has been a steady increase in the proportion of children admitted to PICU for whom the clinical team consider treatment to be inappropriate.
>
> [3.11] To give the court some perspective of TR's neurological status in the context of current PICU practice: In a PICU the size of the Royal Manchester Children's Hospital unit, a child in a clinical condition broadly similar to TR will be admitted for mechanical ventilation at least once every 3 or 4 months. Such children will typically be supported on some form of long-term ventilatory support either at home or in another part of the hospital and suffer an acute deterioration, most commonly pneumonia. In the majority of cases these children will recover to their baseline status and be discharged from PICU to another ward, or home, without the issue of withdrawal of life-sustaining therapy being addressed.
>
> [3.12] There is no practical reason evident why TR could not be managed at home on long-term ventilatory support assuming the necessary pre-conditions can be satisfied.
>
> [3.13] Although no specific data have been published, in my experience, given the increased duration of admission associated with complex chronic disorders, on any given day there will be several children in a clinical condition broadly similar to TR being mechanically ventilated in UK PICUs."

Dr Smith agrees with Dr Playfor's observation that there are other children in most other UK centres with severe neurodisability maintained on long term ventilation at home. Likewise, in her statement of 30 August 2019, Dr D says as follows with respect to Dr Playfor's observations in this regard:

> "I agree with him that there are children with a similar level of damage to Tafida whose lives are sustained long term sometimes in hospital and sometimes at home, sometimes on a tracheostomy alone and sometimes on a tracheostomy plus a ventilator and that sometimes the issue of whether continued treatment is in a child's best interests has not been considered. This can happen for lots of different reasons and in my experience, can sometimes depend on how the injury arose. Whether it is right that there is no consideration of whether more treatment is right for the child is debateable. I have tried to focus on Tafida".

30. Finally in respect of options for future medical care, there is no dispute that, should the court consider that it is in her best interests, the transfer of Tafida to Italy can be effected with minimum risk. In his report considering the efficacy of the proposed transfer, Dr Playfor concludes that the 'Transport Plan' proposed by the Gaslini Hospital in one that is entirely reasonable and that the proposed transfer of Tafida to the Gaslini Hospital is "extremely unlikely to have any medical or welfare impact" on Tafida.

Prognosis

31. With respect to prognosis, as I have noted above, there is no dispute that the catastrophic rupture of the AVM on 9 February 2019 resulted in hypoxic ischaemia that has caused irreversible damage to Tafida's brain. All the doctors concur however that, if maintained on mechanical ventilation, Tafida will live, as Dr Smith puts it, for a substantial period of time. The temporal range given by the medical professionals being between ten and twenty years.

32. Within this context, as to the chances of their being an improvement in Tafida's level of neurological functioning, Dr Smith concludes in his report that:

> "61. It is certainly possible that Tafida could show some small improvements over time if she remains alive. As discussed above, the adult literature contains examples of late improvement from VS and MCS, although almost without exception these individuals were still left with severe neurodisability. The adult literature also emphasises the distinction between traumatic and non-traumatic mechanisms of brain injury, the former having the possibility of some recovery of consciousness for as long as 12 months, whereas the latter are unlikely to improve substantially after 3 months. Tafida's injuries are non-traumatic, and therefore the adult literature would suggest the chances of any substantial improvement at this stage is very small."

And, in the context of considering the concept of brain plasticity:

> "Therefore, whilst the concept of neuroplasticity is entirely valid, the said reality is that the chance of substantial recovery is unfortunately very slim, and there can be no reasonable doubt that Tafida will remain with severe neurodisability for the remainder of her life."

33. Within this context, in the meeting of doctors on 6 September 2019 Dr Smith stated as follows:

> "I am not a dogmatic physician and prefer not to box myself in with absolute statements where possible, but for the purposes of this situation, I have to be as clear as possible that, whilst a further 12 months might see some slight changes, it would nevertheless leave Tafida with a profound neurodisability. I do not consider a further 12 months will transform her situation in any meaningful way which will improve her quality of life."

At the meeting on 6 September 2019, Dr D considered it "incredibly unlikely" that Tafida's neurological function would improve. Professor Nobili considered that there is a "very, very low possibility" of Tafida improving neurologically. Professor Nobili said he could not exclude the recovery of some awareness. Whilst Professor Nobili could not say whether this would be better for Tafida or not, having heard Dr Smith's view, he stated that any change could not be considered as an improvement given the severity of her clinical situation. Dr Playfor stated that, if pressed, he would say Tafida's neurological function will change but not in a way that could be described as an improvement.

34. The question raised by Professor Nobili and Dr Playfor as to whether any change in awareness would be an improvement arises in the context of a further aspect of Tafida's prognosis that is the subject of medical consensus, namely the development of conditions that, were she to develop a greater level of awareness could be burdensome to her. In addition to the continuation of a severe movement disorder and immobility comprising combination of spasticity and dystonia and severe cognitive impairment, those conditions will likely include drug resistant epilepsy, scoliosis with associated cardio-respiratory impairment, which may require surgery, partial or full hip dislocation, pneumonia with worsening respiratory failure, bone disease due to osteopaenia associated with pathological fractures, the development of renal stones, pressure sores, hypertension and malignancy.

Medical Best Interests

35. Tafida's treating doctors are now clear in their opinion that further life-sustaining treatment is not in Tafida's best interests. Dr D considers that such treatment "is a continuing burden for Tafida" and should be discontinued and Tafida palliated. Dr H is of the view that the proposition that because Tafida does not feel pain or distress further treatment will not cause pain or distress is an "artificial semantic construct" as *if* she had a "sentient" brain she would feel pain and distress and considers that she should be allowed "the dignity of dying peacefully."

36. With respect to the experts instructed in this matter, Dr Smith recognises that the legal concept of Tafida's best interests is wider than medical considerations and that that is an issue for the court to decide. Within this context, he states that:

> "After very careful and lengthy consideration and reflection, and with a heavy heart having personally observed and been affected by the devotion of her parents, I have come to the conclusion that the only medical benefit that continued ventilation (whether with or without a tracheostomy) could provide Tafida is the continuation of life. I think any chance of regaining any level of awareness or increased awareness is negligible. With awareness or greater awareness would come awareness of the burdens of her severe neurodisability and these will only increase if ventilation continues."

37. Dr Playfor considers the burdens of ongoing mechanical ventilation, if present at all, are currently modest. However, in light of a lack of convincing evidence that Tafida has any awareness and therefore lacks the ability to derive benefit from continued life, Dr Playfor considers that Tafida's clinical situation meets the RCPCH criteria under which withdrawal of life-sustaining treatment may be ethically permissible. Within this context, Dr Playfor considers that ongoing life sustaining treatment is not in Tafida's best interests, primarily because it is difficult or impossible for her to derive benefit from continued life.

38. The Italian team take, within the framework of Italian law and the ethical framework they apply, the following view regarding the question of best interests:

> "In this ethical and normative frame, the clinical picture of Tafida could not be completely defined. Even if Tafida's brain damage is extensive and irreversible to a great extent, according to recent guidelines, precise

> prognostication after severe brain injury might require up to one year from the acute event in adults. Disorders of consciousness lasting longer than 1 month post injury may still attain functionally significant recovery after 1 year post injury. The natural history and prognosis of children with prolonged disorders of consciousness is not well-defined, with a greater uncertainty about definitive outcome compared to adults. Parents feel that Tafida is occasionally respondent to their stimulation and still hope for possible improvement. Withdrawing care at this stage seems to them unacceptable. Tafida does not seem to respond to pain, if not to very deep stimulation, and she is cared for by parents with extreme dignity and compassion. As suggested by recent guidelines, in case of uncertainty about prognosis and different positions between caring physicians and family, we wonder if it might be advisable to give Tafida more time. Provisional intensive care could be continued until a better prognostic definition is achieved, allowing the development of a plan of care tailored to Tafida's definitive clinical condition. Such plan could include, if appropriate, palliation and end of life care. This approach might also facilitate acceptance and elaboration of grief by the family. Tracheostomy and gastrostomy could be careful taken into consideration to improve Tafida's quality of life, aiming at home care for chronic respiratory support or palliative care, according to her definitive neurological outcome. Tracheostomy should not exclude an eventual future withdrawal of care by weaning of mechanical ventilation, with the necessary sedation to alleviate discomfort. A better prognostic definition might require serial standardised neurological and neurophysiological evaluations in addition to MRI functional studies. With the available date, we do not foresee any specific therapies which might contribute to improve Tafida's neurological outcome other than standard support of vital functions and homeostasis. We will be honoured to take care of Tafida at the best of our professionalism and compassion. Treatments deemed to be disproportionate according to Italian laws, the Italian physician's ethics code, and the available national and international guidelines will be avoided."

The Views of the Parents

39. Finally, and importantly, the court has the views of the parents as to Tafida's current medical condition, level of progress they contend she has made to date and what they contend would be Tafida's wishes and feelings regarding her current situation. In considering and weighing this evidence, the court must have regard *both* to the fact that the parents spend a great deal of time with Tafida *and* the fact that, for parents, the flattering voice of hope can, in cases of this nature and entirely understandably, provide a distorting lens through which the child's presentation is viewed by those who love her.

40. The parents have provided the court with a memory stick containing a series of video clips that they submit demonstrate examples of Tafida's progress and level of awareness. In oral evidence, the mother did not accept the doctors assessment of the latter and considers that Tafida is aware to an extent, and in particular is aware the presence of her parents and family. Within this context, the parents contend that Tafida has defied her initial fatal prognosis, is in a serious but stable condition,

continues to improve on a daily basis and make the following points in their written and in the mother's measured and dignified oral evidence:

i) Following the initial insult, and medical advice that Tafida would die imminently, she started making small but definite progress, opening her eyes and moving her limbs. She has a sleep/wake cycle;

ii) Tafida has demonstrated a level of ability to control urinary functions for a period of time;

iii) Tafida now tries to come forward when her parents sit her up in bed, and moves her head from side to side in response to touch and voice (as also witnessed on one occasion by Dr Smith), which she was not previously doing (in her report the Children's Guardian records witnessing the mother asking Tafida to raise her arm and that Tafida moved her arm, although the Guardian could not say for certain this was in response to her mother's request);

iv) Tafida stretches her feet, legs and whole body when her splint boots are removed and in response to physiotherapy;

v) Tafida removes her hands from under the covers and flings them behind her head, which she was not doing previously;

vi) Tafida reacts to painful stimuli but shows no sign of pain or distress in her resting state.

vii) Tafida "knows" that her mother is present and wakes to her mother's voice.

41. Finally, and importantly, as to Tafida's wishes and feelings were she to be able to express a view on the issues that fall to be decided by this court, in her oral evidence the mother stated that prior to her injury Tafida demonstrated herself to greatly value all life, reiterating a story of Tafida becoming upset at the death of a ladybird and of a goldfish, and of Tafida's gentle, accepting and non-judgmental approach to another child with serious disabilities.

42. Whilst the mother was measured in her evidence regarding Tafida's conception of religion and its consequences (conceding of her own volition, for example, that Tafida is too young to have developed an understanding of end of life issues), she also emphasised the fact that Tafida had begun to follow Islamic practices, showing the court a video of Tafida with her small prayer mat, encouraging her brother to come and pray with her. Within this context, the mother contended that Tafida had a clear understanding that "if you kill or do harm you will be in trouble with Allah" and that Tafida would wish to live whatever life is left to her notwithstanding her current condition. In emotional testimony, the mother also contended that Tafida would ask the court why she is being treated differently to other children in her position in this country who are maintained at home on ventilation.

SUBMISSIONS

Application for Judicial Review

(i) Claimant and Interested Parties

43. It is convenient to deal in summary with the submissions in the judicial review on behalf of Tafida as Claimant, by Mr Sachdeva, and on behalf of the parents as interested parties, by Mr Lock, together, as they advance, essentially, the same case.

44. Tafida and her parents submit that it is plain on the evidence that the Trust made a decision to refuse to permit Tafida to be transferred to the Gaslini Hospital, relying on the Trusts own summary of a discussion with the parents on 8 July 2017 which records Dr D as saying that taking Tafida to Italy would not be possible, which account Dr D confirms in her statement of evidence. Tafida and her parents further rely on the report of a meeting with the parents on 10 July 2019 at which Dr F is recorded as stating "we could not allow the transfer of Tafida as we do not believe it is in [Tafida's] best interests." Tafida and her parents contend that the Trust took the decision it did not on the basis of Tafida's best interests, but rather by reason of the philosophical or ethical differences as between England and Italy regarding best interests decisions concerning continued provision of medical treatment and the fact that Tafida is an English national.

45. In the context of the Trust contending otherwise, Tafida and her parents further submit that the decision of the Trust to refuse to permit Tafida to be transferred to the Gaslini Hospital is a decision amenable to judicial review in circumstances where the Trust is a public body and exercises its public functions under the National Health Service Act 2006, and where the NHS Constitution stipulates that patients have the right to challenge NHS decisions by way of judicial review.

46. As to the lawfulness of the decision, Tafida and her parents submit that as a citizen of the United Kingdom and, therefore a citizen of the EU, Tafida enjoys the full benefit of EU free movement rights and, accordingly the rights Art 56 of the Treaty for the Functioning of the European Union (hereafter TFEU) relating to the provision and receipt of services. Mr Lock also made comprehensive and helpful submissions regarding the impact in this case of the right to freedom of movement under Art 21 of TFEU. I am satisfied however, in the context of this case being, at its heart, about the provision and receipt of services in the form of medical treatment, that it is Tafida's EU rights under Art 56 of TFEU that fall to be considered and it on those rights that I shall concentrate when dealing with the claim for judicial review.

47. Within this context, Mr Sachdeva and Mr Lock contend that the corollary of the freedom to provide services enshrined in Art 56 TFEU is the freedom to *receive* those services in another Member State. Within this context, Tafida and her parents further submit that the provision of intensive care, palliative care and end of life care by a hospital in another EU Member State constitute services for the purposes of Art 56 of TFEU read with EU Directive 2011/24. In this context, Tafida and her parents submit that choice of provider of medical services is a function of parental responsibility and that, where a parent makes a choice for their child to be treated at a particular medical institution in the EU in accordance with orthodox medical practice, the choice made

by parents on behalf of a child who is too young, or otherwise unable to make a decision for herself constitutes an exercise of the child's directly effective EU rights.

48. Accordingly, Tafida and her parents further submit that, where a child has a right under Art 56 to receive healthcare services in another Member State as a function of her EU rights, public authorities in this jurisdiction may not restrict the right to receive such services *unless* there an imperative public policy reason for the purposes of Art 52 of TFEU read with Art 24 of the EU Charter of Fundamental Rights (hereafter the CFR). Within this context, Tafida and her parents submit that the NHS Trust should have recognised that its decision to refuse to permit Tafida's transfer to the Gaslini Hospital interfered with Tafida's right to receive services under Art 56 of TFEU. Further, having regard to Art 52 of TFEU read with Art 24 of the CFR, Tafida and her parents submit that the Trust should then have asked itself whether, having regard to Tafida's best interests as a primary consideration, that interference amounted to a proportionate public policy justification under Art 52 of TFEU such that the Trust was justified in refusing to comply with the instruction of Tafida's parents given in the exercise of their parental responsibility. Tafida and the parents further submit in this context that where, having undertaken this analysis, an NHS Trust objects to a transfer request by parents, that Trust is bound to apply to the court for injunctive relief to provide a proper legal basis for the continued interference in the Art 56 rights that the objection constitutes by demonstrating to the court that the decision is justified by reference to Art 52.

49. Within this framework, Tafida and her parents submit that not only was this analytical process not followed by the Trust in reaching its decision, the Trust failed to consider Tafida's rights under Art 56 of TFEU *at all* when reaching its decision. In the circumstances where this is accepted by the Trust, Tafida and her parents submit that the Trust's decision *must* be held to have been unlawful on public law principles.

50. Further, Tafida and her parents submit that, even had it considered Tafida's EU rights, the Trust could not in this case have discharged the burden of demonstrating that the interference in Tafida's Art 56 rights was justified by a proportionate public policy justification under Art 52 of TFEU. Accordingly, they submit that the decision of the Trust to refuse to permit the parents to transfer Tafida to the care of a specialist medical team in another Member State ready and able to treat her would have been unlawful even had Art 56 been properly considered.

51. As to the contended for absence of a proportionate public policy justification under Art 52 of TFEU, Tafida and her parents submit that in this case, (a) the Trust had determined that it was no longer in a Tafida's best interests to continue life sustaining treatment, (b) a hospital in another EU Member State had agreed to the transfer and continued treatment of the Tafida, (c) the parents had requested such transfer, (d) it was clear that the transfer could be effected without risk to Tafida and (e) no best interests decision had been made by the domestic court. In these circumstances, they submit that there was no basis for asserting a proportionate public policy justification under Art 52 of TFEU for restricting Tafida's EU rights under Art 56 of TFEU and that the Trust was therefore bound to give effect to the child's rights under Art 56 and accede to the parents' request, in the exercise of their parental responsibility, to effect the transfer of Tafida to another EU Member State for continued medical treatment, which would also be consistent with the parents right to change doctors.

52. Further, in circumstances where any justification must be compatible with EU law, Tafida and her parents submit that the decision of the Trust could not have been justified by any philosophical or ethical differences as between EU Member States regarding best interests decisions concerning continued provision of medical treatment, as this would fail to recognise the principles of comity, equivalence and mutual respect that underpin free movement across the EU and would act to prevent Tafida from receiving services that are lawfully available to other EU citizens in another Member State. Nor, it is submitted, could the fact that Tafida was an English national being treated in England be a basis for justification, as underscored by the constitutional right to non-discrimination under Art 18 of TFEU and Art 2 of the EU Charter of Fundamental Rights (hereafter CFR).

53. Finally, Tafida and the parents submit that the fact that there is an extant dispute in this jurisdiction as to Tafida's best interests that the Family Division of the High Court is given jurisdiction to determine pursuant to Art 8 of Council Regulation (EC) 2201/2003 (hereafter BIIa), could also not have amounted to a justification for the decision made by the Trust because (a) EU law takes primacy over UK law, (b) such a situation would be incompatible with the need to establish "overriding reasons of general interest" as required by EU Directive 2011/24, (c) such a situation would be discriminatory as it would apply only to UK nationals and would prioritise a UK approach to best interests over different approaches in other EU Member States and (d) such a situation would impose a substantial obligation on parents to become involved in court proceedings in order to exercise their EU rights.

54. In support of the primary ground of breach of EU rights under Art 56 of TFEU, it is further submitted on behalf of Tafida and her parents that the following further matters further render unlawful the decision of the Trust not to accede to the requested transfer of Tafida to Italy:

i) On behalf of the parents, Mr Lock submits that in making its decision the Trust acted unlawfully for the purposes of the Equality Act 2010 ss 19(1) and 19(2) in adopting an entirely secular, medically based analysis based on the essentially secular RCPCH Guidelines which failed to take any, or any proper account of the parents to manifest their religion pursuant to Art 9 of the ECHR and Art 10 of the CFR by continuing the life of their child. Hence, it is submitted that the Trust discriminated against the parents where the Trust was on notice that the withdrawal of treatment was profoundly against the parents' religious views and preventing the transfer to a country that will care for her in a manner that accords with those views is not a proportionate means of achieving a legitimate aim. Mr Lock further submits that in deciding to refuse the request to transfer Tafida to Italy the Trust also acted unlawfully in that it discriminated against Tafida as compared to a child of Italian nationality in circumstances where the latter would have been returned to Italy by the Trust at the request of his or her parents following initial treatment if he or she fell ill in London, which discrimination was not a proportionate means of achieving a legitimate aim.

ii) Mr Sachdeva submits that the decision of the Trust unlawfully deprived Tafida of her liberty contrary to in Art 5 of the ECHR (right to liberty and security) as read with Art 8 of the ECHR (right to respect for private and family life), Art 9 (right to freedom of thought, conscience and religion) and Art 14 (prohibition of discrimination) in circumstances where her retention in hospital was not for the purposes of keeping her alive but rather to prevent her transfer to Italy, which purpose does not fall within any exception provided by Art 5(1) of the ECHR, and in particular not for the purposes of educational supervision nor bringing her before a competent legal authority. Mr Sachdeva contends that this case is to be distinguished from *R (Ferreira) v HM Senior Coroner for Inner South London* [2018] QB 487 and *Alfie Evans No.2* [2018] 4 WLUK 624.

iii) The parents submit through Mr Lock that in making its decision, the Trust failed to engage in the rights of Tafida and her parents under the NHS constitution. Mr Lock submits that in failing to give serious regard to an acceptable, albeit in the Trust's view not optimal, treatment plan proposed by the parents, offered by the Gaslini and which did not offend against the conscience of the doctors where it was a course accepted by Dr D should the court determine it was in Tafida's best interests, meant that the Trust failed to recognise and consider the NHS Constitution as a factor in its decision to refuse transfer.

55. In the circumstances, Tafida and her parents invite the court to quash as unlawful the decision of the Trust to refuse to comply with the parents request to transfer Tafida to the Gaslini hospital, to grant a mandatory order requiring the Trust to retake the decision or a mandatory order requiring the Trust to permit the transfer of Tafida to the Gaslini Hospital with a declaration that the Trust may not prevent that transfer. As noted above, in this context, Tafida and her parents submit that this court is *functus* in respect of Tafida's wider best interests.

(ii) Defendant Trust

56. In its amended Grounds of Defence, the Trust contended that it had not made a decision to prevent, block or prohibit Tafida's transfer to Italy. However, in its Skeleton Argument, the Trust characterises it decision in slightly different terms. Namely, a decision taken on 8 July 2019 not to agree to the parents request to take Tafida to Italy pending a resolution by the High Court of the question of what medical treatment is and is not in Tafida's best interests; the Trust contending that there is a plain distinction between advising the parents that the hospital would not agree to transfer because it does not consider the transfer to be in the patients best interests and seeking a determination from the court in accordance with the recognised procedure and physically preventing removal of the patient.

57. With respect to whether the decision of the Trust, so characterised, is amenable to judicial review, in its amended Grounds of Defence the Trust contends that it has not made any decision amenable to judicial review because:

i) Where a dispute as to Tafida's best interests had arisen it is well established that it is for the court to determine the issue and not for doctors to impose their opinion on the parents and the child, per *Gard v United Kingdom* (2017) 65 EHRR at [96] and *Evans v Alder Hey Children's NHS Trust* [2018] 4 WLUK 624 at [13], necessitating an application to the court for a decision on whether transfer was in Tafida's best interests, which the court granted the Trust permission to make on 16 July 2019.

ii) The Trust was statutorily obliged to bring the application before the Family Division of the High Court in circumstances where a dispute had arisen between doctors and parents as to the child's best interests, having regard to its obligation under s 11(2) of the Children Act 2004 to safeguard and promote the welfare of children, in the absence of clarity on consent with respect to medical treatment.

iii) An application under s 8 of the Children Act 1989 is the appropriate statutory mechanism by which a public authority may ask the court in the jurisdiction of the child's habitual residence to determine the child's best interests where a dispute has arisen. In making its decision to apply to the Family Division of the High Court the Trust itself exercised no statutory power but rather followed the proper procedure for determining a dispute as to best interests.

iv) The Family Division of the High Court is the plainly appropriate forum for the determination of the best interests dispute and there is no remedy available in the Administrative Court that is not also available in the Family Division.

58. Within the foregoing circumstances, and accepting that Tafida has rights under Art 56 of TFEU to access medical treatment in another EU Member State, the Trust submits there is no right or requirement to an antecedent ruling as to the child's EU rights prior to a best interest decision being made by the court where the issue is not *where* the treatment takes place but whether that treatment is in the child's best interests *per se*. In addition to submitting that the TFEU provides no basis for the claimed right to a procedural ruling on EU rights prior to the court's determination of best interests, the Trust submits that if such a right existed it would act to introduce a threshold before the court could embark on deciding the dispute as to the child's best interests in cases of this nature, a situation expressly deprecated by the Court of Appeal in *Great Ormond Street v Yates and Gard* [2018] 4 WLR 5 at [94]. Within this context, the Trust contends that, once a disagreement as to what is in a child's best interests has coalesced, it is for the court in the EU Member State of the child's habitual residence at the time the court is seised to determine that issue under the jurisdiction conferred by Art 8 of BIIa, without first having to cross any procedural or other threshold for intervention, the child's EU rights falling as one factor for consideration in the best interests evaluation.

59. Further, if Tafida does have the right to an antecedent ruling on her EU rights, the Trust denies that by its decision it imposed restrictions on Tafida's accepted rights under Art 56. In the alternative, the Trust submits that if it has imposed restrictions, the same are justified by a legitimate and proportionate objective, namely the discharge of a requirement to seek a determination from the court as to Tafida's best interests in circumstances where a dispute as those best interests had arisen, per *Gard v UK* (2017) at [96] and *Evans v Alder Hey Children's NHS Trust* [2018] at [13].

60. Within this context, the Trust submits that its actions in declining to agree to Tafida's transfer and applying to court for a best interests declaration were, in circumstances where EU Member States have an area of discretion as to what amounts to public policy, justified by powerful reasons of public interest, namely (a) the public interest in the protection of a child's best interests where the best interests of children are one of the fundamental interests of society and must be taken into account as *at least* a primary consideration in any decision, (b) the equal treatment of all children where a

dispute as to their best interests arises, (c) the public interest in the courts and not doctors determining the outcome of a dispute between parents and doctors as to a child's best interests, (d) the public interest in ensuring that a child has an independent voice in the determination of a dispute between parents and doctors as to the child's best interests, (e) the public interest in doctors having a legally certain route available to them to determine what the law requires of them in cases where there is a dispute as to the child's medical treatment. Accordingly, the Trust submits that the public interest demands that where there is any dispute between a child's doctors and parents regarding whether medical treatment is in a child's best interests that is more than minimal in nature (the Trust contending that the choice between continuing and withdrawing life sustaining treatment constitutes the gravest of disputes) and which they are unable to resolve, that dispute be determined by a court of the child's habitual residence on the basis of the child's best interests broadly construed, pursuant to the jurisdiction conferred by EU law in the form of Art 8 of BIIa.

61. The Trust contends that further support for this submission is derived from the fact that Art 24 of the CFR and Art 3 of the United Nations Convention on the Rights of the Child mandate that Tafida's best interests are treated as a primary consideration. The Trust submits that, in circumstances where Tafida's EU rights are hers and separate to those of her parents, these provisions require that Tafida's best interests are therefore a primary consideration when considering whether any interference in her Art 56 rights is justified, that her best interests are not compartmentalised by separate consideration of travel for treatment and the treatment itself and are not made subordinate to a procedural ruling of the court or other imposed threshold. The Trust also submits that the international instruments mandating the child's best interests be a primary consideration demonstrate further the propriety of it applying to the court for a determination of best interests where a dispute has arisen within a legislative framework that ensures the child's best interests are paramount and contends that to do otherwise would breach Tafida's rights under CFR Art 24 and Art 8 of the ECHR.

62. As to the further grounds relied on by the Claimant and the Interested Parties in the claim for judicial review in support of the contended for breach of Art 56 of TFEU:

i) The Trust denies it has acted in a discriminatory manner by its decision to bring an extant dispute as to a child's best interests before the court as mandated by its domestic and international legal obligations. The Trust submits that that decision was not taken on the grounds of nationality *per se* or on the basis of differences amongst EU Member States in respect of withdrawal of life sustaining treatment. Further, the Trust submits that insofar as Tafida and her parents are alleging unlawful indirect religious discrimination, (a) this court has no jurisdiction to determine a claim of unlawful indirect discrimination by reason of Equality Act 2010 s 114, (b) that in any event Tafida and her parents fail to identify the provision, criterion or practice the Trust is said to have applied in making its decision, (c) that in making its decision all Trust did was to take an individual decision in relation to medical treatment of a specific patient in a specific set of circumstances rather than applying a neutral criteria or rule applied by the Trust to all persons and (d) that, in any event, its decision caused no disadvantage to Tafida by having her best interests considered brought before the court and in so far as it disadvantaged the parents it was proportionate means of protecting Tafida's best interests.

ii) The Trust likewise denies that it has infringed Tafida's Art 5 rights, relying on *Evans v Alder Hey Children's NHS Trust* [2018] 4 WLUK 624 at [12] and *Gard* [2017] 4 WLR 131. Further, the Trust submits that if Tafida's position does constitute an interference with her rights under Art 5(1) of the ECHR, that interference is justified for the purposes of brining Tafida before a competent legal authority for the determination of her best interests, the *Travaux Préparatoires* for the Convention making clear that such exception was intended to cover the detention of a minor prior to civil or administrative proceedings, and that her detention is neither arbitrary nor unjustified but rather to ensure that the court is in a position to determine her best interests. Further, the Trust submits that had it discharged Tafida against her best interests it would itself have been in breach of her ECHR rights, the parents not being able to waive her ECHR rights.

iii) The Trust further submits that is has not contravened the NHS constitution, the legal obligation on the Trust being to have regard to it, with the decision maker being permitted to depart from it where there are good reasons for doing so. The Trust further submits that nothing in the constitutions confers on a parent the right to remove a child from an NHS hospital and take them abroad for treatment that is not in their best interests. Rather, the Constitution imposes a duty on doctors not to provide treatment they assess not to be in the patients best interests or which they consider may be degrading, requires preferences to be reflected only where possible and that, within this context, doctors did all they could to assist parents to explore their preference but ultimately came to conclusion that the same was not in Tafida's best interests. In the circumstances, the Trust submits that it complied with its duties under the NHS Constitution.

63. The Trust accordingly invites the court to dismiss the judicial review proceedings and adopt the ordinary process in the Family Division of considering Tafida's best interests pursuant to its applications under the Children Act 1989 s 8 and the inherent jurisdiction of the High Court.

Application under the Children Act 1989 and the Inherent Jurisdiction

(i) The Trust

64. Ms Gollop submits that whilst human rights are engaged, including the Art 9 right to freedom of thought, conscience and religion, this case is about best interests, per *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 WLR 242. The Trust submits that it is in Tafida's best interests for life sustaining treatment now to be withdrawn and for her to be palliated and, accordingly, it is not in Tafida's best interests for the court to conclude she should continue to receive life sustaining treatment in Italy or otherwise. Trust submits that the best interests question in this case is dominated by health issues.

65. The Trust invites the court to prefer the opinion of Dr Smith, which opinion it contends is that Tafida is in the equivalent of VS. Within this context, the Trust

submits that the evidence demonstrates that Tafida cannot survive without mechanical ventilation and will now always be dependent on the same, with no hope of recovery or only a minimal level of recovery that will be adverse to her welfare. The Trust further submits that the evidence demonstrates that Tafida now has no vision and very altered sensation such that she maintains only a limited ability to feel and *may* retain some ability to process sound. She is described by Ms Gollop as having "animation without experience". The Trust accepts that the evidence suggests that Tafida's existence is not painful, but reminds the court that there is evidence that she can feel pain if a painful stimulus is applied and that the possibility of pain cannot be excluded completely which, the Trust contends, is significant in terms of some of the future conditions prognosticated in respect of Tafida. The Trust submits that it is not possible to determine whether Tafida experiences pleasure.

66. With respect to the question of the benefit and burden of continued treatment, within the foregoing context, the Trust submits that, within the context of the difficult question of how to treat those with little or no awareness, absence of awareness and pain does *not* mean an absence of harm in circumstances where, it submits, there is plainly now *no* benefit to be gained by Tafida from continued medical treatment given the prognosis of no significant improvement in her condition, the lack of ability to derive benefit being an aspect of the assessment of quality of life under the RCPCH Guidance. Within this context, the Trust submits that years in her current condition are not in Tafida's best interests, in particular were she to regain slightly more awareness but remain in a very minimally conscious state given the anticipated development of further severely disabling conditions.

67. As to Tafida's wishes and feelings, when seeking to divine Tafida's views the Trust invites the court to be cautious in accepting that Tafida was raised by parents who take an absolute position on the religious prohibition of the course of action advocated by the Trust in circumstances where the evidence, so submits the Trust, indicates that the mother was prepared at least to contemplate the same. In any event, with respect to the extent to which the court can derive Tafida's wishes and feelings from the religious environment in which she has been raised, and evidence of her consequential attitude to end of life questions, the Trust again cautions the court as what can be *properly* be drawn from such evidence.

68. Whilst accepting that the evidence demonstrates that Tafida had knowledge of her religion and participated in aspects of it, including prayer, the Trust submits that at the age of 4 she can have had no real concept of her mortality or of the possibility of her current situation. Ms Gollop accordingly submits that whilst the court can infer what Tafida thought of her religion generally, it has no information from which to infer he wishes and feelings regarding existing for many years with no or minimal awareness, with the possibility of physical deterioration and the ever present risk of infection. Ms Gollop further submits that in circumstances where her condition is consistent with VS but with the possibility of minimal awareness, compelling evidence would be required to demonstrate she would have wanted a ventilated existence. There is, submits the Trust, in fact no evidence she gave thought to what she would have wanted for herself in this situation. Accordingly, the Trust submits that it is difficult in those circumstances for the parents to make out a submission that Tafida's understanding and commitment to her faith would have meant she subordinated any wish not to endure such an existence to her religious beliefs, there being no evidence

she contemplated and understood that possibility. Moreover, the Trust submits that prior to her injury, all the evidence points to the fact that Tafida understood life as a situation of feeling, communication and experience.

69. With respect to Tafida's Art 9 right to freedom of thought, conscience and religion *per se*, the Trust submits that she is not now capable of manifesting religion in belief, practice or observance, not being able to exercise these freedoms because she is not free but rather trapped by the small amount of her brain that survives. Within this context, Ms Gollop further invited the court to engage in a detailed analysis of the *Fatwa*, including inviting the court to question whether it properly applied to the situation in this case. Ms Gollop submits that Tafida's situation in fact falls out with the prohibitions contained in the *Fatwa* as she cannot consent, and is not consenting to the termination of her own life and accordingly, as a matter of logic, cannot commit the act that is prohibited by her religion as explained in the *Fatwa* (and neither are or could her parents). Neither Tafida nor her parents are asking for her life to be ended. It is the Trust that makes the request and the court which will decide. In all the circumstances, the Trust submits that the relief it seeks does not constitute an unlawful interference with the Art 9 rights engaged.

70. With respect to the question of the parents' religious convictions, the Trust submits that those convictions, and the rights that protect them, are one factor to be considered in the best interests analysis and do not confer on the parents the right to access medical treatment that is not in Tafida's best interests. Within this context, the Trust submits that for the parents to claim a 'right' to have Tafida treated in a way which accords with their religious views is an position that is unsustainable within the context of the international provisions which provide for Tafida's best interests to be a primary consideration and the domestic statutory provisions that require her best interests to be paramount. Further, the Trust submits that where the parents' religious views conflict with Tafida's best interests, the conflict must be resolved in favour of the latter.

71. With respect to the sanctity of life, Ms Gollop submits that Tafida's right to life under Art 2 of the ECHR falls to be considered in the context of her current state. Within this context, Ms Gollop submits that the State, in the form of the court, should not concern itself with teleological or ontological arguments concerning the meaning of life (such as whether a life without awareness or experience is properly consistent with conceptions of being) but rather consider the quality of Tafida's current existence as measured against the principle that sanctity of life is of the highest importance. Within this context, and in circumstances where the Trust submits that Tafida derives no benefit from life and any change of circumstances for Tafida will only be negative, this is a case in which the sanctity of life is outweighed by other considerations.

72. The Trust acknowledges that there is a fully worked out care plan for the transfer of Tafida the Gaslini Hospital, that the evidence demonstrates that such the transfer could occur with minimal risk to Tafida and that the evidence demonstrates that Tafida benefits from the round the clock care from a loving and dedicated family (the Trust further conceding the Tafida continues to benefit from Art 8 right to respect for family life). However, the Trust submits that geography is not the issue in the case. Ms Gollop contends that the antecedent question is whether further mechanical ventilation is in Tafida's best interests. If it is not, then the Trust submits that that

answer holds for Tafida wherever such treatment is available. As the question of dignity, contending that this is a concept that means many different things to many different people, Ms Gollop submits that what would certainly not be dignified for Tafida is being transported across international borders in a moribund state to be kept alive in a moribund state.

73. Finally, with respect to the evidence of Dr Playfor, Dr Smith and Dr D that there are children in a similar situation to Tafida currently ventilated long term both in hospital and at home, Ms Gollop submits there is, in fact, no sufficiently cogent evidence in respect of other children ventilated in this position in the United Kingdom, and in particular no evidence of how similar or otherwise their situations are to that of Tafida.

(iii) The Parents and Interested Party

74. The parents and the maternal aunt contend that it is in Tafida's best interests to continue to receive life sustaining treatment and, on the evidence available, that the court should so declare. Emphasising that each case must be decided on its own facts and that there is no agreed "touchstone of intolerability" per *In re B (A Minor)(Wardship: Medical Treatment)* [1981] 1 WLR 1421 at 1424, the parents and the maternal aunt submit that there is no evidence that Tafida suffers pain and, in this respect, her case is "unique". In any event, the parents and interested party submit that the treatment is not overly burdensome for Tafida.

75. Within this context, the parents and the maternal aunt submit that it is further important in this case for the court to have regard to the medical consensus that brain stem death has not occurred, that Tafida's death is not imminent subject to continued life sustaining treatment (with which Tafida could live a further 10 to 20 years) and that Dr Playfor, Dr Smith and Dr D all acknowledge that children in a similar position to Tafida (to use Dr D's formulation) are treated long term both in hospital and home and that the latter is an available and fully funded option for Tafida in Italy. The parents and the maternal aunt also pray in aid evidence that whilst the chance that Tafida will make improvements in her level of awareness is low, the same cannot be ruled out and rely on their own observations of what they contend are improvements over the significant period of time they have spent with Tafida. Within this context, and reminding the court that the RCPCH Guidance has no force in law and does not purport to replace the best interests requirements under the law, Mr Sachdeva submits that in the absence of pain and suffering, the question of inability to derive benefit becomes a *heavily* value laden factor, with the best evidence as to 'benefit' in those circumstances coming from the wider perspective of the family, and the religious and cultural context in which they live, rather than the narrower, entirely medical perspective of the doctors.

76. Within this context, the parents and the maternal aunt submit that, in her current condition, Tafida's wishes and feelings regarding continuing to receive life-sustaining treatment can be derived from the religious and cultural context in which she was raised and from the evidence before the court that demonstrates that not only was Tafida has been brought up in accordance with the tenets of Islam and but that, on what is submitted to be compelling evidence that prior to her injury she understood the concept of religion and had expressed a clear desire to adhere closely to the Islamic faith, she was developing her own religious identity and value system in this

context. Mr Sachdeva acknowledges that Tafida's capacity to understand the true nature and extent of her religious and cultural background must be limited by her age, but he submits the evidence shows she had a prior understanding and relationship with her Muslim faith. In these circumstances, the parents and the maternal aunt submit that the court can be certain that Tafida *would* have wanted to live in her current circumstances where the withdrawal of treatment causing death would not be in accordance with the beliefs and values of the religion with which she identified and the community to which she belongs. Accordingly, the parents and maternal aunt submit that the benefit that accrues to Tafida from continued life is in part a spiritual one and is protected by her Art 9 right to freedom of thought, conscience and religion. Within this context, it is submitted that in this case the concept of autonomy (as embodied in the child's wishes and feelings) and the sanctity of life point to the same result.

77. The parents further submit that the sanctity of life means that the continuation of Tafida's life is itself inherently a good and that Tafida was growing up in an Islamic community where, although she cannot have realised it in detail, the sanctity of life is of the highest importance. Within this context, they submit that there is a substantial inherent benefit to Tafida of continuing to be alive because the continuation of her life is both an inherent good and accords with the tenets of the belief system of which she was part. Within this context, the parents and the aunt submit that whilst, from a narrow medical perspective, life-sustaining treatment might be considered futile, to Tafida and those who share the belief system in which she grew up, rather than being futile life sustaining treatment confers the benefit of protecting the sanctity of life. The parents and the aunt submit that this conclusion is reinforced by the fact that a life with a severe disability is held, in both domestic and international law, to be of equal value to all the other myriad lives in the world. Within this context, they submit that where she is medically stable and effectively ventilated, where she is not suffering pain and where there is no conflict in this case between sanctity of life and autonomy as articulated by her ascertained wishes and feelings, the sanctity of her life requires that Tafida be allowed live out the remainder of life notwithstanding the severity of her disability.

78. The parents and the aunt further contend that the best interests justification for this course is, in this case, reinforced by the fact that a team of doctors at an internationally renowned paediatric centre of excellence, with more than sufficient medical expertise to meet Tafida's ongoing medical needs, are prepared to treat Tafida and have provided to the court a fully worked up care plan for Tafida, which plan is also full funded. The parents and the aunt further rely on Dr Playfor's evidence that it is very unlikely that Tafida would suffer any pain or discomfort during transfer and that the transfer plan is entirely reasonable and appropriate for Tafida. They further point to the dedication the parents and wider family in caring for Tafida and their willingness to continue to do so. Within this context, the parents and the maternal aunt submit that in this case the court must have regard to the fact that the continuation of life-sustaining care they submit is in Tafida's best interests is care that a European centre of paediatric excellence is prepared to give.

79. Within the foregoing context, the parents and the aunt further point out that the care plan formulated by the team from Gaslini, and fully funded, reflects the evidence from Dr Playfor, Dr Smith and Dr D regarding the approach taken towards other

children in the United Kingdom in a similar situation to that of Tafida. Accordingly, they submit that the continuation of life-sustaining care that they submit is in Tafida's best interests, and that is offered by the Gaslini and fully funded, is care that is regularly provided to other children in like clinical situation and is accordingly care that falls within the mainstream body of medical opinion on the treatment of children in conditions similar to that of Tafida. In these circumstances, the parents submit that all that they seek for Tafida is simply that which is already a well-recognised approach in this jurisdiction to providing long-term care for children in her position, which does not involve the withdrawal of treatment and death.

80. With respect to the question of dignity, the parents and aunt submit that, given her particular situation and levels of awareness, all judgments regarding Tafida's dignity are, by definition, extrinsic, with no evidence before the court to demonstrate that Tafida *herself* would consider her position to be undignified or that living with profound disabilities would render her position so, there being no indignity in disability, even where severe. Within this context, they submit that the court must be astute to avoid holding the life of a severely disabled child to be inherently undignified or as having less dignity than the life of a person without disability.

81. Within the foregoing context, and in circumstances where a team of doctors at a prominent paediatric centre of distinction are prepared to treat Tafida in a manner in which other children in this jurisdiction in a similar condition to Tafida can be treated, the parents and the aunt submit that whilst her quality of life may not be high by the standards of many, it is in Tafida's best interests to continue to receive life sustaining treatment, which treatment will, in the circumstances of this case, deliver to Tafida a life that is pain free with limited awareness and which confer benefits upon her by reference to her cultural and religious heritage, the sanctity of her life and the love and dedication of her family.

(ii) The Child

82. Having completed her investigations, the Children's Guardian contends that it is now in Tafida's best interests for life sustaining treatment now to be withdrawn and her Tafida to be palliated. In her final report dated 3 September 2019 Ms Demery states that:

> "...it is difficult to see how it could be in her best interests for her to have to endure the life that she currently leads devoid of any quality and beleaguered by the burden of illness and procedures that keep her alive. Whilst it is thought that she is no experiencing any pain, the evidence is that she is unable to experience any pleasure or comfort from her environment because of lack of awareness that is a feature of the damage her brain has experienced."

And

> "From all the information currently available to me, it is with great sadness I say that I do not now see how it can be in Tafida's best interests to continue with life sustaining treatment. The current regime is an inevitable burden upon Tafida, regardless of whether she experiences the pain or discomfort that would otherwise be associated with these procedures, such

> as deep suctioning and nasogastric feeding. It is not intended and will not provide any respite from the underlying cause of her disability and, according to medical evidence, is therefore futile."

83. With respect to the burden and benefit of treatment, during his oral submissions Mr Gration contended that if Tafida's treatment is maintained the burden of that treatment upon her will be significant in that her life will be, for ten to twenty years, one that is mechanically sustained, one of no or minimal awareness, with an inability to derive comfort or to interact and with developing conditions set out in prognosis that, if she does recover some awareness, will make her aware of her very difficult situation, more aware of treatment and more aware of these consequential problems and illnesses. Mr Gration submits that whilst modern science can sustain Tafida's life, it will only do so without pleasure, comfort, joy, experience of the love of her family or "anything else that makes life a pleasurable and rich experience for most people". This burden is not, he submits, in Tafida's best interests.

84. With respect to Tafida' ascertainable wishes and feelings, Mr Gration told the court that the Guardian accepts that the evidence regarding Tafida can amount to evidence of her wishes and feelings insofar as she understood her religion. Mr Gration further makes clear that in her assessment the Children's Guardian took account of Tafida's caring and non-judgmental approach to a child with severe disabilities, in so far as it can be said to demonstrate a realisation in Tafida of the sanctity of life and the recognition that people lead full lives notwithstanding challenges to their disability, as well as having regard to Tafida's evident love of life itself. However, Mr Gration submits that this does not provide a complete answer to the best interests question before the court as, with respect to Tafida's wishes and feelings, the proper question is whether she had a concept of the situation she is currently in bearing in mind her age in order to form a view about it.

85. In this respect, Mr Gration submits that this is not at all likely and that Tafida would not have understanding of end of life or of the nature of a life lived with profound illness or disability. Within this context, Mr Gration further submits that, at best and whilst not devaluing the significance of her religious upbringing, the court has evidence of her general views based on her childhood understanding of religious tenets. In the circumstances, the Children's Guardian has not able to accord this significant weight, given that the nature of the situation Tafida would be required to take a view on was one beyond her childhood conception.

86. Within the foregoing context, and making clear that the Children's Guardian has paid due respect to the sanctity of life, Mr Gration indicates that the Guardian comes to the view that continued life sustaining treatment leading to a life of no suffering but no pleasure is not in Tafida's best interests. However, Mr Gration was also at pains to make clear that the Guardian accepts that the case is not one that has an obvious answer and that the court may reach a different conclusion.

THE LAW

EU Law

87. As I have noted, the Trust does not dispute that Tafida, as a citizen of the EU has directly enforceable rights under Art 56 of TFEU to receive medical treatment in

another Member State. The issue in this case is whether the Trust, in refusing to agree to Tafida's transfer to Italy pending a decision by this court as to best interests, breached those EU rights and, if so, whether that derogation from EU rights that have direct effect was justified. In the circumstances, the following legal provisions and jurisprudence are relevant.

88. Art 56 of the TFEU provides as follows regarding the right to provide services within the EU:

> "Within the framework of the provisions set out below, restrictions on freedom to provide services within the Union shall be prohibited in respect of nationals of Member States who are established in a Member State other than that of the person for whom the services are intended.
>
> The European Parliament and the Council, acting in accordance with the ordinary legislative procedure, may extend the provisions of the Chapter to nationals of a third country who provide services and who are established within the Union."

89. Within the foregoing context, I pause to note that Directive 2011/24/EU on the application of patients' rights in cross-border healthcare provides as follows in paragraph 4, 7 and 12 of the recitals to the Directive:

> "(4) Notwithstanding the possibility for patients to receive cross-border healthcare under this Directive, Member States retain responsibility for providing safe, high quality, efficient and quantitatively adequate healthcare to citizens on their territory. Furthermore, the transposition of this Directive into national legislation and its application should not result in patients being encouraged to receive treatment outside their Member State of affiliation.
>
> .../
>
> (7) This Directive respects and is without prejudice to the freedom of each Member State to decide what type of healthcare it considers appropriate. No provision of this Directive should be interpreted in such a way as to undermine the fundamental ethical choices of Member States.
>
> .../
>
> (12) The concept of 'overriding reasons of general interest' to which reference is made in certain provisions of this Directive has been developed by the Court of Justice in its case-law in relation to Articles 49 and 56 TFEU and may continue to evolve. The Court of Justice has held on a number of occasions that overriding reasons of general interest are capable of justifying an obstacle to the freedom to provide services such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high- quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources. The Court of Justice has likewise acknowledged that the objective of maintaining a balanced medical and hospital service open to all may also fall within one of the derogations,

> on grounds of public health, provided for in Article 52 TFEU, in so far as it contributes to the attainment of a high level of health protection. The Court of Justice has also held that such provision of the TFEU permits Member States to restrict the freedom to provide medical and hospital services in so far as the maintenance of treatment capacity or medical competence on national territory is essential for public health."

90. Art 52 of the TFEU provides as follows with respect to the circumstances in which derogation from the rights set out in Chapter 2 of Part 3, Title IV of the TFEU, which includes the EU rights under Art 56, are permitted:

> "1. The provisions of this Chapter and measures taken in pursuance thereof shall not prejudice the applicability of provisions laid down by law, regulation or administrative action providing for special treatment for foreign nationals on grounds of public policy, public security or public health.
>
> 2. The European Parliament and the Council shall, acting in accordance with the ordinary legislative procedure, issue directives for the coordination of the above mentioned provisions."

91. Art 2 of the Treaty of the European Union provides that the EU is founded on the values of respect for human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities. In addition to the fundamental rights set out in the schema of the Treaties, pursuant to Art 6 the Treaty of the European Union, Art 56 must be read subject to rights enshrined in the EU Charter of Fundamental Rights (hereafter CFR). The CFR itself falls to be interpreted in line with the provisions of ECHR, which in turn must be interpreted having regard to the provisions of the UNCRC. Within the context of the judicial review proceedings, the following provisions of the CFR are relevant:

> "**Article 21**
>
> **Non-discrimination**
>
> 1. Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.
>
> 2. Within the scope of application of the Treaty establishing the European Community and of the Treaty on European Union, and without prejudice to the special provisions of those Treaties, any discrimination on grounds of nationality shall be prohibited."

And:

> "**Article 24**
>
> **The rights of the child**

> 1. Children shall have the right to such protection and care as is necessary for their well-being. They may express their views freely. Such views shall be taken into consideration on matters which concern them in accordance with their age and maturity.
>
> 2. In all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration.
>
> 3. Every child shall have the right to maintain on a regular basis a personal relationship and direct contact with both his or her parents, unless that is contrary to his or her interests."

92. Within the context of the foregoing legal framework, I was referred to a large number of authorities during the course of submissions law on the issue of the nature and extent of derogations from EU rights that are permitted. However, six key authorities fall for consideration.

93. Dealing first with the question of public policy as a justification for derogating from fundamental EU rights, in *Van Duyn* (Case 41/74) [1974] ECR1337 at [18] the ECJ considered the interpretation of the public policy exception in the context of freedom of movement for EU Citizens and observed as follows:

> "It should be emphasized that the concept of public policy in the context of the Community and where, in particular, it is used as a justification for derogating from the fundamental principle of freedom of movement for workers, must be interpreted strictly, so that its scope cannot be determined unilaterally by each Member State without being subject to control by the institutions of the Community. Nevertheless, the particular circumstances justifying recourse to the concept of public policy may vary from one country to another and from one period to another, and it is therefore necessary in this matter to allow the competent national authorities an area of discretion within the limits imposed by the Treaty."

94. Staying with the question of public policy restrictions on fundamental EU rights, in *Ministerul Administraţiei Şį Internelor – Direcţia Generala De Paşapoarte Bucureşti v Jipa* (Case C-33/07) [2008] CMLR 23 the ECJ held at [28] that the question of whether the derogation in issue is properly founded on reasons of public policy, or public security, is one for the *national* court to answer on the basis of the matters of fact and law said to justify such derogation. Within this context, the court went on to hold that:

> "[29] When making such an assessment, the national court will have also to determine whether that restriction on the right to leave is appropriate to ensure the achievement of the objective it pursues and does not go beyond what is necessary to attain it. According to Art.27(2) of Directive 2004/38 and the Court's settled case law, a measure which restricts the right of freedom of movement may be justified only if it respects the principle of proportionality (see, for example, to that effect *Alluè v Universita degli Studi di Venezia* (C-259/91, C-331/91 & C-332/91) [1993] E.C.R. I-4309 at [15]; *Baumbast v Secretary of State for the Home Department* (C-413/99)

> [2002] E.C.R. I-7091; [2002] 3 C.M.L.R. 23 at [91]; and *Ministre de l'Intérieur v Oteiza Olazabal* (C-100/01) [2002] E.C.R. I-10981; [2005] 1 C.M.L.R. 49 at [43])."

95. Within the foregoing context, in *Society for Protection of Unborn Children Ireland Limited v Grogan and others* Case C-159-90 [1991] 3 CMLR 849 at [37] the Advocate General dealt with the question of national rules that may actually or potentially restrict the freedom to receive services under Art 56 of TFEU on the basis of public policy as follows:

> "(21) ... that national rules which, albeit not discriminatory, may, overtly or covertly, actually or potentially, impede intra-Community trade in services fall in principle within the scope of Articles 59 and 60 EEC. I say 'in principle' advisedly, because such national rules may nevertheless be compatible with those Treaty provisions where they are justified by imperative requirements of public interest (see section 22 et seq., below)...
>
> (22) The Court has consistently held, in particular in its judgment in Case 279/80, *Webb* [1981] E.C.R. 3305, [1982] 1 C.M.L.R. 719 (in paragraph 17, which refers to the judgment in Joined Cases 110-111/78, *Van Wesemael* [1979] E.C.R. 35, [1979] 3 C.M.L.R. 87, that regard being had to the particular nature of certain services, specific requirements imposed on the provider of the services cannot be considered incompatible with the Treaty where they have as their purpose the application of rules governing such activities. However, the freedom to provide services is one of the fundamental principles of the Treaty and may be restricted only by provisions which are justified by the general good [intérêt général] and which are imposed on all persons or undertakings operating in the said State in so far as that interest is not safeguarded by the provisions to which the provider of the service is subject in the member-State of his establishment.
>
> .../
>
> (24) It is in the light of this frame of reference (which is similar for trade in goods and trade in services) that the national rule at issue must, in my opinion, be considered. The questions arising in this connection are whether the rule pursues an objective which is justified under Community law, that is to say whether it can rely on imperative requirements of public interest which are consistent with or not incompatible with the aims laid down in the Treaty provisions, and whether that rule has no effects beyond those which are necessary and, in particular, is not disproportionate, that is to say whether it satisfies the test of the principle of proportionality."

96. Staying with restrictions on the Art 56 rights, in *Gebhard v Consiglio dell'ordine degli avvocati eprocuratori di Milano* C55/94 EU:C:1995:411 the ECJ, in a case concerned with the freedom to provide services, observed as follows regarding measures taken by EU Member States that hinder the exercise of fundamental freedoms under the EU Treaty:

> "...national measures liable to hinder or make less attractive the exercise of fundamental freedoms guaranteed by the Treaty must fulfil four conditions:

> they must be applied in a non-discriminatory manner; they must be justified by imperative requirements in the general interest; they must be suitable for securing the attainment of the objective which they pursue; and they must not go beyond what is necessary in order to attain it (see Case C- 19/92 *Kraus v Land Baden-Württemberg* [1993] ECR I - 1663, paragraph 32)."

The passaged in *Kraus v Land Baden-Württemberg* at [32] referred to by the court reads as follows:

> "Consequently, Articles 48 and 52 preclude any national measure governing the conditions under which an academic title obtained in another Member State may be used, where that measure, even though it is applicable without discrimination on grounds of nationality, is liable to hamper or to render less attractive the exercise by Community nationals, including those of the Member State which enacted the measure, of fundamental freedoms guaranteed by the Treaty. The situation would be different only if such a measure pursued a legitimate objective compatible with the Treaty and was justified by pressing reasons of public interest (see to that effect, judgment in Case 71/76 *Thieffry v Conseil de l'Ordre des Avocats à la Cour de Pans* [1977] ECR 765, paragraphs 12 and 15). It would however also be necessary in such a case for application of the national rules in question to be appropriate for ensuring attainment of the objective they pursue and not to go beyond what is necessary for that purpose (see judgment in Case C-106/91 *Ramrath v Ministre de la Justice* [1992] ECR I-3351, paragraphs 29 and 30)."

97. With respect to the domestic application of these principles in a claim for judicial review involving the right to receive medical services in another EU Member State, in *R v Human Fertilisation and Embryology Authority ex parte Blood* [1999] Fam 151, [1997] 2 WLR 806, [1997] 2 FLR 742 the Court of Appeal considered the terms of Art 56 (formerly Art 49 of the Treaty of the European Community and referred to as such in the judgment of the Court of Appeal). In that case the Court of Appeal held that preventing a person from receiving treatment in another Member State (in that case by prohibiting the export of the sperm of the claimant's late husband for the purposes of fertility treatment in another Member State) constituted a restriction on the freedom to receive services, which restriction had to be justified by the challenged State, for example on public policy grounds, if it was to be lawful. Within this context, the Court of Appeal at [47] identified a two stage process for the application of EU law having direct effect:

> "This illustrates the two-stage process in the application of Community law where it has direct effect: first, the court or decision taker must consider whether the challenged actions or decisions are an infringement of the relevant cross-border rights of the affected Community citizen, and then whether they are justified by the legitimate requirements of the state whose actions or decisions are challenged."

98. The question of infringement falls to be evaluated on a practical basis. Thus, in *Blood* the Court of Appeal noted that were a decision has the practical effect of withholding the provision of treatment in another EU Member State, from a functional point of

view the ability to provide and to receive those services is not only substantially impeded but made impossible.

99. As to the second question of whether, if there has been a practical interference in the claimant's EU rights, the interference is justified by the legitimate requirements of the state whose actions or decisions are challenged, in *Blood* the Court of Appeal noted as follows at [53] and [54]:

> "[53] However the fact that there is interference with the freedom to provide services does not mean that Article 59 is infringed. It means no more than the second stage has been reached and the interference has to be Justified in accordance with the well-established principles if it is not to contravene Article 59. Those principles are correctly summarised by Lord Lester in the case of an administrative decision as being that the decision must be non-discriminatory, it must be justified by some imperative requirement in the general interest, it must be suitable for securing the attainments of the objects which it pursues and it must not go beyond what it is necessary to attain that objective...
>
> [54] Furthermore the provision of services in relation to artificial insemination raise difficult ethical and moral considerations which Member States can appropriately feel it is necessary to protect by imposing regulations to prevent abuse and undesirable practices occurring."

100. In the circumstances, in evaluating the behaviour of the decision maker in a claim for judicial review in the foregoing context, the Court of Appeal in *Blood* concluded as follows:

> "[56] Article 59 cannot therefore be relied upon as preventing the Authority from imposing any restriction on the export of sperm, where a particular direction is sought, and in each case it is a question of degree whether the restriction is justified by the considerations to which reference has already been made. This in the first instance is a question for the Authority. The Courts will only intervene in one of two situations. First where the Authority does not comply with the usual administrative law standards which are enforced by judicial review, including directing themselves correctly as to the law. Secondly where the Authority's decision wrongly evaluates the considerations Lord Lester identified to an extent which goes beyond the margin of appreciation European law allows in the case of administrative decisions of this sort."

Within this context, I further note that in *Blood* the Court of Appeal was clear at [59] that a failure by an authority to take into account that its decision would act to impede the right under Art 56 to receive treatment in another EU Member State and to ask itself whether in the circumstances the interference is justified, renders the decision unlawful.

101. Finally, I note that the question of whether denying or otherwise preventing parents from moving a child from the United Kingdom to another EU Member State to receive continued life-sustaining treatment constitutes an unjustified interference in EU rights under Art 56 has been raised before the domestic courts on two recent

occasions in the same case. As Mr Sachdeva and Mr Lock point out, when the point was taken before the Court of Appeal in *Evans v Alder Hey Children's NHS Foundation Trust* [2018] EWCA Civ 984 at [29] it was not fully argued and, in any event, that decision of the Court of Appeal was concerned only with permission to appeal. However, the arguments were attempted at an earlier stage before the Court of Appeal, and in more detail, in the first appeal in *Evans v Alder Hey Children's NHS Foundation Trust* [2018] 2 FLR 1269, which appeal was heard and determined on the merits. Within this context, at paragraph [53], whilst not deciding the point, the Court of Appeal observed as follows regarding the arguments concerning contended for breach of EU rights under Art 56 of TFEU:

> "The other rights to which Mr Diamond has referred – the rights of the parents; the right to free movement; the right to access medical treatment – are not unlimited rights. This is apparent from the authorities relied on by Mr Diamond. For example, in *R v Human Fertilisation and Embryology Authority ex parte Blood* [1999] Fam 151, [1997] 2 WLR 806, [1997] 2 FLR 742 the court made clear that the right to receive medical treatment in another Member State could be limited if justified."

Medical Disputes and Parental Responsibility

102. Parental responsibility is defined in the Children Act 1989 s 3(1) as comprising "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property." The concept of parental responsibility describes the responsibility of a parent to secure the welfare of their child. This responsibility does not confer upon parents an unfettered right to make welfare decisions in respect of their children (see *Alder Hey Children's NHS Foundation Trust v Evans* [2018] EWCA Civ 805).

103. Within this context, pursuant to s 8(1) of the Children Act 1989 the court retains jurisdiction to determine questions which have arisen in connection with the exercise of parental responsibility by means of the exercise of its independent and objective judgment of the child's best interests. The Family Division of the Hight Court may also exercise its inherent jurisdiction to determine questions which have arisen in connection with the exercise of parental responsibility. Within this context, with respect to the interrelationship between role of parents with parental responsibility, the role of treating doctors and the role of the court in relation to the medical care of children, in *Re J (a minor)(wardship: medical treatment)* [1990] 3 All ER 930 at 934, [1991] Fam 33 at 41, Lord Donaldson MR observed as follows:

> "The doctors owe the child a duty to care for it in accordance with good medical practice recognised as appropriate by a competent body of professional opinion (see *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582). This duty is, however, subject to the qualification that, if time permits, they must obtain the consent of the parents before undertaking serious invasive treatment. The parents owe the child a duty to give or to withhold consent in the best interests of the child and without regard to their own interests. The court when exercising the *parens patriae* jurisdiction takes over the rights and duties of the parents, although this is not to say that the parents will be excluded from the decision-making process. Nevertheless in the end the responsibility for the

> decision whether to give or to withhold consent is that of the court alone. It follows from this that a child who is a ward of court should be treated medically in exactly the same way as one who is not, the only difference being that the doctors will be looking to the court rather than to the parents for any necessary consents. No one can dictate the treatment to be given to the child, neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist upon treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents."

104. Dealing in more detail with the role of the court, whilst in some contexts a statutory threshold of harm must be met before the court can make orders with respect to the care of children by the State, it is now established that no such threshold applies in disputes concerning the *medical* care of children by the State. The sole criteria to be applied by the court in determining disputes of that nature is that of the child's best interests. In *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates and others* [2018] 1 All ER 569 the Court of Appeal made clear that this proposition holds good even where the parents have identified alternative options for continued treatment, McFarlane LJ (as he then was) making stating at [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."

105. Within the context of the application for judicial review, and relevant to its determination, I also heard submissions regarding the proper procedure to be adopted domestically where a dispute arises between a parent with parental responsibility and treating doctors as to the medical treatment of a child and in particular, whether an NHS Trust is *required* to apply to court for a determination where such a dispute arises. In *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates and others* McFarlane LJ described an application of the type with which I am concerned as "conventional", with the decision as to where the child's best interests lie being a choice falling to be made by a judge following a child-focused, child-led evaluation and not by the hospital forcing its views on the parents. Later, at [119] McFarlane LJ stated that "The system *requires* any dispute to be determined by a judge" (emphasis added and see also *Airdale NHS Trust v Bland* at 859 E-F per Lord Keith).

106. Within this context, I further note that in *Gard v United Kingdom* (2017) 65 EHRR 65, the ECtHR recapitulated the principles regarding the withdrawing of life sustaining treatment from the stand point of the State's positive obligations under Art 2 of the ECHR, a key aspect of compatibility being held to be the possibility of approaching the courts in the event of doubts as to the best decision to take in the patient's interests, following *Lambert v France* (2016) 62 EHRR 2 at [143]. In this context, in *Gard v United Kingdom* at [96] the ECtHR stated that:

> "The third element is the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests. It is evident from the domestic proceedings that there was not only the possibility to approach the courts in the event of doubt but, in fact, a duty to do so (see [39]–[45] above). The Court also recalls that in its judgment in *Glass* (2004) 39 EHRR15, this Court criticised the treating hospital for failing to approach the courts in similar circumstances. The facts of the present case are wholly different, GOSH quite properly applied to the High Court under the relevant statute and the inherent jurisdiction of that court to obtain a legal decision as to the appropriate way forward."

And at [106]:

> "On the question of state interference where there is a conflict between a parent's desire concerning medical care for their child and the opinion of medical professionals treating the child, the Court has found that it is appropriate for the medical professionals involved to bring such conflicts before a court for resolution (see *Glass* (2004) 39 EHRR 15 at [83])."

And at [117]:

> "It is therefore clear that it was appropriate for the treating hospital to turn to the courts in the event of conflict"

107. That the proper route for an NHS Trust to take, in the event of a dispute between a parent with parental responsibility and treating doctors as to the medical treatment of a child, is an application to the court in this jurisdiction under the Children Act 1989 and/or the inherent jurisdiction of the High Court is reinforced by a number of further factors.

108. First, and most fundamentally, EU law confers jurisdiction to determine a dispute between a parent with parental responsibility and treating doctors as to the medical treatment of a child on the courts of the Member State of the child's habitual residence pursuant to Art 8 of BIIa, which provides as follows:

> "**Article 8**
>
> **General Jurisdiction**
>
> 1. The courts of a Member State shall have jurisdiction in matters of parental responsibility over a child who is habitually resident in that Member State at the time the court is seised."

Having regard to the independent and uniform interpretation given to the term 'habitual residence' throughout the EU for the purposes of Art 8 of BIIa, no party to these proceedings has sought seriously to suggest that this court does not have jurisdiction in respect of questions of parental responsibility concerning Tafida. Within this context, the ECJ has made clear in *Detiček v Sgueglia* C-403/09 PPU, EU:C:2009:810 that where there is a dispute (in that case in the context of Art 24(3) of the CFR) as to the child's best interests (emphasis added):

> "...a balanced and reasonable assessment of all the interests involved, which must be based on objective considerations relating to the actual person of the child and his or her social environment, *must* in principle be performed in proceedings before the court with jurisdiction as to the substance in accordance with the provisions of [BIIa]."

In addition to Art 8, Art 20 of BIIa provides that in urgent cases the provisions of the Regulation will not prevent the courts of a Member State from taking such provisional, including protective, measures available under the law of that Member State. As I will come to, when considering the application for judicial review it is important to bear in mind that EU law thus confers jurisdiction on the domestic court to determine the dispute between the parents and the treating doctors as to the medical treatment of Tafida in the proceedings under the Children Act 1989.

109. Second, I accept Ms Gollop's submission that the duty of an NHS Trust under s.11(2)(a) of the Children Act 2004 to ensure that its functions are discharged having regard to the need to safeguard and promote the welfare of children require it, where there is a dispute between a parent with parental responsibility and treating doctors as to the medical treatment of a child, to give consideration to and if necessary to make an application to the domestic court for the determination of the dispute. To do otherwise in such circumstances is to leave a void in relation to consent. This cannot be consistent with the duty on the NHS Trust to ensure that its functions (in this case, the medical treatment of a child) are discharged having regard to the need to safeguard and promote the welfare of children, nor with the best interests of the individual child concerned. It would also have the effect, if no such application were made, of conferring on the parents an unimpeachable authority to make welfare decisions in respect of their children notwithstanding countervailing medical advice, which is not the position in law.

110. Third, in cases that raise sensitive moral and ethical issues the EU recognises that different Member States will take different views concerning such issues and, in the circumstances, accord Member States a margin of appreciation in the manner in which it deals with such issues. Thus, in the context of life sustaining treatment, in *Gard v United Kingdom* at [84] the ECtHR observed as follows:

> "Accordingly, the Court considers that in this sphere concerning the end of life, as in that concerning the beginning of life, states must be afforded a margin of appreciation, not just as to whether or not to permit the withdrawal of artificial life-sustaining treatment and the detailed arrangements governing such withdrawal, but also as regards the means of striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy (see, mutatis mutandis, *A v Ireland* (2011) 53 EHRR 13 at [237]). However, this margin of appreciation is not unlimited (at [238]) and the Court reserves the power to review whether or not the state has complied with its obligations under art.2 (*Lambert (*2016) 62 EHRR 2 at [148])."

And further at [122]:

> "The Court also recalls that where there is no consensus within the Member States of the Council of Europe, either as to the relative importance of the

> interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin of appreciation of the domestic authorities will be wider (see *Dubská* (2015) 61 E.H.R.R. 22 at [178] and *Parrillov Italy* (2016) 62 E.H.R.R. 8 at [169]). The Court has previously considered in the context of art.8 that in respect of the lack of consensus on access to experimental medical treatment for the terminally ill, the margin of appreciation is wide (see *Hristozov* (47039/11 and 358/12) 13 November 2012 at [124]). Moreover, it is clear that the case before it raises sensitive moral and ethical issues."

111. Fourth, the need for EU Member States to have a mechanism for resolving disputes between parents with parental responsibility and treating doctors as to the medical treatment of a child according to law is reflected in Art 6(2) of the Council of Europe's Convention on Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine which provides that:

> "Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law."

112. During his submissions, Mr Sachdeva also sought to persuade the court that where the parents and a body of reputable medical opinion are in agreement as to the treatment of the child, this negates the need for the court to be involved at all, notwithstanding that a different body of reputable medical opinion disagrees. Mr Sachdeva relied for support on the decision of the Supreme Court in *An NHS Trust v Y* [2018] UKSC 46 at [102] to [113] that in cases where it is proposed to withdraw life-sustaining treatment from a patient lacking capacity for the purposes of the Mental Capacity Act 2005, and there is a consensus between a body of medical opinion and the family that this should be done, the permission of the court is not required. I am not persuaded by that submission.

113. First, *An NHS Trust v Y* concerned the Mental Capacity Act 2005 as applied to a man in his fifties who had capacity until her suffered a cardiac arrest, and not the Children Act 1989. In the circumstances, the Supreme Court was not required to consider the applicability to children of the principles it formulated. Second, *An NHS Trust v Y* concerned a consensus between the family and the only doctors treating the patient. The Supreme Court was not required to give consideration to the position that pertains in this case, namely different teams of reputable clinicians take contrasting views as to the appropriate way forward and offering different options (which, of course, by definition, would denote a dispute). Finally, and in the context of the matters I have set out above regarding the proper course of action where matters *are* in dispute, I also note that Lady Black made clear in *An NHS Trust v Y* at [109] that (emphasis added):

> "The opportunity to involve the court is available whether or not a dispute is apparent, and is of particular benefit where the decision is a finely balanced one. No one would discourage an application in any case where it is felt that the assistance of the court would be valuable. And if a dispute has arisen and cannot be resolved, it *must inevitably be put before the court*."

114. Having regard to the matters set out in the foregoing paragraphs, I am satisfied that in the event of a dispute between a parent with parental responsibility and treating doctors as to the medical treatment of a child habitually resident in this jurisdiction which is not capable resolution by agreement, that dispute requires to be put before the court, either by the parents or the treating doctors, for determination by a judge. In this jurisdiction, that course will be achieved by means of an application to the Family Division of the High Court for a specific issue order under s.8 of the Children Act 1989 or by an application for declarations under the inherent jurisdiction. I will come later to the significance of this conclusion regarding this 'national' procedure for the application for judicial review.

Best Interests in the Context of Medical Disputes

115. Where a dispute arises between parents and treating doctors regarding the proper course of treatment for a seriously ill child, 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 *Re B (A Minor)(Wardship: Medical Treatment)* (1982) 3 FLR 117). 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* [2006] EWHC 507 (Fam)). The court has no power to require doctors to carry out a medical procedure against their own professional judgment.

116. As regards the application by the court of best interests principle in the context of the provision of medical treatment to children who are not 'Gillick' competent, this is well settled. The following key principles can be drawn from the authorities, in particular *Re J (A Minor)(Wardship: Medical Treatment)* [1991] Fam 33, *R (Burke) v The General Medical Council* [2005] EWCA 1003, *An NHS Trust v MB* [2006] 2 FLR 319, *Wyatt v Portsmouth NHS Trust* [2006] 1 FLR 554, *Re Ashya King* [2014] 2 FLR 855, *Kirklees Council v RE and others* [2015] 1 FLR 1316 and *Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust* [2017] EWCA Civ 410:

i) The paramount consideration is the best interests of the child. The role of the court when exercising its jurisdiction is to take over the parents' duty to give or withhold consent in the best interests of the child. It is the role and duty of the court to do so and to exercise its own independent and objective judgment.

ii) 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 the wise words of Hedley J in *Portsmouth NHS Trust v Wyatt and Wyatt, Southampton NHS Trust Intervening* [2005] 1 FLR 21 should be recalled: "This case evokes some of the fundamental principles that undergird our humanity. They are not to be found in Acts of Parliament or decisions of the courts but in the deep recesses

> of the common psyche of humanity whether they be attributed to humanity being created in the image of God or whether it be simply a self-defining ethic of a generally acknowledged humanism."

iii) Each case is fact specific and will turn entirely on the facts of the particular case.

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) The starting point is to consider the matter from the assumed point of view of the patient. The court must ask itself what the patients attitude to treatment is or would be likely to be. Within this context, the views of the child must be considered and be given appropriate weight in light of the child's age and understanding.

vi) 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 (see *Airedale NHS Trust v Bland* [1993] ACR 789 at 825). 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. Within this context, as I noted in *Re Y (No 1)* [2015] EWHC 1920 (Fam) at [37], the right to life under Art 2 of the ECHR imposes a positive obligation to provide life sustaining treatment, but that that obligation does not extend to providing such treatment if that treatment would be futile in nature and where responsible medical opinion is of the view that the treatment would not be in the best interests of the patient concerned (see *R (Burke) v The General Medical Council* [2005] EWCA 1003).

vii) The views and opinions of both the doctors and the parents must be considered. The views of the parents may have particular value in circumstances where they know well their own child. However, the court must also be mindful that the views of the parents may, understandably, be coloured by emotion or sentiment. There is no requirement for the court to evaluate the reasonableness of the parents' case before it embarks upon deciding what is in the child's best interests. In this context Waite LJ, in *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906 at 916 to 917 stated:

> "In this instance, however, in agreement with Butler-Sloss LJ, I consider that the judge was betrayed into an error of law by his concern with the need to form a judgment about the reasonableness of the mother's approach. An appraisal of parental reasonableness may be appropriate in other areas of family law (adoption, for example, where it is enjoined by statute), but when it comes to an assessment of the demands of the child patient's welfare, the starting point—and the finishing point too—must always be the judge's own independent assessment on the balance of advantage or disadvantage of the particular medical step under consideration. In striking that balance, the judge will of course take into account as a relevant, often highly

> relevant, factor the attitude taken by a natural parent, and that may require examination of his or her motives. But the result of such an inquiry must never be allowed to prove determinative. It is a mistake to view the issue as one in which the clinical advice of doctors is placed in one scale and the reasonableness of the parent in the other."

And later:

> "All these cases depend on their own facts and render generalisations— tempting though they may be to the legal or social analyst—wholly out of place. It can only be said safely that there is the scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare, widely accepted by the generality of mankind; and at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations, it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases of the latter end of the scale, there must be a likelihood (though never, of course, a certainty) that the greater the scope of general debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature."

viii) 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.

ix) Regard must be paid to the rights of the child, in particular her right to life under Art 2 and her right to respect for private and family life under Art 8. Regard must also be paid to the parents rights, in particular their right to respect for private and family life under Art 8. In this case, the right of Tafida and her parents to freedom of thought, conscience and religion under Art 9 of the ECHR is also engaged and must be considered.

x) 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.

117. Within the foregoing context, as I also noted in *Kings College Hospital NHS Foundation Trust v Haastrup*, in *Re A (A Child)* 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 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."

And

> "[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."

118. The court has heard a number of detailed submissions regarding the manner in which the foregoing principles should be interpreted and applied, both generally and in the particular circumstances of this case. These submissions concentrated on (a) the nature and application of the best interests test, (b) the weight to be given to ascertainable wishes and feelings of the child, (c) the weight to be attached to the human rights engaged in this case and (d) the significance of an absence of pain and/or awareness to the best interests evaluation. I will deal with each of them in turn.

119. As to the nature and application of the best interests test, within the context of the evidence that Tafida is likely to develop in the future further and potentially discomforting or painful sequalae as a result of her cerebral injuries, Mr Lock submits the court cannot, in determining Tafida's best interests, look into the future but rather must evaluate best interests at the point the decision falls to be made. Whilst this is the position under the Mental Capacity Act 2005, the Children Act 1989 s 1(3)(e), under which this court proceeds, provides *expressly* for consideration of risk of future harm when determining a child's best interests. In the circumstances, I accept Mr Gration's submission that, contrary to the proposition advanced by Mr Lock, Tafida's extended prognosis falls to be considered under s 1(3)(e) of the 1989 Act, including areas of physical deterioration that are covered in the medical evidence, when her best interests are being considered.

120. With respect to wishes and feelings, on behalf of the maternal aunt in the Children Act proceedings, Mr Sachdeva sought to establish that, in cases of this nature, the court should give something like pre-eminent weight (the exact starting weight Mr Sachdeva sought to articulate remained unclear) to the ascertainable values and beliefs of the child in its best interests analysis. To make good this submission, Mr Sachdeva sought to draw an equivalence between s 1(3)(a) of the Children Act 1989 and s 4(6) of the Mental Capacity Act 2005, submitting that the latter demonstrates

that when considering the best interest of the child in a case of this nature, the beliefs and values that the child would be likely to influence the child's decision must be a consideration. Mr Sachdeva also prayed in aid s 4(7)(b) of the 2005 Act, which requires the court to have regard to the views of others as to the patients beliefs and values.

121. Within this context, Mr Sachdeva further submitted that as the jurisprudence with respect to the Mental Capacity Act 2005 has grown, the extent to which an individual's values and wishes have shaped the assessment of their best interests have also grown in importance, to the point where 'substituted judgment' informed by the beliefs and values of the patient, as informed by others who know the patient is now the key driver of the court's best interests decision. Mr Sachdeva submits that this is the effect of the seminal the decision of the Supreme Court in *Aintree University Hospital NHS Foundation Trust v James* [2014] AC 591, a case concerning the treatment of a 68 year old man who had lost capacity. Mr Sachdeva accordingly submits that, whilst the child's views have always been a material factor in cases of this nature, the consequence of *Aintree* is that in cases concerning children, whilst not determinative or a legally magnetic factor, the child's beliefs and values must be given something like pre-eminent weight (again, the exact starting weight Mr Sachdeva sought to articulate remained unclear). To further support this submission, Mr Sachdeva also draws the court's attention to Art 12(4) of the UN Convention on the Rights of Persons with Disabilities, which provides that measures relating to the exercise of legal capacity respect will and preferences of the disabled person. Mr Sachdeva further contends that the equivalence he seeks to draw between the operation of the Children Act 1989 s 1(3)(a) and the Mental Capacity Act 2005 s 4(6) was recognized by Hayden J's citing of *Aintree* in *Manchester CC v M* [2019] EWHC 468 at [28]. I am not persuaded by these submissions.

122. It is clear that the starting point of the court's analysis is to consider the matter from the assumed point of view of the child. The court must ask itself what the child's attitude to treatment is or would be likely to be. Within this context, in accordance with s 1(3)(a) of the Children Act 1989, the ascertainable wishes and feelings of the child on this question, which will include his or her values and beliefs, must be considered and be given appropriate weight in light of the child's age and understanding. But that is a very different to the proposition that the child's values and beliefs must start with elevated importance or some pre-assigned weight in the balance. Whilst I accept that paragraphs [22] and [39] of judgment of Baroness Hale in *Aintree* are often cited in cases concerning children as conveniently encapsulating the overall approach to best interests in medical cases (and were used in this way by Hayden J in *Manchester CC v M*), I do not read those passages as *requiring* the court to give preferential weight to the values and beliefs of the child in the balancing exercise. As Mr Gration submits, the position under s 1(3)(a) of the Children Act 1989 is clear. The wishes and feelings of the child do not carry any presumption of precedence over any of other the other factors in the welfare checklist. The child's wishes and feelings are only one factor in the case and the court is not bound to follow it. Having regard to the words of section 1(3)(a), what governs the weight to be attached to any ascertainable values or beliefs of the child in each case is the principle of the evolving capacity of the child, expressed as a function their age and understanding. The weight to be attached to the child's wishes and feelings will depend on the particular circumstances of each case and the final decision is that of

the court and not of the child (see *Re P (Minors)(Wardship: Care and Control)* [1992] 2 FCR 681). At all times, the child's best interests are the court's paramount consideration and this demands that other factors, including the wishes and feelings of the child, may, in a given case, outweigh the ascertained beliefs and values of the child. Thus, whilst in an individual case, the child's values and beliefs may attract the most weight, in all cases they start with an equal value to that of all other relevant factors.

123. Within the context of the foregoing submissions by Mr Lock and Mr Sachdeva, I agree with Ms Gollop that in cases under the Children Act 1989, and in particular those cases concerning the medical treatment of younger children and infants, it is not helpful to seek to import, wholesale, principles from the Mental Capacity Act 2005. To take Mr Sachdeva's submission regarding values and beliefs as an example, beyond the obvious fact that children below the age of 16 are outwith the jurisdiction of the 2005 Act, that Act deals with a fundamentally different constituency of people to that of the Children Act 1989. Within this context, the emphasis placed on beliefs and values by s 4(6) and the views of others in respect of the same by s 4(7) is consistent with the fact that those with whom the Mental Capacity Act 2005 is concerned, namely adults and children over the age of 16, are more likely to have developed sophisticated religious, moral or philosophical beliefs and values before losing capacity and to have discussed them with others than are the young children or infants that the Children Act 1989 is often concerned with. Given the fact of evolving capacity, the sophistication of the values and beliefs of those children vary widely in accordance with their age and understanding, the concepts of thought, conscience and religion implying a developing capacity to understand, appreciate and engage rationally with competing ideas and beliefs and, ultimately, the fully formed capacity to exercise choice in respect of those ideas and beliefs. These matters explain the wider wording of s 1(3)(a) of the Children Act 1989 and why it is well suited to evaluating the proper weight to be attached to the widely differing sophistication of children's values and beliefs (see *Re P (Section 91(14) Guidelines)(Residence and Religious Heritage)* [1999] 2 FLR 573) and highlight the undesirability of placing a gloss on s 1(3)(a) by using s 4(6) of the 2005 Act.

124. To use ss 4(6) and 4(7) of the Mental Capacity Act 2005 to add a gloss to s 1(3)(a) of the 1989 Act risks imputing to a young child matters beyond their comprehension and failing to take account of principle of evolving capacity (which is nowhere mentioned in s 4(6) of the 2005 Act), contrary to the express requirement by s 1(3)(a) of the 1989 Act. This is a particular risk where one is dealing with the complex area of religious belief, where the child's age and understanding is key to determining the weight to be attached to any such belief. Within this context, I again note the terms of Art 6(2) of Council of Europe's Convention on Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, which stipulates that "The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity."

125. Turning to the legal submissions regarding the rights engaged in this matter, during the course of her submissions, Ms Gollop appeared to suggest that were the Trust to continue treating Tafida it may or would breach her rights under Art 3 of the ECHR. This argument was raised only during the course of the hearing and was not pressed in detail. Indeed, at this stage the argument amounts to the contention that if the court

refuses the Trust's application the court will act to breach Tafida's Art 3 rights by compelling the continuation of inhuman or degrading treatment. In the circumstances, I do not consider it necessary to address this argument in detail. Within its best interests analysis the court is required to 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 and will do so. Likewise, it is expressly required to consider the benefits and burdens on the child. If having undertaken that exercise, the court considers that treatment should continue in Tafida's best interests, it is difficult to see how that decision could simultaneously amount to a breach of Art 3.

126. The parents and the maternal aunt also submit that Tafida is being unlawfully deprived of her liberty pursuant to Art 5 of the ECHR. In this regard, I need only note the following observations of the Court of Appeal in *Evans v Alder Hey Children's NHS Foundation Trust* [2018] 2 FLR 1269 at [60] to [62]:

> "[60] In *R (Ferreira) v Inner South London Senior Coroner (Intensive Care Society and Others Intervening)* [2017] EWCA Civ 31, [2017] 3 WLR 382, the Court of Appeal decided that a person is not being deprived of their liberty where they are receiving treatment and are physically restricted by their physical infirmities and by the treatment they are receiving: para [10]. In reaching this conclusion the court referred to *Nielsen v Denmark* in which the European Court of Human Rights had concluded that the hospitalisation of the child in a child psychiatric ward did not amount to a deprivation of liberty. A critical part of the court's assessment was that (at para 72):
>
> > '… the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital. The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many medical wards where children with physical disorders are treated.'
>
> [61] In *Ferreira* Arden LJ adopted the expression used in the European Court of Human Rights' decision of *Austin and Others v United Kingdom* (Application Nos 39692/09, 40713/09 and 41008/09) [2012] ECHR 459, (2012) 55 EHRR 14, [2012] Crim LR 544, 32 BHRC 618 when excepting from the scope of Art 5 'commonly occurring restrictions on movement'. Arden LJ concluded, at paras [88]–[89], that restrictions resulting from the administration of treatment, because they are the 'well-known consequences of a person's condition, when such treatment is required', do not amount to a deprivation of liberty. [62] This clearly applies to Alfie's situation. We see no basis for any submission that he is being deprived of his liberty in terms either of Art 5 or the doctrine of habeas corpus."

127. The parents place their religious faith and practices, and Tafida's contended for understanding of and belief in the same at the heart of their objection to the course of action proposed by the Trust. Art 9 of the ECHR provides as follows:

> **“Article 9**
>
> **Freedom of thought, conscience and religion**
>
> 1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
>
> 2. Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.”

128. The right to freedom of thought, conscience and religion has been described as a far reaching and profound right encompassing freedom of thought on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others (see Human Rights Committee General Comment No 22 1993 HRI/GEN/1/Rev 8, p 194, para 1). In *Grzelak v Poland* (2010) Application No 7710/02 at [8] the European Court of Human Rights reiterated that:

> “… freedom of thought, conscience and religion, as enshrined in Article 9, is one of the foundations of a ‘democratic society’ within the meaning of the Convention. It is, in its religious dimension, one of the most vital elements that go to make up the identity of believers and their conception of life, but it is also a precious asset for atheists, agnostics, sceptics and the unconcerned. The pluralism indissociable from a democratic society, which has been dearly won over the centuries, depends on it. That freedom entails, inter alia, freedom to hold or not to hold religious beliefs and to practise or not to practise a religion.”

129. International law does not establish a minimum age above which a person may enjoy freedom of thought, conscience and religion. Further, a person’s right to freedom of thought, conscience and religion will often, as in this case, exist in the context of beliefs embedded within the values of local communities, which communities themselves have a cohesive ethical, moral, spiritual, cultural and social framework. Within this context, Mr Sachdeva refers the court to the decision in *IH (Observance of Muslim Practice)* [2017] EWCOP 9 in which Cobb J considered at [40] that P derived benefit from his family feeling that he was being enabled to follow Muslim custom to the fullest possible extent. Mr Sachdeva also cites *IH (Observance of Muslim Practice)* as an example of the court taking into account religious belief and practice even where P had limited or no understanding of it and of cultural and religious beliefs, including those held by parents and community, having a significant impact on the assessment of best interests.

130. Against this, Art 9(2) makes clear that derogations from the right to freedom of thought, conscience and religion are permitted in certain narrowly defined circumstances. Whether a particular act constitutes interference in the rights enshrined in Art 9(1) will depend on all the circumstances of the case in question, including the extent to which in the circumstances an individual can reasonably be

expected to be at liberty to manifest his or her beliefs in practice (see *Kalac v Turkey* (1997) 27 EHRR 552 cited in *R (Williamson) v Secretary of State for Education and Employment* [2005] 2 AC 286 at [38]). In the circumstances, the right to freedom of thought, conscience and religion may be circumscribed where this conflicts with the child's best interests assessed by reference to the terms of s 1 of the Children Act 1989. In *Prince v Massachusetts* (1944) 321 US 158 the US Supreme Court held that parents' rights to manifest their religion are necessarily circumscribed by the interests of the child in that:

> "… neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor [*sic*] and in many other ways. Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death … [T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare; and that this includes, to some extent, matters of conscience and religious conviction …"

131. Finally on the submissions as to the law, in circumstances where the medical consensus in this case is that Tafida does not feel pain in her resting state and has with no awareness or a minimal current level of awareness, the parties made submissions regarding the significance of these factors, and the question of dignity, for the best interests analysis.

132. Ms Gollop submitted that in *Re J (A minor) (wardship: medical treatment)* [1991] Fam 33 at page 46 and in *Re A* [2016] EWCA Civ 759 at [58] the Court of Appeal made clear that the absence of pain does not prevent, in an appropriate case, the court concluding that life-sustaining treatment should nonetheless not be continued. Within this context, I further note that in the Court of Appeal in *Airedale NHS Trust v Bland* [1993] AC 806 at 829, Hoffman LJ observed as follows with respect to the argument of the Official Solicitor that Anthony Bland felt no pain or awareness and therefore had no interests which suffered from his being kept alive:

> "I think that the fallacy in this argument is that it assumes that we have no interests except in those things of which we have conscious experience. But this does not accord with most people's intuitive feelings about their lives and deaths."

133. In *Airedale NHS Trust v Bland* [1993] AC 789, whilst the House of Lords upheld the decision of the Court of Appeal, in the course of their speeches both Lord Keith and Lord Mustill articulated the potential difficulties with the Hoffman LJ's proposition where it is the best interests of the *patient* who suffers no pain and is unaware and not those of others that are the focus of the court. Within this context, at 858 Lord Keith observed as follows:

> "It is argued for the respondents, supported by the amicus curiae, that his best interests favour discontinuance. I feel some doubt about this way of putting the matter. In *In re F. (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 this House held that it would be lawful to sterilise a female mental patient who was incapable of giving consent to the procedure. The ground of the decision was that sterilisation would be in the patient's best interests because her life would be fuller and more agreeable if she were sterilised than if she were not. In *In re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33 the Court of Appeal held it to be lawful to withhold life-saving treatment from a very young child in circumstances where the child's life, if saved, would be one irredeemably racked by pain and agony. In both cases it was possible to make a value judgment as to the consequences to a sensate being of in the one case withholding and in the other case administering the treatment in question. In the case of a permanently insensate being, who if continuing to live would never experience the slightest actual discomfort, it is difficult, if not impossible, to make any relevant comparison between continued existence and the absence of it. It is, however, perhaps permissible to say that to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity in this world, it must be a matter of complete indifference whether he lives or dies."

And Lord Mustill at 897 observed that:

> "Quite apart from this the case of Anthony Bland seems to me quite different. He feels no pain and suffers no mental anguish. Stress was laid in argument on the damage to his personal dignity by the continuation of the present medical regime, and on the progressive erosion of the family's happy recollections by month after month of distressing and hopeless care. Considerations of this kind will no doubt carry great weight when Parliament comes to consider the whole question in the round. But it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none. What other considerations could make it better for him to die now rather than later? None that we can measure, for of death we know nothing. The distressing truth which must not be shirked is that is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind."

134. In *Airedale NHS Trust v Bland* at 899 Lord Mustill further highlighted the potential for the difference between no awareness and some awareness to change the court's best interest evaluation:

> "In law, if my conclusion is right, the way is clear for the doctors to proceed as they and the family think best. If the principle of *Bolam* applies that is the end of the matter, since nobody could doubt that a body of reasonable medical opinion would regard the proposed conduct as right. But even if

> *Bolam* is left aside, I still believe that the proposed conduct is ethically justified, since the continued treatment of Anthony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality. Some who have written on this subject maintain that this is too narrow a perspective, so I must make it clear that I do not assert that the human condition necessarily consists of nothing except a personality, or deny that it may also comprise a spiritual essence distinct from both body and personality. But of this we can know nothing, and in particular we cannot know whether it perishes with death or transcends it. Absent such knowledge we must measure up what we do know. So doing, I have no doubt that the best interests of Anthony Bland no longer demand the continuance of his present care and treatment. This is not at all to say that I would reach the same conclusion in less extreme cases, where the glimmerings of awareness may give the patient an interest which cannot be regarded as null. The issues, both legal and ethical, will then be altogether more difficult."

135. During the course of the hearing, the court also heard a number of submissions concerning the role of the concept of dignity in the best interests analysis. Ms Gollop reminded the court that Art 1 of the CFR provides that human dignity is inviolable and must be respected and protected. She further reminds the court that Art 3 of the CFR enshrines the right to respect for a person's physical integrity. Within this context, I note the observations of Hoffman LJ, as he then was, in the Court of Appeal in *Airedale NHS Trust v Bland* [1993] QC 806 at 826:

> "And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person."

And of Handler J in the American decision *In re Conroy* (1985) 486 A.2d 1209, 124 at p 1249:

> "The medical and nursing treatment of individuals in extremis and suffering from these conditions entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best of motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough."

136. Against this, Mr Sachdeva submitted that dignity is a subjective concept that means different things to different people and, as such, is heavily value laden and extremely

difficult to define. In the circumstances, Mr Sachdeva cautioned against its use of such a mercurial concept as a reliable factor in the best interests analysis.

137. Not all human life is lived in dignity. Dignity also depends on the subjective frame of reference that is adopted (see *Christian Education South Africa v Minister of Education* (2000) 9 BHRC 53, Const Ct of South Africa). For example, whilst "the constant and extensive handling and manipulation of the body" by dedicated nursing staff in a medical establishment may in time reach a certain threshold of indignity, the location of that threshold and the extent to which it is reached might be very different if the "the constant and extensive handling and manipulation of the body" is undertaken at home by dedicated and loving parents. Within this context, in *M v N* [2015] EWCOP 76 at [72] Hayden J observed that, "There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain".

138. Finally, and related to these difficult issues, the Royal College of Paediatrics and Child Health has issued guidance entitled '*Making Decisions to Limit Treatment in Life-limiting and Life-threatening Conditions in Children: a Framework for Practice*', published in March 2015. The guidance was considered by the President in *Re Jake (A Child)* [2015] EWHC 2442 (Fam). With respect to the issues raised in this case, the Guidance states as follows with respect to the sets of circumstances when treatment limitation can be considered because it is no longer in the child's best interests to continue, as treatments cannot provide overall benefit:

> "**I When life is limited in quantity**
>
> If treatment is unable or unlikely to prolong life significantly it may not be in the child's best interests to provide it. These comprise:
>
> A. Brain stem death, as determined by agreed professional criteria appropriately applied;
>
> B. Imminent death, where physiological deterioration is occurring irrespective of treatment;
>
> C. Inevitable death, where death is not immediately imminent but will follow and where prolongation of life by LST confers no overall benefit.
>
> **II When life is limited in quality**
>
> This includes situations where treatment may be able to prolong life significantly but will not alleviate the burdens associated with illness or treatment itself. These comprise:
>
> A. Burdens of treatments, where the treatments themselves produce sufficient pain and suffering so as to outweigh any potential or actual benefits;
>
> B. Burdens of the child's underlying condition. Here the severity and impact of the child's underlying condition is in itself sufficient to produce such pain and distress as to overcome any potential or actual benefits in sustaining life;

> C. 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."

139. In respect of circumstances where life may be of limited quality due to a lack of ability to benefit from continued life, the Guidance provides further illumination as follows:

> "**C. Lack of ability to derive benefit**
>
> In other children the nature and severity of the child's underlying condition may make it difficult or impossible for them to enjoy the benefits that continued life brings. Examples include children in Persistent Vegetative State (PVS), Minimally Conscious State, or those with such severe cognitive impairment that they lack demonstrable or recorded awareness of themselves or their surroundings and have no meaningful interaction with them, as determined by rigorous and prolonged observations. Even in the absence of demonstrable pain or suffering, continuation of LST may not be in their best interests because it cannot provide overall benefit to them. Individuals and families may differ in their perception of benefit to the child and some may view even severely limited awareness in a child as sufficient grounds to continue LST. It is important, here as elsewhere, that due account of parental views wishes and preferences is taken and due regard given to the acute clinical situation in the context of the child's overall situation. Although it is possible to distinguish these different groups of decisions to limit LSTs that are based on quality-of-life considerations, in practice combinations may be present. For example, a child or infant in intensive care may have sustained such significant brain injury that future life may provide little benefit, while both intensive treatment and future life are likely to cause the child substantial pain and distress."

DISCUSSION

Judicial Review

140. I am satisfied in this case that, as is clear from the evidence filed and served by the Trust, that on or around 8 July 2019, in response to a request by the parents to transfer Tafida to the Gaslini Hospital in Italy, the Trust decided not to agree to that transfer pending an application to the High Court in light of the dispute concerning Tafida's best interests. I am further satisfied that the evidence demonstrates clearly that the Trust took this decision on the basis of its own assessment of Tafida's best interests. Contrary to the submissions made on behalf of the parents and Tafida, I am satisfied that there is no sufficiently cogent evidence to ground a conclusion that the Trust based its decision either on Tafida's nationality or on any philosophical or ethical differences as between the United Kingdom and Italy regarding the withdrawal of life sustaining treatment.

141. I am equally satisfied that, contrary to the submissions of Ms Gollop, the decision made by the Trust is amenable to judicial review. The Trust is a public body that exercises statutory functions under the National Health Service Act 2006. As

conceded by Ms Gollop, the treating doctors were acting in their capacity as employees of the Trust when they took the relevant decision. As I will come to, it is plain that the decision by the Trust acted to restrict the exercise of EU rights from which Tafida benefits and that have direct effect in domestic law. More widely, it is plain from the authorities that decisions of NHS bodies are amenable to judicial review (see for example *R(JB) v Haddock* [2006] EWCA Civ 961, [2006] HRLR 1237). Finally, I note that the NHS Constitution itself provides at page 10 that:

> "You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority."

142. Within this context, I am not persuaded by the Trust's submission that the existence of a requirement on the Trust, both procedurally and pursuant to its statutory duties, to bring the dispute as to Tafida's best interests before the High Court, and the existence of a statutory regime to determine the dispute, renders the Trust's decision immune from judicial review. Whilst those matters will plainly be relevant to the question of whether the decision made constituted an interference with the EU rights engaged and, if so, the question of whether that interference was justified, I am entirely satisfied that they do not act to take the decision itself outside the proper ambit of judicial review.

143. I am not persuaded that the decision of the Trust deprived Tafida of her liberty for the purposes of Art 5 of the ECHR. The Court of Appeal has made clear that a person is not being deprived of their liberty where they are receiving treatment and are restricted physically by their infirmities and by the treatment they are receiving (see *Evans v Alder Hey Children's NHS Trust* [2018] 4 WLUK 624 at [12] and *Gard* [2017] 4 WLR 131). I am likewise not able to accept the submission that in taking the decision it did, the Trust discriminated against Tafida or her parents for the purposes of the Equality Act 2010. I am satisfied that, in deciding to refuse to agree to Tafida being transferred to the Gaslini Hospital pending a determination by the court as to her best interests in accordance with established procedure, the Trust cannot be said to have applied a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of Tafida or her parents. I am also satisfied that it cannot be said that in taking its decision the Trust failed to have regard to, or contravened the NHS Constitution. However, I am satisfied that Tafida and her parents have made out their case under Art 56 of TFEU.

144. The Trust does not deny that, in making its decision not to agree to Tafida being transferred to the Gaslini Hospital, it did not give any consideration to whether that decision would interfere with Tafida's EU directly effective rights under Art 56 nor, if it did so interfere, to whether that inference was justified on the grounds of public policy. In the circumstances, and having regard to the decision of the Court of Appeal in *Blood*, it is beyond sensible dispute that the Trust did not comply with the usual administrative law standards which are enforced by judicial review, including failing to direct itself correctly as to the applicable EU law. In the circumstances, I am satisfied that the Trust's decision on 8 July 2019 was *prima facie* unlawful. I am however, also satisfied that *had* it considered Tafida's Art 56 rights when making its decision not to agree to Tafida being transferred to the Gaslini Hospital, the Trust would have reached the same decision for the following reasons.

145. As I have noted, the Trust does not dispute that Tafida benefits from EU rights under Art 56 having direct effect. Within this context, asking and answering the first question posed by the Court of Appeal in *Blood*, I am satisfied that, from a functional point of view, the ability for Tafida to benefit from her directly effective EU rights under Art 56 to receive medical treatment in another Member State was not only substantially impeded but made impossible by the decision of the Trust not to agree to her parents request that she be transferred to the Gaslini Hospital. Accordingly the decision of the Trust constituted a plain interference with Tafida's directly effective EU rights under Art 56 of TFEU.

146. However, interrogating the second question set out in *Blood*, I am also satisfied that it is clear that, having regard to the established national procedure in this jurisdiction for determining disputes between parents and doctors over whether a child should or should not continue to receive life-sustaining treatment and to the fact that the relevant EU jurisdictional provisions in the form of BIIa confer jurisdiction for the use of that national procedure in this case, had the Trust asked and answered the second question when making its decision, the Trust would have come to the conclusion that the interference in Tafida's EU rights constituted by its decision was justified on public policy grounds.

147. For the reasons set out above, I am satisfied that the position in this jurisdiction is that, in the event of a disagreement between a parent with parental responsibility and treating doctors as to the medical treatment of a child habitually resident in this jurisdiction that is not capable resolution by agreement, the resulting dispute as to best interests requires to be put before the court, either by the parents or the treating doctors, for determination by a judge. In this jurisdiction, that course is achieved by means of an application for a specific issue order under s.8 of the Children Act 1989 or by an application for declarations under the inherent jurisdiction of the High Court. It is this procedure that the Trust chose to invoke when it became apparent that the parents wished to transfer Tafida to the Gaslini Hospital and the Trust considered this transfer not to be in Tafida's best interests.

148. In considering whether this established national procedure for the determination of a dispute between parents and doctors concerning an aspect of a child's best interests amounts to a justification on public policy grounds for derogating from Tafida's directly effective EU rights under Art 56, the case law considered above makes clear that this is a question for the *national* court and that the following factors fall to be considered in answering it:

i) Is the measure equally applicable to all persons and undertakings operating in the Member State in question (and if not is it justified by one of the Treaty exceptions (see *Gouda v Commissariat voor de Media* C288/89 EU:C:1991:157))?

ii) Is the measure justified by some legitimate public interest objective that is consistent with, or not incompatible with, the aims laid down in the Treaty provisions?

iii) Is the measure suitable for securing the attainment of the objective that it pursues?

iv) Is the measure proportionate to the objective, i.e. does ensure the objective it pursues and not go beyond what is necessary to attain that objective?

149. Subject to the jurisdictional provisions of BIIa, which are applicable in all EU Member States save Denmark, the national procedure for the determination of a dispute between parents and doctors concerning a child's medical treatment is equally applicable to all children in this jurisdiction. In so far as the procedure cannot be invoked in relation to an EU citizen child who is not habitually resident in England and Wales for the purposes of Art 8 of BIIa, this distinction is solely a function of directly effective EU law. Moreover, the domestic procedure remains available with respect to such children in a case of urgency, pursuant to Art 20 of BIIa, and in relation to any EU citizen child whose habitual residence cannot be established, pursuant to Art 13 of BIIa. In circumstances where the jurisdictional foundation for the national procedure in question is provided by EU law, I am not able to accept the submission that that procedure conflicts in anyway with the primacy of EU law or is discriminatory on the grounds of nationality or otherwise.

150. Further, I am satisfied that the national procedure for the determination of a dispute between parents and doctors concerning a child's medical treatment is justified by a legitimate public interest objective that is consistent with, and not incompatible with, the aims laid down in the EU Treaty provisions.

151. The national requirement to bring a dispute between parents and doctors concerning a child's medical treatment before the court is promoted by a public policy objective in the United Kingdom founded on imperative requirements of public interest, namely:

i) The public interest in the protection of a child's best interests in the context of medical decision making, where the best interests of children are one of the fundamental interests of society and are the paramount consideration;

ii) The public interest in the courts and not treating doctors determining the outcome of a dispute between parents and treating doctors as to whether a child should continue to receive life-sustaining treatment;

iii) The public interest in treating doctors having a legally certain route available to them to determine what the law requires of them in cases where there is a dispute as to the child's medical treatment;

iv) The public interest in ensuring that a child has an independent voice in the determination of a dispute between parents and doctors as to the child's medical treatment;

v) The public interest in ensuring equal treatment of all children where a dispute arises as to their medical treatment.

In my judgment, the conclusion that the national procedure is justified on the grounds of public policy is further reinforced by the principle that on difficult moral or ethical questions there is a wider margin of appreciation accorded to Member States with respect to national measures. The question which the national procedure seeks to answer relates to a policy choice of a moral and philosophical nature which is a matter for Member States within the margin of appreciation and in respect of which they are entitled to invoke the ground of public policy referred to in Art 56.

152. The foregoing imperative requirements of public interest are consistent with the aims laid down by the EU Treaty provisions, which require the directly effective EU rights under Art 56 to be implemented in a manner that treats the child's best interests as a primary consideration. Within this context, EU law would not reproach a national authority for seeking to ensure that the Art 56 rights of a child are implemented in a manner consistent with the best interests of that child by determining, where there is a dispute, whether it is in the child's best interests to receive medical treatment in another Member State, particularly having regard to paragraphs 4, 7 and 12 of Directive 2011/24 EU. Again, that this must be the position is made clear by the fact that *EU law*, in the form of the jurisdictional provisions of BIIa, confers jurisdiction to determine such a dispute on the Member State of the child's habitual residence. Where there is a dispute in the Member State of the child's habitual residence between treating doctors and parents exercising their parental responsibility on an issue as fundamental as whether it is in a child's best interests to continue to receive life sustaining treatment in another Member State, the EU has *expressly* conferred upon the Member State of the child's habitual residence jurisdiction to determine that welfare dispute pursuant to Art 8 of BIIa in accordance with the child's best interests.

153. I am further satisfied that the national procedure is suitable for securing the attainment of the objective that it pursues, namely the fair and expeditious determination of a disagreement between doctors and parents as to what medical treatment in the child's best interests. The procedure adopted in this jurisdiction to attain that objective ensures that the dispute is put before an independent judge, who evaluates the dispute on the available evidence by reference to a legal framework that places the child's best interests as the paramount consideration (and which provides for consideration of the EU rights engaged) and in which process the child is provided with an independent voice on the issue central to his or her future. In order for a national rule to be justified under EU law it must be objectively necessary in order to help achieve the aim sought by the rule: that means that it must be useful (or relevant) and indispensable, in other words, it must not be capable of being replaced by an alternative rule which is equally useful but less restrictive of the freedom to supply services. In this respect, and once again, EU law *itself* confers jurisdiction on the domestic court in this case to determine the dispute between the parents and the treating doctors as to the medical treatment of the child using the procedure described. Further, the suitability of the national procedure for determining disputes of this nature is reinforced by the fact that it will generally be the jurisdiction in which the child is habitually resident who will have the information required to deal with the question that falls for decision. Within the foregoing context, I cannot accept the submission of advanced by Mr Sachdeva and Mr Lock that, where it is satisfied that the *transfer* itself is not antithetic to the child's best interests, the court could in the alternative proceed to determine the substantive best interests issue *after* the child has been transferred to receive treatment. Such a system plainly could not be said to be equally useful but less restrictive of the freedom to supply services. In addition, it would be manifestly contrary to a child's best interests to transfer a child between EU Member States in order to receive treatment where an extant dispute as to whether this is in the child's best interests remains to be determined.

154. Finally, I am satisfied that the national procedure is proportionate to the objective, i.e. it ensures the objective it pursues and does not go beyond what is necessary to attain that objective. The national procedure goes no further than the jurisdiction conferred by BIIa, namely the determination of a dispute concerning an aspect of parental responsibility. Where receipt of treatment is held to be in the child's best interests then the relevant EU right is implemented. Where it is not held to be in the child's best interests, then EU law would not require effect the implementation of an EU right in a manner that is antithetic to the child's best interests having regard to the provisions of the CFR. Within this context, whilst the national procedure does constitute a *prima facie* derogation from the EU rights under Art 56, such derogation is accordingly temporary and lasts only as long as necessary to determine the issue in dispute in accordance with the jurisdictional provisions of EU law. Within this context, I am satisfied that the national requirement to bring before the court a dispute between treating doctors and parents on an issue as fundamental as whether life sustaining treatment should continue of be withdrawn does not have an effect beyond that which is necessary and complies with the principle of proportionality.

155. Within the foregoing context, I am satisfied that in making its decision not to agree to Tafida being transferred to the Gaslini Hospital pending a decision of the court, the Trust did not give *any* consideration to Tafida's Art 56 rights and, in particular did not ask itself whether its decision constituted an interference in those directly effective rights and, if so, whether it was nonetheless justified. I am further satisfied therefore that, applying the principles in *Blood*, the decision of the trust is unlawful. I am also satisfied however, that had the Trust asked itself the first and second questions posed in *Blood* by reference to Art 56 of TFEU, it would inevitably have reached the same decision not to agree to Tafida's transfer pending a decision of the court on the basis that the national procedure it chose to follow constitutes a justified derogation from Tafida's rights under Art 56. In short, had the Trust adopted the correct approach, this matter would, I am satisfied, have arrived at precisely the point it has now reached.

156. As to any remedy in the judicial review proceedings in this context, the general approach should be that a claimant who succeeds in establishing the unlawfulness of administrative action in a claim for judicial review is entitled to be granted a remedial order. The court does however, have common law discretion to withhold a remedy (or grant a declaration) where a remedy would serve no practical purpose or where to do so would result in unacceptable delay. Whilst the common law discretion to refuse a remedy is a narrow one, and narrower still where the claimant has succeeded in demonstrating a directly effective right under European law, the existence of an EU law right does not act as a complete bar to the court's discretion.

157. Within this context, I am satisfied that it would now serve no practical purpose to quash the decision of the Trust not to agree to the transfer of Tafida to Italy pending court proceedings to determine her best interests where I am satisfied that this is the decision the Trust would have made had it properly taken its decision, where those proceedings are now before the court for determination and where the court is in a position to determine them. In addition, quashing the Trust's decision and remitting it to be retaken would engender unacceptable delay for Tafida (see *R v Legal Aid Board, ex p W (Minors)* [2001] 1 WLR 2502. Finally, and in any event, pursuant to the Criminal Justice and Courts Act 2015 s.84, the High Court must refuse relief on an application for judicial review if it appears to the court to be highly likely that the

outcome for the applicant would not have been substantially different if the conduct complained of had not occurred. That is the position here for the reasons I have given.

158. On this basis, whilst satisfied that decision of Trust is unlawful in circumstances where the Trust failed to consider Tafida's directly effective EU rights under Art 56 of TFEU at all when deciding whether to agree to the parents' request for Tafida to be transferred to the Gaslini Hospital, in the particular circumstances of this case I am also satisfied that it is not appropriate to grant relief on the application for judicial review, including a declaration in circumstances where this judgment speaks for itself.

Children Act 1989 and Inherent Jurisdiction Proceedings

159. In light of foregoing decision, I am satisfied that it is appropriate now to go on to determine the Trust's applications pursuant to s 8 of the Children Act 1989 and under the inherent jurisdiction of the High Court. Having anxiously balanced all of the conflicting considerations in this case, I have decided that I am *not* satisfied on the totality of the evidence that it is appropriate in this case to grant the declarations sought by the Trust and that, accordingly, the applications made by the Trust should be dismissed. My reasons for so deciding are as follows.

(a) Tafida's Medical Condition and Prognosis

160. In circumstances where the medical evidence in this case is unchallenged, and in the context of the assessment of Tafida's best interests, the medical issues that are central to that assessment are, in my judgment, the level of Tafida's awareness, the question of whether Tafida experiences pain, the question of the extent to which Tafida is able to benefit from treatment and the prognosis for Tafida in respect of each of these factors.

161. With respect to Tafida's level of awareness, it is clear on the medical evidence that she has a very severe generalised cerebral dysfunction. Tafida has a sleep wake cycle, with eye opening and closing, her eyes can sometimes be maintained fixed in axis with a direct and consensual pupillary light reflex and a 'dolls eye' response that is equivocal but not entirely absent. I have taken careful account of the evidence of the parents that Tafida demonstrates some level of awareness and small incidents of volitional response, some of which they contend are evidenced on the videos to which I have given detailed consideration. Whilst I am satisfied that this evidence must be viewed with caution for the reasons I have already articulated, I note that Dr Smith in his report makes reference to video (also shown to the court) where Tafida appeared to lift her arm and turn it outwards to place rolled up bandage into the hand of her nanny and to his observations of Tafida moving her eyes to the location of her mother in response to voice and touch, although after two incidences of this, that result was not replicated. Within this context, there is a consensus of medical opinion is that it is not possible to exclude in Tafida some level of conscious awareness. Dr Smith in particular is clear that he would be very wary of the risk of misinterpreting the absence of responses in Tafida as VS because of the inevitable limitations on the accuracy with which medical science is able to test for awareness in a child with Tafida's injuries. Within the context of this difficulty, and mindful of Dr Smith's evidence that, at least in a paediatric context, the distinction between VS and MCS is somewhat artificial, having regard to the totality of the evidence available to me I proceed on the basis that Tafida is likely to retain a minimal level of awareness.

162. With respect to the question of Tafida's ability to feel pain, I again bear in mind Dr Smith's caution that accurate and reliable assessment of ability to experience pain, like assessment of awareness, is fraught with difficulty in a patient as severely neurologically impaired as Tafida. As to the evidence that is available, Dr T noted in early July 2019 that Tafida "flexes to pain". The Italian team elicited similar flexion in the limbs with "intense pain stimulation" but also noted no EEG changes as the result of such painful stimulation. Within this context, the preponderance of medical evidence is to the effect that Tafida shows no facial grimace to deep pain, does not cough or gag to endotracheal tube suction and does not respond to pain by way of an increase in heart rate or withdrawal from painful stimuli. Accepting the difficulties, and doing the best I can on the available evidence, I am satisfied that, at least in her resting state or standard condition, it is likely that Tafida does not perceive pain.

163. With respect to Tafida's prognosis, on the unchallenged medical evidence before the court I am satisfied that Tafida's current medical condition is substantially irreversible. Whilst I am satisfied that the consensus of medical opinion is that some minimal neurological progress *may* be made by Tafida in the future, I am equally satisfied that Tafida will remain profoundly neurologically disabled for the rest of her life. I am further satisfied that, if she continues to receive life-sustaining treatment, Tafida will likely live for a further ten to twenty years. I am equally satisfied that it is more likely than not that over the course of this period she will develop a range of consequential conditions that will, in addition to the continuation of a severe movement disorder and immobility comprising combination of spasticity and dystonia and severe cognitive impairment, likely include drug resistant epilepsy, scoliosis with associated cardio-respiratory impairment, which may require surgery, partial or full hip dislocation, pneumonia with worsening respiratory failure, bone disease due to osteopaenia associated with pathological fractures, the development of renal stones, pressure sores, hypertension and malignancy.

164. Finally, the evidence is clear that Tafida is currently medically stable and has some ongoing breathing effort, albeit not sufficient to enable her to breath without the aid of a mechanical ventilator. In this context, I note that whether Tafida is capable of being weaned from that ventilator is a question that the Italian medical team consider requires further and detailed evaluation to definitively answer this question. The Italian medics likewise consider that a better prognostic definition might require serial standardised neurological and neurophysiological evaluations in addition to functional MRI studies.

(b) Best Interests

165. Within the foregoing medical context, it is plain that there are substantial factors in this case that tend to support the case made by the Trust that it is not in Tafida's best interests for life-sustaining treatment to continue. However, in this case, I am also satisfied that there are compelling factors on the opposite side of the balance that argue against the best interests declaration sought by the Trust in respect of Tafida's medical care. On balance, I am satisfied that the latter prevail over the former.

166. Taking as a starting point the assumed view of Tafida, there are obvious difficulties in a judge seeking to place him or herself in the shoes of a four year old child. However, the court must do the best it can on the evidence available. In this case, the parents and the maternal aunt in particular urge upon the court evidence of Tafida's

understanding of the religious tradition in which she was being raised as the basis for establishing Tafida's assumed view on the question of whether or not treatment should continue. Within this context, I accept the submission of Ms Gollop and Mr Gration that caution is needed when seeking to establish an assumed point of view for Tafida as a basis for taking account of her wishes and feelings. In relation to matters of thought, conscience and religion, children will move along a continuum from relying on the direction and guidance provided by their parents to ultimately having their own ideas and making their own choices about matters of religion and conscience. In the formative stages, their understanding will not be sophisticated. On the evidence available to the court, I am satisfied that that is the position in this case. It is plain on that evidence that Tafida had a growing understanding of the practices of Islam, had developed a concept of the importance of life and an accepting and non-judgmental approach to those with disability. However, and as fairly conceded by the mother, given Tafida's age and understanding, I am also satisfied that she would have had in February 2019 no concept or contemplation of her current situation, or of the complex and grave legal, moral and ethical issues it raises.

167. Within this context, in seeking an assumed point of view for Tafida as a starting point, it is important that the subject matter of that assumed view is properly formulated by reference to the issue before the court. In the context of this case, that subject matter is framed by the Trust as a bare situation of continued life likely, but not certainly, pain free but in a situation of minimal or no awareness, with no hope of recovery and the certain prospect of developing further debilitating conditions, which with any improvement in awareness will further burden Tafida. On the evidence, this is an accurate but as I will come to, incomplete formulation. Within this context, a formative appreciation that life is precious, a wish to follow a parent's religious practice and a non-judgmental attitude to disability is very different to the far more complex concept of living a life of minimal awareness with no prospect of substantive recovery. In such circumstances, and notwithstanding her developing conception of the value of life and of the religion in which she was being raised, I accept that it would be unsafe to infer from the available evidence an acceptance by Tafida of, or wish to live such an existence *per se*.

168. However, in this case I am satisfied that the subject matter of Tafida's assumed view must be framed somewhat more widely than the formulation contended for by the Trust having regard to the medical consensus between the doctors in this jurisdiction and in Italy of what can ultimately be achieved for Tafida, namely care by her family at home on ventilation in the same manner as children in a similar position to Tafida elsewhere in this jurisdiction. Further, I must also bear in mind that a person may wish to continue to receive treatment notwithstanding the presence of profound disability and that a child's attitude is often influenced by the views, beliefs and guidance of his or her parents. Within this context, whilst for the reasons I have set out above I am cautious about imputing to Tafida any sophisticated views generally given her age the levels of religious, I am satisfied that if Tafida was asked she would not reject out of hand a situation in which she continued to live, albeit in a moribund and at best minimally conscious state, without pain and in the loving care of her dedicated family, consistent with her formative appreciation that life is precious, a wish to follow a parent's religious practice and a non-judgmental attitude to disability.

169. Turning to the principle of the sanctity of life, the parents have, understandably, placed emphasis on the contents of the *fatwa* secured from the Muslim Council of Europe. Within the context of these proceedings however, the *fatwa* is simply a valuable restatement of the sanctity of life, a sanctity recognised by all the great religions and also by those who view life through a secular or scientific prism. The sanctity of life is a fundamental, indeed sacred, principle from which there flows a strong presumption in favour of a course of action that will prolong life. Within this context, Tafida's life has inherent value. It is also of value to Tafida herself, it is precious to her parents, sibling and family and even now it adds, in whatever small and incomplete way, to the body of collective human experience. Tafida is profoundly disabled but a life of disability is of equal value to all other lives.

170. Within this context, the *key* principle in these proceedings is that the sanctity of Tafida's life is, for the purposes of the law, not absolute but may give way to countervailing factors. At the urging of Ms Gollop, I have paid careful regard to fact that the authorities establish that the sanctity of life *may* be overborne in circumstances where a child feels no pain but where the child has, as Tafida has, minimal or no awareness of her family and social relationships, minimal or no ability to respond to external stimuli so as to take comfort or enjoyment from those who love her or the world around her and engage in the enlargement of knowledge and will derive no benefit from the medical treatment being administered such that she will continue to suffer from profound cognitive impairment that will not change. Within this context, the following extract from the RCPCH Guidelines *Making Decisions to Limit Treatment in Life-limiting and Life-threatening Conditions in Children: a Framework for Practice* is of particular relevance in this case (emphasis added):

> "In other children the nature and severity of the child's underlying condition may make it difficult or impossible for them to enjoy the benefits that continued life brings. Examples include children in Persistent Vegetative State (PVS), Minimally Conscious State, or those with such severe cognitive impairment that they lack demonstrable or recorded awareness of themselves or their surroundings and have no meaningful interaction with them, as determined by rigorous and prolonged observations. Even in the absence of demonstrable pain or suffering, continuation of LST *may* not be in their best interests because it cannot provide overall benefit to them."

171. With respect to the question of benefit, I accept that there is some force in the Trust's submission as to the minimal or absent *medical* benefit in continuing to maintain Tafida with life sustaining treatment. Within this context, a further important factor supportive of the Trust's application is that fact that the care proposed by the Gaslini Hospital in Italy is substantially the same as that currently being given to Tafida by the Trust and will not result in any substantial improvement in her condition, albeit that the Gaslini consider (and the clinicians in this jurisdiction agree) that Tafida can achieve a position whereby she is able to go home on ventilation. In these circumstances, I accept that further medical treatment may be considered futile (using that word in its technical sense) in that it will confer minimal neurological or physical restoration.

172. Against this, Tafida is more than simply a patient who is the subject of medical treatment. Within this context, the benefits of life-sustaining treatment may extend

beyond the merely medical. If the argument in *Bland* that Anthony Bland felt no pain or awareness and therefore had no interests which suffered from his being kept alive is demonstrated to be a fallacy because, in the words of Hoffman LJ (as he then was), "it assumes that we have no interests except in those things of which we have conscious experience", then the argument that a child who feels no pain and no or minimal awareness can derive no benefit from being kept alive is similarly fallacious in circumstances where, again to echo the words of Hoffman LJ, the foregoing assumption does not accord with many people's intuitive feelings about their lives, and particularly those people who have a strong religious faith.

173. Within this context, and again having regard to the medical consensus of what can ultimately be achieved for Tafida, namely care by her family at home on ventilation in the same manner as children in a similar position to Tafida elsewhere in this jurisdiction, the benefits for Tafida of continued life sustaining treatment include being at home, being in the care of her loving and dedicated family, and, insofar as she is minimally aware, gaining from such awareness as she has of those matters. Further, I accept the submission that within the religious and cultural tradition in which Tafida was being raised, and whilst not by itself sufficient to justify the continuation of life sustaining treatment on the basis of Art 9 or otherwise, a further benefit of continued life sustaining treatment is that it permits Tafida to remain alive in accordance with the tenets of the religion in which she was being raised and for which she had begun to demonstrate a basic affinity.

174. Finally, and in addition, I have born in mind the evidence from the Italian team that the question of whether Tafida could be weaned off a ventilator following a tracheostomy, and hence could return home without ventilation, requires further, detailed evaluation. I have also borne in mind the evidence of the Italian doctors that the natural history and prognosis of children with prolonged disorders of consciousness is not well-defined, with a greater uncertainty about definitive outcome compared to adults and that better prognostic definition might require serial standardised neurological and neurophysiological evaluations, in addition to MRI functional studies.

175. With respect to the question of burden, the medical consensus in this case is that there is in Tafida an absence of demonstrable pain or suffering. This is not a case where doctors have concluded that the subject child can probably feel pain but are unsure how he or she processes it, nor is it a case where the doctors have concluded that the subject child is suffering pain and suffering it at a significant level. It is not a case, to use the terms of the RCPCH Guidance where "intensive treatment and future life are likely to cause the child substantial pain and distress". I have given careful consideration to the submission of the Trust and the Children's Guardian that the *possibility* that Tafida feels pain cannot be completely excluded and that, accordingly, that Tafida will be increasingly burdened by pain consequent upon the other physical disabilities she will develop in the future, as she would be were she to develop a greater level of awareness, can likewise not be excluded as a possibility. However, some caution must be exercised in respect of this submission. The standard of proof applicable in these proceedings is the balance of probabilities. Whilst it is tempting to say simply that the possibility that Tafida's feels pain cannot be entirely ruled out and therefore the court must proceed on the basis that it is better to err on the side of caution, this does not maintain fidelity to the applicable standard of proof. Such

fidelity is important every case, but all the more so when the outcome being considered is so grave.

176. I have also paid careful regard to the Trust's submission that even if Tafida feels no pain, further invasive treatment over an extended period of time will impose an unacceptable burden on her human dignity, which burden will be increased as she develops further debilitating physical symptoms. Again, I accept that within the context of the frame of reference advanced by the Trust, namely continued invasive medical treatment over many years with little recuperative benefit may, for example in the manner articulated *Bland*, reach the point of indignity for Tafida. The concept of human dignity as an element of the best interests analysis is however, not without difficulty. The term 'human dignity' does not lend itself to precise definition and there is no universal agreement as to its meaning. The concept of human dignity must, accordingly, contain a significant element of subjectivity and thus be influenced by, for example, the religious or cultural context in which the question is being considered. In *M v N* [2015] EWCOP 76 at [72] Hayden J observed that:

> "There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected. But choice where rational, informed and un-coerced is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too."

177. Within this context, the question of whether continued treatment would burden Tafida with indignity falls to be considered, once again, in the context of the agreed evidence that, ultimately, whilst moribund, with minimal awareness and entirely dependent on the care of others, it will be possible for Tafida to be cared for at home by a loving and dedicated family and consistent with the religious code and community values within which she had been raised. In the context of the concept of human dignity, although difficult to define, I am satisfied that this is a significantly different proposition to, for example, continued care over a period of years confined in a Tier 2 ICU unit.

178. Turning to the views of the doctors in this case, I have given weight to the fact that both the treating doctors from this jurisdiction, and those doctors from this jurisdiction who have provided expert reports in these proceedings are agreed in their view that it is no longer in Tafida's medical best interests to receive life sustaining treatment. Against this, two matters fall for consideration. First, it is clear from the report of Dr Smith that he considered the question of medical best interests to be a complex and finely balanced one in this case to which he had had to give anxious consideration. Second, in this case the court has a contrary view from a centre of paediatric excellence obtained with full co-operation of the applicant Trust rather than, as in some recent and unfortunate examples, the clandestine involvement of inappropriately qualified foreign medical practitioners (see *Kings College Hospital NHS Foundation Trust v Haastrup* [2018] 2 FLR 1028 at [15] and [81] and *Alder Hey Children's NHS Foundation Trust v Evans* [2018] EWHC 308 (Fam) at [45], it appearing that those two incidents were in fact part of a single orchestrated effort per

Evans [2018] EWCA Civ 984 at [39] and [40]). Whilst I accept that the opinion of the Italian team that it would be appropriate to maintain Tafida on life-sustaining treatment is a view reached in the context of the particular legal and ethical framework applicable in Italy, this jurisdiction does not hold the monopoly on legal and ethical matters. Further, Italy is a Member State of the EU in which the rights and normative principles enshrined in EU and international law apply. Further, and in any event, in this case there is a compelling evidence that the course of action advocated by the Italian doctors is one that is often adopted in *this* jurisdiction with respect to children in a similar situation to Tafida, Dr Smith, Dr Playfor and Dr D being agreed on this. Within this context, whilst the positive obligation to provide life sustaining treatment under Art 2 does not extend to providing such treatment if that treatment would be futile in nature and where responsible medical opinion is of the view that the treatment would not be in the best interests of the patient concerned, in this case there is a body of responsible medical opinion who takes the contrary view.

179. Turning to the nature of the medical treatment, as I have stated, I have borne in mind the argument of the Trust that the care proposed by the Gaslini Hospital in Italy is substantially the same as that currently being given to Tafida by the Trust. However, as also noted above, that is not the end of the story. The care proposed by the Italian team comprises a detailed, fully thought out and funded care plan that will look to move Tafida to a position where she can, following a tracheostomy and a gastroscopy, be care for by her family at home on a ventilator (although the Italian team intends to further evaluate the potential for weaning Tafida from the ventilator). The Italian team are clear that a tracheostomy could be managed safely at home by well-trained family caregivers. Moreover, this evidence is not disputed by the Trust, Dr D expressing herself to be reasonably confident that, with a care package and training, Tafida will be able to go home. Professor Nobili agreed, as did Dr Playfor and Dr Smith. In the circumstances, this not a case where transport of child remains simply a theoretical option that carries with it the risk of inducing further damage to the brain through seizures, possibly fatal, rendering the whole process of transfer a risk. It is not a case in which what is proposed is transfer for the purposes of untried experimental treatment with no scientific basis for application to the child in question and it is also not a case where the only option for future care is a tier 2 ICU unit in hospital. Further, and once again, the care plan proposed by the Italian team is not only advanced by that competent body of professional opinion but is, on the Trust's own evidence, consistent with the domestic approach in other areas to children in a similar position to that of Tafida. I also bear in mind Tafida's directly effective Art 56 right to receive medical treatment in another EU Member State.

180. The views of Tafida's parents are important and fall to be considered within the foregoing context. The RCPCH Guidance recognises that:

> "Individuals and families may differ in their perception of benefit to the child and some may view even severely limited awareness in a child as sufficient grounds to continue LST. It is important, here as elsewhere, that due account of parental views wishes and preferences is taken and due regard given to the acute clinical situation in the context of the child's overall situation"

181. Further, whilst there is no requirement for the court to evaluate the reasonableness of the parents views before it embarks upon deciding what, objectively, is in the child's

best interests, as I have noted in *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906 at 916 to 917 Waite LJ observed as follows with respect to influence of the principle that, ordinarily, decisions affecting the length and quality of a child's life will be taken for that child by the parents in the exercise of their parental responsibility:

> "There is the scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare, widely accepted by the generality of mankind; and at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations, it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases of the latter end of the scale, there must be a likelihood (though never, of course, a certainty) that the greater the scope of general debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature."

182. Within the context I have set out above, in circumstances where Tafida is not in pain, where the burden of the treatment is low, where there is a responsible body of medical opinion that considers that she can and should be maintained on life support with a view to her being cared for at home on ventilation by her family in the same manner in which a number of children in a similar situation to Tafida are treated in this jurisdiction, where there is a funded care plan to this end, where Tafida can be safely transported to Italy, where the continuation of life-sustaining treatment is consistent with the religious and cultural tenets by which Tafida was being raised and having regard to the sanctity of Tafida's life, this case *does* in my judgment lie towards the end of the scale where the court should give weight to the reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of the child's life will be taken for the child by a parent in the exercise of their parental responsibility. Further, whilst I did not hear detailed submissions on the import of Art 8 of the ECHR in the context of this case, and whilst the Art 8 rights of the parents are subordinate to the best interests of the child where the two conflict, in the circumstances I have just summarised there is in my judgment a cogent argument that the making of orders the effect of which would be to override the choice made by the parents in the exercise of their parental responsibility would not constitute a necessary and proportionate justification for the interference in their Art 8 rights that would thereby occur.

183. In addition to rights under Art 2 and Art 8, the Art 9 rights of the parents and of Tafida are engaged in this case. Within this context, Ms Gollop sought to persuade me to engage in a fine textured analysis of the *fatwa* with a view to establishing that, as a matter of logic, the declarations sought by the Trust would not imperil either the parents' or Tafida's religious beliefs in circumstances where it is the Trust who seek and the court who would endorse the cessation of life sustaining treatment, it is

neither desirable nor necessary for me to do so. As Hoffman LJ (as he then was) observed in *Bland*:

> "Why do we think it would be a tragedy to allow Anthony Bland to die? It could be said that the entire tragedy took place at Hillsborough and that the curtain was brought down when Anthony Bland passed into a persistent vegetative state. Until then, his life was precious to him and his family. But since then, he has had no consciousness of his life and it could be said to be a matter of indifference to him whether he lives or dies. But the fact is that Anthony Bland is still alive. The mere fact that he is still a living organism means that there remains an epilogue of the tragedy which is being played out. This is because we have a strong feeling that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else. Those who adhere to religious faiths which believe in the sanctity of all God's creation and in particular that human life was created in the image of God himself will have no difficulty with the concept of the intrinsic value of human life. But even those without any religious belief think in the same way. In a case like this we should not try to analyse the rationality of such feelings. What matters is that, in one form or another, they form part of almost everyone's intuitive values. No law which ignores them can possibly hope to be acceptable."

184. Within this context, whilst not determinative, the Art 9 rights of the parents and of Tafida to freedom of thought, conscience and religion fall for consideration in this case and in my judgment must be accorded weight in the balancing exercise in circumstances where the parents' beliefs, which beliefs would have influenced Tafida, included the belief that to withdraw life sustaining treatment from Tafida would be a sin in circumstances where they believe that where the breath of life subsists so too the soul.

185. Within the foregoing context, I consider this to be a very finely balanced case and one that I have wrestled with in reaching my decision. As Waite LJ made clear in *Re T (a minor)(wardship: medical treatment)* [1997] 1 All ER 906 at 916-917 "The starting point—and the finishing point too—must always be the judge's own independent assessment on the balance of advantage or disadvantage of the particular medical step under consideration". Balancing as I must the welfare factors I have summarised that inform the best interest evaluation, and having regard to Tafida's best interests as my paramount consideration, I am on balance *not* satisfied that I can conclude on the evidence before the court that life sustaining treatment is no longer in Tafida's best interests.

186. The court must face head on the question of whether it can be said that the continuation of life sustaining treatment is in Tafida's best interests. 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. In this context, I do not discount the grave matters prayed in aid by the Trust. However, the law that I must apply is clear and requires that the best interests decision be arrived at by a careful and balanced evaluation of *all* of the factors that I have discussed in the foregoing paragraphs. Having undertaken that balance, in circumstances where, whilst minimally aware, moribund and totally reliant on others, Tafida is not in pain

and medically stable; where the burden of the treatment required to keep her in a minimally conscious state is low; where there is a responsible body of medical opinion that considers that she can and should be maintained on life support with a view to placing her in a position where she can be cared for at home on ventilation by a loving and dedicated family in the same manner in which a number of children in a similar situation to Tafida are treated in this jurisdiction; where there is a fully detailed and funded care plan to this end; where Tafida can be safely transported to Italy with little or no impact on her welfare; where in this context the continuation of life-sustaining treatment is consistent with the religious and cultural tenets by which Tafida was being raised; where, in the foregoing context, transfer for treatment to Italy is the choice of her parents in the exercise of their parental responsibility and having regard to the sanctity of Tafida's life being of the highest importance, I am satisfied, on a fine balance, that it is in Tafida's best interests for life sustaining treatment to continue. It follows from this conclusion that I am also satisfied, the court having determined the dispute regarding best interests in favour of the treatment being offered to Tafida in Italy, there can be no justification for further interference in Tafida's EU right to receive services pursuant to Art 56.

CONCLUSIONS

187. In the circumstances, on the evidence before the court and for the reasons set out in this lengthy judgment:

i) In the proceedings for judicial review, I decline to grant relief to the claimant on her application for judicial review.

ii) In the proceedings under the Children Act 1989 and the inherent jurisdiction of the High Court I dismiss the application of the applicant NHS Trust for an order under s 8 of the Children Act 1989 and I dismiss the application of the applicant NHS Trust for declarations under the inherent jurisdiction of the High Court.

188. The effect of these decisions is that either the NHS Trust or the Gaslini Hospital in Italy (or another hospital) will have to continue to provide Tafida with life-sustaining treatment (see *Evans* [2018] EWCA Civ 984 at [27]). With respect to treatment by the Gaslini Hospital, as I have noted, it also follows from my decision that there is now no apparent justification for interfering with Tafida's Art 56 right to receive treatment in another EU Member State and it is to be anticipated that this transfer will now take place.

189. During the course of the case, Ms Gollop on behalf of the NHS Trust urged the court to provide further guidance as to the proper course of action in cases where the child's EU rights are engaged. The first point to make is that each case will fall to be decided on its own facts and in such circumstances, detailed guidance is likely to be unhelpful. Second, the detailed position is made clear in the body of this judgment. However, for the avoidance of doubt, it follows from the matters set out above that, as matters currently stand, when faced with a request by parents of an EU citizen child for transfer for medical treatment in another Member State, in deciding whether or not to agree to that course of action an NHS Trust will need to consider the directly effective EU rights of the child. That said, and again for the reasons set out above, where an NHS Trust, having properly considered those directly effective EU rights, considers

that a transfer would not be in the best interests of the child and that an application to the Family Division of the High Court is required to determine the resulting dispute as to the child's best interests, it is highly likely that that decision will constitute a justified derogation from the EU rights engaged on public policy grounds.

190. Finally, as Hoffman LJ (as he then was) noted in *Airedale NHS Trust v Bland* at 825 "Modern medicine therefore faces us with fundamental and painful decisions about life and death which cannot be answered on the basis of normal everyday assumption". As Dr Smith notes in his report, "We have the technology to maintain the lives of children with severe neurodisability, the question for each individual child is whether it is right to make use of it." These difficult issues that arise from question are also now far more likely to require answering in a public rather than a private context. In the decision of the US Supreme Court in *Cruzan v Director, Missouri Department of Health B* (1990) 110 S.Ct. 284 Brennan J observed:

> "Medical advances have altered the physiological conditions of death in ways that may be alarming: highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than as its continuation. But those same advances, and the reorganisation of medical care accompanying the new science and technology, have also transformed the political and social conditions of death: people are less likely to die at home, and more likely to die in relatively public places such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions."

191. Within this context, and particularly where a child is not in pain and is not aware of his or her parlous situation, these cases can place the objective best interests test under some stress. Absent the fact of pain or the awareness of suffering, the answer to the objective best interests tests must be looked for in subjective or highly value laden ethical, moral or religious factors extrinsic to the child, such as futility (in its non-technical sense), dignity, the meaning of life and the principle of the sanctity of life, which factors mean different things to different people in a diverse, multicultural, multifaith society. Nevertheless, the gold standard against which cases of this nature are measured and determined remains that of the child's best interests and as the march of medical innovation continues to bring cases of this nature before the courts the courts will be required to apply this standard to the best of their ability. That is what I have endeavoured to do in this very sad case.

192. That is my judgment.

Neutral Citation Number: [2021] EWCA Civ 362

Case No: B4/2021/0124

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
FAMILY DIVISION
The Honourable Mr Justice Poole
FD20P00135

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19 March 2021

Before :

LADY JUSTICE KING
LORD JUSTICE BAKER
and
LADY JUSTICE ELISABETH LAING

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IN THE MATTER OF THE SENIOR COURTS ACT 1981
AND IN THE MATTER OF PIPPA KNIGHT (A CHILD)

Between :

PAULA PARFITT	**Appellant**
- and -	
(1) GUY'S AND ST THOMAS' CHILDREN'S NHS FOUNDATION TRUST **(2) PIPPA KNIGHT (by her children's guardian)**	**Respondents**

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Vikram Sachdeva QC, Victoria Butler-Cole QC and Catherine Dobson (instructed by **Sinclairslaw**) for the **Appellant**
Michael Mylonas QC (instructed by **Hill Dickinson LLP**) for the **First Respondent**
Neil Davy (instructed by **Cafcass Legal**) for the **Second Respondent**

Hearing date : 9 February 2021

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Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand down is deemed to be 10.30am on Friday 19 March 2021.

LORD JUSTICE BAKER:

Introduction and summary

1. This is a profoundly sad and moving case about the life of a small child.

2. Pippa was born in April 2015 into a loving family. She has a brother who is two years older than she. When she was 20 months old, she was diagnosed with a rare and usually terminal condition known as acute necrotising encephalopathy ("ANE"), probably caused by a viral infection, from which she suffered very severe brain damage. Over the next few months, her health deteriorated rapidly. She is now totally dependent on mechanical ventilation and has respiratory instability with frequent desaturations requiring specialist nursing and physiotherapy interventions. She is doubly incontinent and has cortical blindness.

3. Shortly after Pippa's second birthday, her father, who had previously lost a child during an earlier relationship, took his own life. Her mother, supported by other family members, has devoted her life to Pippa, looking after her herself for as long as possible. During the last two years when Pippa has been continuously in hospital, her mother has lived in hospital accommodation and spent up to 16 hours a day by her bedside. Pippa's brother is living with his grandmother and is having video calls with his sister, but because of restrictions imposed under the Covid-19 regime has not visited the hospital since February 2020.

4. Through the dedication and skill of doctors, nurses, therapists and other hospital staff, Pippa has received medical and nursing care of the highest quality but, despite their efforts, she has slipped into a persistent vegetative state ("PVS"). The medical evidence indicates that almost certainly she neither feels pain nor is able to experience pleasure and that there is no prospect of any improvement in her condition. Her mother disagrees, believing that there are signs of improvement and that Pippa shows an awareness of her family and circumstances from which she is capable of deriving pleasure.

5. When a disagreement about a child's medical treatment arises between doctors and the family, an application may be made to the court to resolve the dispute. When considering such an application, the judge must exercise his own independent and objective judgment about what is in the child's best interests. In this case, on 9 March 2020, the NHS Trust ("the Trust") responsible for the hospital where she is being treated, the Evelina London Children's Hospital, applied to the court for declarations and orders that would permit the withdrawal of life-sustaining treatment. Her mother opposed the application and instead proposed that Pippa should return home. It was common ground that in order to have any chance of being managed in a home environment, Pippa would require a tracheostomy to deliver ventilation safely and that she would need to be transferred to a portable ventilator which could be used in a step-down unit and subsequently at home. The mother sought the court's approval for a trial of portable ventilation to establish whether Pippa was sufficiently stable to return home.

6. The application came before Poole J shortly before Christmas 2020. Before the judge and before this Court, the parties have been represented by lawyers who are very experienced in cases involving decisions about serious medical treatment. The judge

had the benefit of evidence from a number of highly respected specialist doctors. This is not a case where any of the parties has relied on evidence from outside the mainstream of orthodox medical opinion. The treating clinicians who gave evidence included Dr A, a paediatric intensive care consultant who is Pippa's lead consultant and who has been involved in her care throughout her time at the Trust's Paediatric Intensive Care Unit ("PICU"), Dr B, the lead consultant paediatric neurologist, Dr C, a respiratory consultant, who has led Pippa's respiratory care, and Ms F, a clinical specialist paediatric respiratory physiotherapist. The hospital clinicians were unanimously of the view that the mother's proposal was contrary to Pippa's best interests. But some of the independent specialists instructed with the court's leave took a different view. These included Dr Colin Wallis, a consultant respiratory paediatrician at Great Ormond Street Hospital for Children, Dr Stephen Playfor, a consultant paediatric intensivist at the Royal Manchester Children's Hospital, and Dr Michelle Chatwin, a consultant paediatric respiratory physiotherapist at the Royal Brompton Hospital. It was Dr Wallis who first suggested that it might be possible to transfer Pippa home on long-term ventilation, a proposal supported by Dr Playfor and Dr Chatwin.

7. At the conclusion of the hearing, the judge reserved judgment which he considered and drafted over Christmas and delivered on 8 January 2021. After a comprehensive analysis which was characterised by great insight and humanity, he concluded that the Trust's application should be granted and made declarations that it was lawful and in Pippa's best interests that (a) she should not be provided with a tracheostomy, (b) mechanical ventilation should be withdrawn, and (c) there be clearly defined limits on the treatment provided to her after the withdrawal of ventilation, with the effect that she would be allowed to die.

8. The mother filed a notice of appeal citing four grounds of appeal and on 25 January 2021 my Lady, King LJ, listed the application for permission to appeal for hearing with appeal to follow if permission were granted. Proceedings before the Court of Appeal involve a review of the judge's decision, not a full rehearing of the case. The law provides that this Court can only allow an appeal where it concludes that the judge's decision was wrong or that there had been a serious procedural or other irregularity. No one has suggested that there was any irregularity in this case. In simple terms, the question for us is whether the judge's decision was wrong.

9. The judge's decision was rightly based on his assessment of Pippa's best interests because her welfare in the widest sense is the paramount consideration. He looked at all the evidence, including importantly the views of her family, in particular her mother who has dedicated her life to Pippa and fought so hard to find a way of keeping her alive. Having considered all the evidence, the judge concluded that it was not in Pippa's best interests to continue to receive life-sustaining treatment nor to embark on a trial of portable ventilation which if successful could lead a transition process, carried out over a number of months, towards home care.

10. In my view, the judge's decision was not wrong. Having considered all the evidence drawn to our attention and the submissions made to us, I am satisfied that he was right. For the reasons set out in detail below, I would refuse permission to appeal on three of the four grounds. On the fourth ground, I would grant permission to appeal but dismiss the appeal.

The law

11. Cases in this jurisdiction involving applications to withdraw life-sustaining treatment for patients, in particular children, have attracted national and sometimes international attention, most notably the proceedings involving Charlie Gard, which included the hearing before this Court in May 2017 leading to the judgment reported as *Yates v Great Ormond Hospital for Children NHS Foundation Trust* [2017] EWCA Civ 410, [2018] 4 WLR 5 ("*Yates*"). The media and the wider general public are understandably and properly interested not only in the human stories lying at the heart of every case but also about the process by which these difficult decisions are made. Each case requires care and attention of the utmost sensitivity.

12. The legal principles, however, are clear and well established. As my Lady pointed out in *Re A (A Child)* [2016] EWCA Civ 759, a case involving the withdrawal of treatment from a child, the principles were succinctly summarised by Baroness Hale of Richmond in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591, a case concerning an adult patient receiving clinically-assisted nutrition and hydration. At paragraph 22 she said:

> "…the focus is on whether it is in the patient's best interests to give the treatment, rather than on 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 that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

At paragraph 39, Baroness Hale continued:

> "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 to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

Further on, at paragraph 42, Baroness Hale summarised the role of the appellate court in such cases:

> "if the judge has correctly directed himself as to the law, as in my view this judge did, an appellate court can only interfere with his decision if satisfied that it was wrong: *Re B (A Child) (Care Proceedings: Appeal)* [2013] UKSC 33. In a case as sensitive and difficult as this, whichever way the judge's decision goes, an appellate court should be very slow to conclude that he was wrong."

13. The approach to be adopted by a court conducting the necessary balancing exercise was summarised by Holman J in *An NHS Trust v MB* [2006] EWHC 507, [2006] 2 FLR 319, in a passage (at paragraph 16 of the judgment) that has been cited in many later cases, including by Poole J in the present case:

> "i) As a dispute has arisen between the treating doctors and the parents, and one, and now both, parties have asked the court to make a decision, it is the role and duty of the court to do so and to exercise its own independent and objective judgment.
>
> ii) The right and power of the court to do so only arises because the patient, in this case because he is a child, lacks the capacity to make a decision for himself.
>
> iii) I am not deciding what decision I might make for myself if I was, hypothetically, in the situation of the patient; nor for a child of my own if in that situation; nor whether the respective decisions of the doctors on the one hand or the parents on the other are reasonable decisions.
>
> iv) The matter must be decided by the application of an objective approach or test.
>
> v) That test is the best interests of the patient. Best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision. These include, non-exhaustively, medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations.
>
> vi) It is impossible to weigh such considerations mathematically, but the court must do the best it can to balance all the conflicting considerations in a particular case and see where the final balance of the best interests lies.
>
> vii) Considerable weight (Lord Donaldson of Lymington MR referred to "a very strong presumption") must be attached to the prolongation of life because the individual human instinct and desire to survive is strong and must be presumed to be strong in the patient. But it is not absolute, nor necessarily decisive; and may be outweighed if the pleasures and the quality of life are sufficiently small and the pain and suffering or other burdens of living are sufficiently great.

> viii) These considerations remain well expressed in the words as relatively long ago now as 1991 of Lord Donaldson of Lymington in *Re J (A minor) (wardship: medical treatment)* [1991] Fam 33 at page 46 where he said:
>
> > 'There is without doubt a very strong presumption in favour of a course of action which will prolong life, but … it is not irrebuttable … Account has to be taken of the pain and suffering and quality of life which the child will experience if life is prolonged. Account has also to be taken of the pain and suffering involved in the proposed treatment… We know that the instinct and desire for survival is very strong. We all believe in and assert the sanctity of human life …. Even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable. People have an amazing adaptability. But in the end there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause it increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's, and mankind's desire to survive.'
>
> ix) All these cases are very fact specific, i.e. they depend entirely on the facts of the individual case.
>
> x) 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."

14. The approach was succinctly summarised by this Court in *Wyatt v Portsmouth Hospital NHS Trust* [2005] EWCA Civ 1181 where the judges, having considered various earlier authorities including *Re J (A Minor) (Wardship: Medical Treatment*, [1991] Fam 33, and *Re A (Male Sterilisation)* [2000] 1 FLR 549, summarised the legal principles in these terms (at paragraph 87):

> "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 (*Re*

> *J*). There is a strong presumption in favour of a course of action which will prolong life, but that presumption is not irrebuttable (*Re J*). The term 'best interests' encompasses medical, emotional, and all other welfare issues (*Re A*). The court must conduct a balancing exercise in which all the relevant factors are weighed (*Re J*) …."

15. A number of further reported cases were cited to us, some of which are considered below when dealing with the grounds of appeal. The only other authority to which I should refer at this stage is *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2530 (Fam), [2020] 3 All ER 663, ("*Raqeeb*"), which was cited at a number of points in the appellant's submissions. It concerned a five-year-old girl, Tafida, who was being kept alive by artificial ventilation in a Trust hospital after sustaining irreversible brain damage. The medical evidence demonstrated that she was unlikely to experience pain and was, at best, only minimally aware. Although she was unlikely to recover, it was anticipated that, if kept on mechanical ventilation, she would live for a further ten to twenty years. The Trust's clinicians concluded that it was not in her best interests to continue the life-sustaining treatment. The parents, however, disagreed, in part because the withdrawal of treatment went against their religious beliefs. They contacted doctors at an Italian hospital who, whilst not believing that the child could be "cured", offered to carry out a course of treatment including a tracheostomy which would allow Tafida to be cared for at home on a ventilator. The child, through a litigation friend, sought judicial review of the Trust's refusal to agree to her being transferred to the Italian hospital.

16. MacDonald J refused the Trust's application for a declaration and granted the child's application for judicial review, although for reasons which are irrelevant to the present appeal, he declined to grant any relief on the child's application. His judgment traversed a number of legal issues but the passages cited to this Court relate only to his approach to the determination of best interests, and in particular the analysis of the benefits and burdens of the treatment programme. With regard to benefits, he said:

> "171. …. I accept that there is some force in the Trust's submission as to the minimal or absent medical benefit in continuing to maintain Tafida with life sustaining treatment. Within this context, a further important factor supportive of the Trust's application is the fact that the care proposed by the Gaslini Hospital in Italy is substantially the same as that currently being given to Tafida by the Trust and will not result in any substantial improvement in her condition ….
>
> 172. Against this, Tafida is more than simply a patient who is the subject of medical treatment. Within this context, the benefits of life-sustaining treatment may extend beyond the merely medical. If the argument in *Bland* that Anthony Bland felt no pain or awareness and therefore had no interests which suffered from his being kept alive is demonstrated to be a fallacy because, in the words of Hoffman LJ (as he then was), "it assumes that we have no interests except in those things of which we have conscious experience", then the argument that a child who feels no pain and no or minimal awareness can

> derive no benefit from being kept alive is similarly fallacious in circumstances where, again to echo the words of Hoffman LJ, the foregoing assumption does not accord with many people's intuitive feelings about their lives, and particularly those people who have a strong religious faith.
>
> 173. Within this context, and again having regard to the medical consensus of what can ultimately be achieved for Tafida, namely care by her family at home on ventilation in the same manner as children in a similar position to Tafida elsewhere in this jurisdiction, the benefits for Tafida of continued life sustaining treatment include being at home, being in the care of her loving and dedicated family, and, insofar as she is minimally aware, gaining from such awareness as she has of those matters. Further, I accept the submission that within the religious and cultural tradition in which Tafida was being raised, and whilst not by itself sufficient to justify the continuation of life sustaining treatment on the basis of Art 9 or otherwise, a further benefit of continued life sustaining treatment is that it permits Tafida to remain alive in accordance with the tenets of the religion in which she was being raised and for which she had begun to demonstrate a basic affinity."

17. As for the burdens, MacDonald J made these observations:

> "176. I have also paid careful regard to the Trust's submission that even if Tafida feels no pain, further invasive treatment over an extended period of time will impose an unacceptable burden on her human dignity, which burden will be increased as she develops further debilitating physical symptoms. Again, I accept that within the context of the frame of reference advanced by the Trust, namely continued invasive medical treatment over many years with little recuperative benefit may, for example in the manner articulated [in] *Bland*, reach the point of indignity for Tafida. The concept of human dignity as an element of the best interests analysis is however, not without difficulty. The term 'human dignity' does not lend itself to precise definition and there is no universal agreement as to its meaning. The concept of human dignity must, accordingly, contain a significant element of subjectivity and thus be influenced by, for example, the religious or cultural context in which the question is being considered. In *M v N* [2015] EWCOP 76, Hayden J observed that
>
> > 'There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be

> respected. But choice where rational, informed and un-coerced is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too.'
>
> 177. Within this context, the question of whether continued treatment would burden Tafida with indignity falls to be considered, once again, in the context of the agreed evidence that, ultimately, whilst moribund, with minimal awareness and entirely dependent on the care of others, it will be possible for Tafida to be cared for at home by a loving and dedicated family and consistent with the religious code and community values within which she had been raised. In the context of the concept of human dignity, although difficult to define, I am satisfied that this is a significantly different proposition to, for example, continued care over a period of years confined in a Tier 2 ICU unit."

18. At paragraph 182 of his judgment in *Raqeeb*, MacDonald J concluded:

> "… in circumstances where Tafida is not in pain, where the burden of the treatment is low, where there is a responsible body of medical opinion that considers that she can and should be maintained on life support with a view to her being cared for at home on ventilation by her family in the same manner in which a number of children in a similar situation to Tafida are treated in this jurisdiction, where there is a funded care plan to this end, where Tafida can be safely transported to Italy, where the continuation of life-sustaining treatment is consistent with the religious and cultural tenets by which Tafida was being raised and having regard to the sanctity of Tafida's life, this case does in my judgment lie towards the end of the scale where the court should give weight to the reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of the child's life will be taken for the child by a parent in the exercise of their parental responsibility. Further, whilst I did not hear detailed submissions on the import of Art 8 of the ECHR in the context of this case, and whilst the Art 8 rights of the parents are subordinate to the best interests of the child where the two conflict, in the circumstances I have just summarised there is in my judgment a cogent argument that the making of orders the effect of which would be to override the choice made by the parents in the exercise of their parental responsibility would not constitute a necessary and proportionate justification for the interference in their Art 8 rights that would thereby occur."

The proposal of a trial of portable ventilation

19. Both the treating clinicians and the experts instructed independently for the hearing are in agreement that the continuation of life-sustaining mechanical ventilatory support and treatment within the PICU setting is not in Pippa's best interests and they would therefore each support the withdrawal of treatment.

20. The central issue in the present case is whether the court should authorise a trial of portable ventilation with a view to Pippa returning home notwithstanding the challenges such a course would present. This would be with a view to her remaining on a ventilator at home for what would be likely to be a relatively short period of time given that it is inevitable that the medical care that Pippa would receive at home, whilst dedicated and loving, cannot hope to match that available in the PICU where Pippa has been cared for the last two years.

21. It should be made clear that this proposal is different from any arrangement for Pippa to be transferred home in the immediate future with a view to ventilation being removed shortly afterwards in order to allow her to die at home with her family around her. That is an arrangement that the hospital are both able and willing to facilitate.

22. The proposal for long-term ventilation at home was first put forward by Dr Wallis in his initial report in April 2020. Although Pippa has respiratory instability with frequent desaturations which require specialist nursing and physiotherapy interventions, Dr Wallis expressed the opinion in his report that Pippa could be safely managed outside a critical care unit:

> "[Pippa] requires a high level of nursing, physiotherapy and technological support. Although management outside of a critical care unit can never be as safe as the 1-1 multiprofessional support that she receives within an intensive care [environment], if certain parameters were in place and conditions were met, it could be possible to manage [Pippa] in a non-intensive care environment."

He advised that a number of steps would have to be taken to be managed in a home environment or step-down unit. First, she would need a tracheostomy to safely deliver ventilation. Secondly, she would need to be transferred to a portable ventilator for use at home or in a step-down unit and it would need to be demonstrated that this ventilator could maintain her respiration and gas exchange. Thirdly, Dr Wallis thought Pippa would benefit from a gastrostomy in preference to her current nasogastric tube feeding. Fourthly, she would need a team of carers and relatives present 24 hours a day including a nurse or similarly-trained carer at all times with probably one other additional trained person present. This high level of care package was required because of her episodic desaturations. Carers and nurses would need to be trained and competent in all aspects of her care, including chest physiotherapy which is not regularly available in a community setting. A period of observation would be required to ensure that carers were able to provide effective intervention in the home setting.

23. In his report, Dr Wallis concluded:

> "Home care may not be possible due to the high level of nursing and therapeutic input but this is currently not known with certainty. To explore the feasibility of this option would require a tracheostomy and gastrostomy and the introduction of a package of management, tailored to Pippa's needs that can feasibly be provided by a team of home carers in a non-intensive care environment …. Although she is at the outer limits of possibility, living at home might be possible …. If the clinical trial and move to a step-down unit was successful, I consider it would be in the child's best interests to then move home with a long term ventilation package of care, as this would give her a more appropriate environment and receive such life-sustaining support and enjoy the daily benefits of close family life."

Dr Wallis illustrated his proposals of the steps to be taken towards home care in a flowchart which the judge attached to his judgment as Appendix 1. In the notes to the flowchart, he acknowledged that the process of assembling a complex care package for Pippa would take "many months" because of her high needs.

24. In oral evidence, Dr Wallis suggested for the first time a number of additional measures which could be taken to address Pippa's episodes of substantial desaturation – increasing the ventilation, raising the level of oxygen administered, increasing suctioning, entraining oxygen into a bag from a concentrator, and moving onto a so-called AMBU bag commonly used in the community. These late additions to Dr Wallis's evidence gave rise to difficulties which were considered in the judgment as I shall illustrate below.

25. Following the production of Dr Wallis's report, the Trust's clinicians raised a number of concerns about the proposal. Despite their view that such a course would not be in Pippa's best interests, they produced a draft protocol for implementing the trial. Dr Wallis and Dr Playfor, who supported the proposal, thought the protocol was too limited and designed in a way that was set up to fail. Dr Playfor thought the Trust's suggested plan for supporting Pippa at home was too prescriptive:

> "No child mechanically ventilated in a domestic setting receives care of an equivalent standard to that delivered in a Paediatric Critical Care Unit. For a child in [Pippa]'s position, a genuine trial of the feasibility of portable mechanical ventilation requires a flexible and pragmatic iterative development of an individualised, structured plan for mechanical ventilation and associated interventions."

Dr Chatwin gave some support to the proposal. She agreed with the list of services identified by Dr Wallis as to what would be required if Pippa were to be moved. She concluded in her report:

> "If this management strategy outlined above is deemed in [Pippa]'s best interests and [Pippa] is successfully cared for in a step down unit or high dependency unit, I agree with Dr Wallis that a long term ventilation package of care should be sought.

> In my opinion being in the home rather than a critical care unit would provide the daily benefits of close family life, which cannot occur in critical care. As previously stated, the family should have a full understanding that the care provided at home is not to the same standard as within the critical care environment. It is possible that this would mean that PK only has a short period of time at home but the benefit for her would be that she is with all her family. Being with her family is something that is also very difficult at the present time due to the Covid-19 situation."

The judgment

26. After summarising the background to the case, the judge identified the issues in these terms:

> "16 In my judgment, it is necessary to determine Pippa's best interests, and whether to make the declarations sought, in the context of three available options:
>
> A. Continuation of life-sustaining mechanical ventilatory support and treatment within a PICU setting.
>
> B. A trial of portable ventilation with a view to transition to long term ventilation and life-sustaining treatment at home.
>
> C. Withdrawal of life-sustaining mechanical ventilatory support."

He noted that none of the clinical or expert witnesses had contended that option A would be in Pippa's best interests, but he found it necessary to consider it because her mother said in evidence that she would prefer option A to option C. Thus, were he to determine that option B should be preferred, the trial home might well fail leaving the parties remaining in dispute about whether continued ventilation in the PICU was in Pippa's best interests.

27. He set out his approach to option B at paragraph 17:

> "… the evidence does allow me to consider:
>
> (a) The nature of the end goal of long term ventilation and life sustaining treatment at home.
>
> (b) The prospect that the trial and transition process would result in the end goal of home care being achieved.
>
> (c) What that process would entail for Pippa: what would be the means by which the end would be achieved.
>
> By considering those factors, the court can make an assessment of whether it is in Pippa's best interests to embark upon the trial and transition process – option B. It would be wrong in my

> judgment to focus exclusively on the very first step in that process. The initial trial of portable ventilation is not an end in itself, it is a means to an end, or, more precisely, a necessary but not sufficient means to the end of providing Pippa with life sustaining treatment at home. If it would not be in Pippa's best interests to reach the destination, then it is unlikely to be in her best interests to embark on the journey."

28. The judge then set out the legal principles, citing passages from a number of the reported authorities. He quoted from professional guidance, including the definition of vegetative state and minimally conscious state in the guidelines published by the Royal College of Physicians "Prolonged disorders of consciousness following sudden onset brain injury" (2020) and advice about the limitation and withdrawal of treatment in guidance approved by the Royal College of Paediatrics and Child Health and published in the form of an article on the Archives of Disease of Childhood, "Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice" (Larcher and others, Arch Dis Child 2015).

29. The judge then set out the evidence about Pippa's condition. He summarised the consensus of the clinicians and expert witnesses as follows (at paragraph 32):

> "a. Pippa has suffered very severe brain damage as a result of ANE.
>
> b. She is in a persistent vegetative state ("PVS"). She has no conscious awareness of herself or her environment.
>
> c. On the balance of probabilities Pippa cannot experience pain or discomfort.
>
> d. On the balance of probabilities Pippa cannot derive any pleasure from her environment or interaction with others.
>
> e. Pippa has random movements of her neck, head, and limbs. She has no purposeful movement. She shows no response to visual, auditory, or tactile stimulation.
>
> f. She is wholly dependent on others for all her care.
>
> g. She has no respiratory effort – she cannot breathe at all – and is wholly reliant on mechanical ventilation.
>
> h. She has respiratory instability with frequent desaturations which require specialist nursing and physiotherapy interventions.
>
> i. She is doubly incontinent.
>
> j. She has cortical blindness.
>
> k. Her condition has been static for well over a year and there is no prospect of any improvement."

30. The judge summarised the evidence about various aspects of her condition. With regard to her respiratory condition, he recorded that she was unable to breathe for herself and was dependent on mechanical ventilation. Currently this was being administered via an endotracheal tube ("ETT") rather than a tracheostomy tube. The particular challenges with her respiratory condition were not related to ventilation in itself but rather to her tendency to desaturate – for her oxygen saturation to fall – because she has poor oxygen reserve and a tendency for her lungs to collapse ("atelectasis") and secretions and saliva accumulate in her airway because she cannot swallow or cough and has no gag reflex. To address these problems, she receives regular respiratory physiotherapy, and spends at least two hours a day in a prone position to remove pressure on the back of her lungs and build up her oxygen reserves. She also receives assistance two or three times a day from a cough-assist machine, administering saline under pressure and then reversing the flow to stimulate a cough, and undergoes a process called saline lavage. Even with these interventions, Pippa experiences desaturations every one to four hours, which are treated in a variety of ways including by deep suctioning, by adjustments to the ventilator pressures, and by the use of anaesthetic bagging which introduces oxygen under pressure. Once a week, she experiences a more serious episode of desaturation when her level of oxygen drops significantly below 80%.

31. At paragraph 42, the judge summarised her prognosis in these terms:

> "Pippa receives excellent care on the Evelina PICU, but she is vulnerable to profound desaturations or some other complication that could take her life at any time. Predicting her life expectancy with continued long term ventilation on the PICU is difficult, but the balance of the evidence to me was that Pippa would live longer on the PICU than she would if on long term ventilation in a home setting, and whilst she could die at any time, she could live on the PICU for some years yet."

32. The judge then considered Dr Wallis's proposal for a trial of portable ventilation with a view to transition to home care. Before considering the substance of this proposal, he expressed some dissatisfaction about the way the proposal had been presented:

> "44. The manner in which evidence about a trial of portable ventilation and transition to home care has been rolled out has not been very satisfactory. That is not a criticism of the legal representatives. I do however say that Dr Wallis ought to have recognised that his proposal of a trial and transition to home care would require considerably more detailed explanation than he had given prior to the hearing, particularly once he knew that the treating team opposed it. For example, he gave very little further detail in his joint statement with Dr C, responding to some key questions merely by referring back to his first report. As a consequence, although Dr Chatwin had previously raised some issues about potential alterations to Pippa's regime, Dr Wallis gave a great deal of evidence about the process under questioning at the hearing, which he had not previously raised. Even in re-examination he introduced striking new evidence as to the nature of home care. This made it difficult for the

> Applicant to respond. When witnesses for the Trust were able to respond, their evidence, in turn, prompted further investigation by the Second Respondent, so that even after the hearing had concluded, a fourth report from Dr Chatwin was submitted. After representations by email I ruled against admission of Dr Chatwin's fourth report. It mainly concerned evidence of Pippa's oxygen saturation levels when not desaturating, and other aspects of her past respiratory management, and I do not find such further evidence to be necessary to my determination of the issues in this case."

The judge's decision to refuse to admit Dr Chatwin's fourth report submitted after the hearing is one aspect of the fourth ground of appeal which the appellant seeks to pursue before this Court.

33. At paragraph 45, the judge then summarised Dr Wallis's proposal by reference to his initial report. At paragraph 46 of his judgment, the judge summarised the conflicting opinions of the clinicians and other medical experts and set out what had been established by the close of the evidence:

> "(a) The transition to home care is an iterative process involving a multi-disciplinary team working in conjunction with the family. There will be many obstacles and a positive approach to overcoming them is required if the goal is to be achieved.
>
> (b) Every stage requires planning and risk assessment, but it has to be accepted that care at home will not be of the same clinical standard as care in the PICU. The care at home will not be optimal but it has to be "good enough". To embark on the process all have to agree that a lower standard of care is the price worth paying for the reward of caring for the child in a more nurturing environment, and one that suits the family.
>
> (c) The first step would be to trial Pippa on a portable ventilator. She would remain in the PICU during this trial supported by the nurses and therapists who currently manage her, and all other equipment presently used.
>
> (d) Although Dr Wallis initially maintained that it would be "pointless" to embark on the trial without first performing a tracheostomy, he relented at the hearing and said that the trial could be performed with the ETT still in situ.
>
> (e) If, but only if, Pippa achieved stability during a two week period on a portable ventilator, which would include an absence of profound desaturations, she could then move to a non-PICU setting .... The initial trial stage might take more than two weeks if the view was taken that some of the settings on the ventilator could be altered, or other measures taken, to promote stability.

> (f) If it had not already been performed, a tracheostomy would be performed soon after transfer to the transitional unit. At some stage thereafter Pippa would have to undergo a gastrostomy.
>
> (g) The non-PICU setting to which Pippa could be moved would still be within hospital and all equipment such as anaesthetic bagging and the cough assist machine, and therapies would be available. The next process is a lengthy one, lasting months. Pippa would remain on a portable ventilator barring any further setbacks. Step by step adjustments to her care would be made to replicate the care that would be available and needed at home. Plans for funding for her care, recruitment of a nursing team etc. could begin during this stage….
>
> (h) When home care has been replicated, and the home care package is assembled, Pippa would be ready to be transferred home ….
>
> (i) … [W]ere Pippa successfully transferred to home care, her life expectancy would be modest. She would be susceptible to complications including profound saturations that could not be as readily reversed in the community as they could in a PICU. When asked how long he would expect Pippa to survive if transferred to home care, Dr Playfor told me 'many weeks …. some months'."

34. The whole process of trial and transition would take at least six months. It was Dr Wallis's view that overall there was a 1 in 4 chance of Pippa reaching the point of being discharged home, but if the initial trial were successful there would then be a 90% chance that she would progress from the transition unit to home. Once there she would continue to receive ventilation with the intention of keeping her alive as long as possible. All the medical witnesses agreed, however, that Pippa's life expectancy would be shorter if cared for at home than if she remained under her current treatment regime in the PICU, because of the limits of what can be provided in the home setting.

35. The treating clinicians did not agree with Dr Wallis's proposal. It was their combined view that there was no realistic chance that, with less sophisticated equipment and less specialist personnel, she could survive more than a very short time at home. They would not be willing to perform a tracheostomy for the purpose of a trial, believing that the exercise would be futile. It was the Trust's view that Pippa could not be cared for safely outside the PICU. At paragraph 49, the judge summarised the reasons for this view:

> "(a) Pippa needs a PICU ventilator which can be frequently adjusted as needed. A portable ventilator of the sort that would have to be used at home has a limited number of settings. Dr Wallis described to me how portable ventilators used by those of his patients who have been discharged home tend to have a "well" setting, a "sick" setting and perhaps one other setting for

> specific circumstances. In contrast the PICU ventilator can be operated with multiple adjustments during the day and night.
>
> (b) As agreed by the respiratory physiotherapists Ms F and Dr Chatwin:
>
> > i. An anaesthetic bag of the kind currently used to rescue Pippa when she desaturates cannot be used to administer oxygen in the community. Only an Ambu bag could be used, albeit with "entrained" oxygen rather than merely with air.
> >
> > ii. There are no community respiratory physicians in the area of Pippa's family home. In any event, even if there were, their role would only be to provide reviews of the care given. There would be no possibility of a respiratory physician visiting Pippa on a weekly or even monthly basis, let alone being on call in case of emergencies upon an episode of profound desaturation.
> >
> > iii. Saline lavage cannot be practised in the community – it is too risky.
>
> (c) Proning would be potentially hazardous if practised in the community: if Pippa were to be cared for at home she would be ventilated through a tracheostomy. The advantage of such tubes is that they can easily be re-inserted, whereas an ETT requires re-insertion under general anaesthetic. However, when a child with a tracheostomy tube is in the prone position it is difficult to monitor whether the tube is still in situ. With Pippa's unpredictable head and neck movements, she could dislodge the tube without the disconnection being noted, with catastrophic results.
>
> (d) Home care would involve a team of between 12 and 15 qualified nurses working in shifts and providing care 24 hours a day. Dr Wallis told me that half of the team could be health care assistants, but Dr Chatwin and the Trust's witnesses disagreed, advising that all staff would have to be qualified nurses. At least two nurses would be on duty at any one time. It would be very difficult to recruit such a team of nurses who could manage Pippa's respiratory condition.
>
> (e) There is currently no funding in place for a sufficient package of home care, and no other Trust approached by the Applicant has yet agreed to undertake the transition process (the Trust itself being unwilling to perform a tracheostomy on Pippa, which would be an essential part of the transition)."

36. As to the latter point, the judge (at paragraph 51(b)) noted that:

> "There has been no assessment of the suitability of Pippa's family's home for accommodating her, her equipment, and the necessary care team. Hence, I have no reassurance that her envisaged package of home care is practically achievable. Whilst appreciating that the CCG will not address Pippa's needs and funding decisions until necessary, it does strike me as a gap in the evidence that no-one has made even a cursory assessment of the suitability of Pippa's family home as a venue for her long term care. The Second Respondent's case is focused on Pippa's best interests being served by her being cared for at her home, not in some other community setting but I have no evidence that her home is suitable to accommodate her, her mother and brother, all the equipment needed, and a team of nurses who would need space and facilities of their own in order to function effectively."

37. At paragraph 51(d), the judge considered certain possible adjustments to Pippa's care which Dr Wallis had "politely suggested" in his oral evidence might optimise the chances of a successful trial of portable ventilation and to which some of the Trust witnesses had responded in evidence. The judge summarised the proposed adjustments as

> "including the use of Glycopyrrolate and/or Scopolamine patches to reduce Pippa's secretions, Botox injections of her salivary glands to reduce the production of saliva, surgical removal of the salivary glands, a change in ventilator settings so that Pippa was on a higher setting, and super-oxygenation".

He continued (at paragraph 52):

> "I do not think it necessary or appropriate for me to make detailed findings as to whether the proposed adjustments should be made to how Pippa is cared for now or in the future, how the trial and transition process should be managed, or how the prospects of transition to home care could be optimised. It is not the court's function to give detailed directions as to a patient's medical management. On the other hand, it is necessary for me to form a view on all the evidence of the prospects of success in transferring Pippa to home care. Dr Wallis proposed that such a transition should be attempted, and I take full account of his experience and his evidence to the court. I accept that there may be several adjustments that could be made to optimise the chances of success of the trial and transition, but the trial and transition could only succeed if Pippa's current tendency to suffer intermittent profound desaturations ceased or was significantly reduced."

The judge's approach to Dr Wallis's proposals for adjustments to the treatment programme is a further aspect of the fourth ground of appeal which the appellant seeks to pursue before this Court.

38. The judge noted that in his report Dr Wallis had described Pippa's clinical condition as being "at the absolute outer limits of what might be achievable at home." In oral evidence he had said that he knew of only two children with similar neurological conditions who had been transferred to home care but neither had had the same severe respiratory problems. At paragraph 53 he recorded:

> "A distinctive difference in attitude to transition emerged during the hearing. The Second Respondent's experts were more inclined to accept risk, to acknowledge that care at home could not and need not be optimal – it only had to be "good enough". If the alternative is withdrawal of ventilation in the PICU and death, then, they contended, it is worth taking the chance that transition to home care might work even if the chance is as low as 25%. In contrast the treating clinicians were adverse to giving Pippa less than optimal care and concerned that the proposed process was based on wishful thinking rather than the reality of Pippa's unstable respiratory condition."

39. He concluded that Dr Wallis's assessment of a 25% chance of a successful transfer to long term ventilation at home was too optimistic, observing that it could not easily be reconciled with his observation that her condition was "at the absolute outer limits of what might be achievable at home." He expressed his conclusion on the chances of the transition succeeding in these terms (at paragraph 54):

> "She has had only a handful of respiratory infections during nearly two years on the PICU. Considerable thought, effort, and resources have been put into managing her complex respiratory problems. Even so, she has suffered numerous profound desaturations, and would have suffered more had her desaturations not been intensively and expertly managed. Against that background it is difficult to see how transfer to a less sophisticated ventilator and the removal of some of the interventions that have so far protected Pippa, could realistically alleviate her respiratory problems or lead to fewer or less profound desaturations, even with adjustments to her management. I give weight to the direct knowledge of managing Pippa that the Trust's witnesses have and which informs their pessimism about the prospects of a trial and transition to home care. I also take into account the chances of a fatal complication occurring during the transition period, and the practical difficulties in setting up a care regime at home. Weighing all the evidence I have read and heard, I am satisfied that the chances of Pippa being able to be transferred to long term ventilation at home are remote. There is only a remote possibility of the trial and transition succeeding such that she could be discharged home."

40. The judge then turned to consider the views of Pippa's family. He observed that no one is closer to Pippa than her mother and proceeded on the basis that she spoke for the entire family. At paragraph 56, he summarised the reasons for her view that it was in Pippa's best interests to continue to receive life-sustaining treatment:

> "(a) It is "God's law" – by which I understand her to mean that there is a duty to preserve Pippa's God-given life. I received no other evidence to suggest that Ms Parfitt or her family actively practise within any faith, or hold other strong ethical views based on religious or secular teaching or values.
>
> (b) Some patients recover from severe brain injury. Pippa made progress after her first episode of ANE, and she has made some recovery since January 2019. She has the basis from which further recovery could be made.
>
> (c) The home environment and her mother's care are the contexts most likely to allow Pippa to achieve further recovery.
>
> (d) Keeping Pippa alive would allow her to enjoy the benefits of any developments in medical science.
>
> (e) Pippa will benefit from being in the warm embrace of her family in a familiar home. Her brother would return home – he is currently looked after by relatives in their own home - and Pippa would be reunited with him."

41. In scrutinising these views, the judge recorded the mother's reasons for believing that there was a basis for some cognitive recovery:

> "I base this opinion on my unique intricate maternal knowledge of my daughter and the extent to which she is presently responding which I see daily."

The judge recorded that none of the medical witnesses, including those on whose evidence the mother relied, believed it likely that Pippa will make any form of recovery. Dr Playfor advised the court that changes in Pippa's movements represented the neurological evolution and maturation of the underlying brain injury rather than any form of improvement in her condition. As for keeping her alive to allow her to enjoy the benefits of any developments in medical science, the judge observed (at paragraph 59):

> "no court could sanction giving a child life-sustaining treatment merely because there might be some medical breakthrough from which they could benefit at some indefinable point in the future."

The judge then considered the views of the medical professionals on Pippa's best interests. He observed that the opinion of clinicians and medical experts on all matters touching on Pippa's best interests was "welcome because their experience in caring for very ill children gives them considerable insight". Although the views of all the medical witnesses on the non-medical aspects of best interests carry less weight than their views on medical matters, they should be taken into account.

42. Next, the judge considered briefly the child's ascertainable wishes, feelings values and beliefs. He noted that it was not possible to ascertain her current wishes and

feelings, but took into account that before she lost capacity for conscious awareness she knew she had the unconditional love and dedication of her mother, brother and other family members. He added (at paragraph 68):

> "There can be little doubt that any young child who is loved and well cared for, would want to be at home with their family rather than in a hospital. However, it is not possible to know what Pippa's wishes and feelings would be in relation to the continuation of long term ventilation and other life sustaining treatment needed to allow her to attempt a transition to home care."

43. The judge then turned to his analysis of Pippa's best interests. It is important to note that he conducted this analysis in two sections, the first (paragraphs 70 to 90) addressing the option of continuation of long-term ventilation on the PICU and the second (paragraphs 91 to 108) considering the option of embarking on a trial of home ventilation.

44. Turning first to continuation of long-term ventilation on the PICU, the judge started by noting that, although the mother would prefer that outcome if the only alternative were withdrawal of ventilation, her counsel did not submit that it would be in Pippa's best interests. He recorded that he gave "considerable weight" to the preservation of life, but added:

> "there is, in law, no rule that life must be preserved in all circumstances and at whatever cost to the child. The presumption that life should be preserved is not a determinative factor and must be considered together with other factors relevant to Pippa's welfare and best interests."

He recorded that the medical evidence "overwhelmingly" supported the conclusion that she was in a persistent vegetative state with no prospect of improvement. In circumstances in which

> "she cannot see, breathe, or communicate, she has no awareness of her environment or of interactions with others, she has no purposeful movement, she is unresponsive to visual, auditory or tactile stimulation, she is doubly incontinent and she has to receive interventions throughout the day and night to prevent potentially fatal oxygen desaturations"

he concluded that there was

> "no subjective benefit to Pippa from being kept alive on the PICU."

45. At paragraphs 75 to 77, the judge considered but rejected a submission made on behalf of the mother that by definition there is no physical harm caused by the provision of medical treatment to a person with no conscious awareness. He held that:

> "it would be an error to allow the absence of pain or any sensation to prevent a wider consideration of welfare incorporating a consideration of physical and other harm or detriment to Pippa, from her condition, and from the treatments she needs to keep her alive."

His rejection of this submission forms the first ground of appeal to this Court and I shall consider the reasons for his decision below. Applying this approach to the circumstances of this case, he continued (at paragraph 78):

> "In the light of these considerations, I do take into account the detriment to Pippa's welfare caused by her condition and the treatment for it, even though she is unaware of that detriment. She is a five year old girl who has lost virtually all her functioning. She is constantly subject to invasions of her person to keep her alive. It is insufficient to view her condition as depriving her of benefit. Her condition and the treatment it necessitates are significant burdens. Even if one discounted these factors in the welfare assessment, on the grounds that Pippa has no conscious awareness of them, they ought to be taken into account in the broad assessment of her interests. It must be relevant to any assessment of her interests that she has such grave loss of function and requires such intensive and intrusive treatment to preserve her life."

At paragraph 79, he continued:

> "Pippa cannot derive any pleasure from life because she has no conscious awareness. Are there nevertheless other benefits to her, from the prolongation of her life, such as preserving her dignity, or allowing her to remain the focus of the love of her family, that the court should take into account? Or, if those are not benefits to her welfare, are they matters that should nevertheless be considered when assessing her best interests?"

I shall return to the judge's apparent distinction between "welfare" and "best interests" below.

46. At this point, the judge cited passages from MacDonald J's judgment the _Raqeeb_ case, in particular paragraphs 172 and 176-7. He summarised a passage from the report of Dr Playfor (who had given evidence in _Raqeeb_) and had subsequently changed his mind about rare cases of this type. In his report, Dr Playfor said:

> "5.18 Although severely disabled. with no demonstrable awareness of the environment and entirely dependent on the care of others, [Pippa]'s life has inherent value; it is nurtured and precious to her mother, sibling and wider family. [Pippa]s existence can be said to add, admittedly in a modest manner. to the body of collective human experience. With a tracheostomy and the provision of a portable mechanical ventilator, it should be possible, with considerable multi-disciplinary training and

> support, for Pippa to be cared for at home by her dedicated family in a manner consistent with values with which she has been raised. I note the observation of MacDonald J in [*Raqeeb*] that the prospect of being cared for at home is a relevant factor in determining the burden of indignity ….”

47. In response to this evidence the judge commented:

> “81. I would respectfully agree with Dr Playfor except that I would replace the word "modest". With "significant". A child such as Pippa can contribute significantly to the lives of others and to the body of collective human experience. She is an exceptional child who has inspired exceptional behaviour from others: the selfless devotion of her mother, the sacrifices of her brother, the loving support of other family members, the dedication and skill of the PICU doctors, nurses, and therapists….
>
> 82. I however, have difficulty in accepting Dr Playfor's analysis, not least because MacDonald J found that although it was likely that Tafida Raqeeb could not perceive pain in her resting or standard state [162], she had "retained a minimal level of awareness" [161]. As MacDonald J said, in medical cases like Pippa's and Tafida Raqeeb's, where there can be no absolute certainty as to their subjective experience, it is important to maintain fidelity to the standard of proof, particularly when the decisions for the court are so grave [175]. Applying the standard of proof, this court must assess Pippa's best interests on the basis that she has no conscious awareness, whereas MacDonald J assessed Tafida Raqeeb's best interests on the basis that she retained minimal awareness. In the present case there is a high degree of probability that Pippa has no conscious awareness. This distinction affects consideration of the benefits to Pippa of human interaction and loving care from the family.”

48. At this point, the judge considered the role of “dignity” in the analysis of best interests. He observed (paragraph 84):

> “Insofar as a plea to respect the "inherent value of life" or to the "innate dignity of life" directs the court's attention to the presumption that life should be preserved, it is uncontroversial.”

He disagreed, however, with Dr Playfor’s revised views on this issue:

> “Insofar as Dr Playfor's view is that the value of Pippa's life can be seen in what she can bring to others, I am afraid that I do not accept that I should take that into account in an assessment of her welfare or her best interests. Her life does have worth and value which can be seen most clearly in what it brings to

> others, but the assessment of best interests has to be made from the point of view of the child. Pippa's condition renders her unaware of the benefits she brings to others. Not only is her welfare my paramount consideration, but it would be wrong, in my judgment, to take into account the welfare of others when determining her best interests."

49. He continued (at paragraph 86):

> "The concept of "dignity" to which MacDonald J referred in *Raqeeb* at [176] to [177] (above) and which has influenced the view of Dr Playfor, is, I believe, problematic and does not assist me in identifying what is in Pippa's best interests. In an adult or older child the concept of dignity might be linked to their exercise of autonomy and be a crucial factor in determining what is in their best interests, but that factor does not apply in the case of a young child like Pippa, whose values, beliefs, and wishes cannot reliably be ascertained or inferred. Perhaps we all think we can recognise human dignity when we see it, but there is obviously a high degree of subjectivity involved in describing someone's life or death as having dignity …. There is a wide range of opinion as to what constitutes a dignified death …. I take into account the views of Pippa's mother and of others about her best interests, but given the very different ideas expressed to the court about what would constitute dignity for Pippa in life and in her dying, I shall not presume to adopt some supposedly objective concept of dignity to determine her best interests."

50. The judge then returned to seeking to identify whether there were any benefits to Pippa from the prolongation of her life in the PICU:

> "88. So what is the "impalpable factor" or other benefit that continuation of life will bring to Pippa beyond the prolongation of life itself, beyond the advantages or comfort it might bring to others, and beyond the subjective and malleable concept of dignity? Dr Wallis and Dr Playfor cannot find any benefit in continued care in the PICU, even though Pippa would continue to be the focus of the unconditional love of her mother and wider family, and to receive exceptional family, medical and nursing care. Counsel for Ms Parfitt do not point to any such benefits in their submissions. Likewise, I cannot find any palpable or impalpable benefit to Pippa from prolonging her life in the PICU. Is it inconsistent to find that a young child with no conscious awareness suffers burdens but enjoys no benefits from the prolongation of life? I do not believe so. The profound loss of function and the daily invasion of her bodily integrity necessary to prolong her life constitute objectively identifiable burdens on Pippa's person. Factors that might constitute some kind of benefit to an adult or young person,

> such as affirmation of deeply held values, or respect for autonomy, do not apply to a very young child such as Pippa."

51. Drawing the threads together, the judge concluded that he was unable to find any benefit to Pippa from prolonging her life in the PICU. He took into account her mother's wish for Pippa to be kept alive, but "balancing all the relevant factors", he was satisfied (paragraph 90) that it was not in Pippa's best interests to continue to receive long-term ventilation or other life-sustaining treatment on the PICU.

> "Notwithstanding the presumption that life should be preserved, it is not in her best interests that her life should be prolonged…. She has no conscious awareness and she gains no benefit from life but she daily bears the dual burdens of her profoundly disabling condition and the intensive treatment she requires to prevent it from ending her life. …. there is no hope of improvement in her condition and no medical benefit from prolonging her life on the PICU. I cannot identify any non-medical benefits to Pippa from continued ventilation on the PICU, whether social, emotional, psychological, or otherwise. Prolonging her life on the PICU will only prolong her burdens. Continued care on the PICU is not the primary wish of her family, although they would prefer her to live rather than to have ventilation withdrawn. I take into account their wishes and views. I also take into account the view of the treating team and the independent experts. Ultimately, however, the court has to take an objective view of Pippa's best interests. Taking a broad view of Pippa's medical and non-medical interests, but with her welfare as the paramount consideration, I conclude that it is not in her best interests to continue to receive mechanical ventilation on the PICU."

52. At paragraph 91, the judge then started his analysis of the option of embarking on the trial proposed by Dr Wallis. He took as his starting point his assessment that it was not in Pippa's best interests to continue with long-term ventilation on the PICU and asked what would be different about prolonging her life at home. He considered the mother's submission that such a course would be in her best interests because it would place her in her home environment surrounded by her loving family. Having set out the passages from the authorities cited to him by the mother's counsel on the weight to be attached to the views of a child's parents – *Re T (Wardship: Medical Treatment)* [1997] 1 FLR 502, *Re G* [2012] EWCA Civ 1233, and *Yates* – he concluded:

> "Accordingly, the court should take into account the wishes of those close to Pippa to care for her at home but only as part of the broad assessment of Pippa's best interests, and without detracting from the fundamental principles that Pippa's welfare is my paramount consideration and that the assessment of best interests is made from her perspective. If it would be contrary to Pippa's best interests to be cared for on long term ventilation at home, then it would be lawful not to accede to her family's wishes in that regard, and unlawful to do so. Their Article 8 rights would not be contravened. Dr Playfor, Dr Wallis, and

> many other people might think that when a child can feel no pain, the courts should seek a solution that gives the most comfort to the child's family, and that there is a cruelty in depriving them of that comfort and curtailing the life of the child they cherish. But the law seems to me to be clear that the benefits that Pippa has brought, and may continue to bring, to others, and the satisfaction of the wishes of a child's family, are not the focus of the court's attention. It is her welfare that is paramount, not the welfare of others, and her best interests that are the court's concern."

53. He found on the evidence that a transfer to home care would not benefit Pippa's medical condition and that, as home care could never replicate the exceptional standards of PICU care, transfer home would, if anything, be a detriment to her. Furthermore, he was unable to discern any non-medical benefit to her welfare from her care being at home. He did not agree with the opinion of Dr Wallis and Dr Playfor that the benefits of family life at home changed the balance from withdrawing to continuing treatment. He acknowledged that there was a "clinical sterility" in the PICU and that it was a "busy place with healthcare professionals constantly coming and going" and that, in contrast, "at home the environment would be more personal, perhaps more peaceful". Given the level of medical interventions and treatment that would still be required, however, her environment would in many ways be similar and "her home life would have many of the same features as life in PICU". In addition, he observed at paragraph 103(c):

> "It is agreed by all the medical witnesses that Pippa has no conscious awareness of her environment or interactions with others. Therefore, there would be no benefit to her from being in a home bedroom as opposed to a hospital unit. Family members may be able to spend more time with her at home in a more peaceful and welcoming environment, but she would not be aware of their visits or of the benefit to others. She would not be aware of any of the changes in her environment or in her care regime."

54. He then set out his ultimate conclusion at paragraphs 104 to 107:

> "104. Pippa would continue to bear nearly all of the burdens of her condition and treatment that she has on the PICU were she to receive long term ventilation at home. Having regard to all the evidence, including the views of Ms Parfitt, I am not satisfied that home care would confer any benefits to Pippa's welfare. Any benefits of home care that do exist would fall to her family, rather than to Pippa because she has no conscious awareness and derives no benefit from interactions with others, including family members. That is not to say that Ms Parfitt's advocacy of home care is motivated by her own needs – no-one could have been more selfless in her devotion to her daughter. But I have to focus on Pippa's welfare and so it is necessary to be clear as to the benefits and burdens to her of home care, as opposed to PICU care….

105. Looking at the wider question of whether home care, as opposed to PICU care, would serve Pippa's best interests, I accept that I should take into account the wishes of Pippa's family to care for her at home, and that home care is a goal that, as a much loved five year old girl, Pippa would be likely to share. As a generality it is in a young child's interests to be cared for by a loving family, living with them at home, rather than away from home.

106. Standing back to consider and balance all welfare considerations and factors affecting best interests, I am sure that it would be detrimental to Pippa's welfare and contrary to her best interests to receive long term ventilation at home, assuming that home care is a feasible option.

(a) The first matter I take into account is the preservation of Pippa's life. In fact, home care would be a less effective means of prolonging life than care in the PICU because the standard of care on the PICU could not be matched. However, that is an artificial comparison if the alternative to attempting a transfer to home care is to withdraw ventilation. Long term ventilation at home, if achievable, would at least serve to prolong Pippa's life, albeit only for ‘some months’.

(b) Weighed against the prolongation of life is the fact that long term ventilation at home would not improve Pippa's underlying neurological condition. She would remain unaware of her environment and interactions with others and remain unable to derive any pleasure from life. Prolonging her life at home would be no more beneficial to Pippa's welfare than prolonging her life in the PICU.

(c) Pippa would continue to suffer the burdens of her condition and the treatment it requires. She might be spared some of the interventions currently performed on her in the PICU such as saline lavage, but she would need a tracheostomy and gastrostomy which she does not currently have. At home she would continue to receive artificial nutrition and hydration, therapies to protect her bones and muscles, 24 hour nursing care, ventilation, suction, cough assist, turning, proning, and bagging. Prolonging her life by long term ventilation at home would prolong those burdens.

(d) I take into account the wishes of Pippa's mother to care for her at home, that Pippa would have been likely to have wanted to be at home rather than in hospital, and that there might be some benefits to Pippa's family from home care as opposed to hospital care, but Pippa would not be aware that her family were benefiting, their welfare is not the focus of the court's consideration, and although Pippa may well have

> wanted to be cared for at home, she would not be aware that she was at home.
>
> (e) I cannot give weight to Ms Parfitt's view that home care would improve Pippa's condition, because it is at odds with the unanimous view of the clinicians and medical experts.
>
> Dr Wallis asks what is there to lose by trying to transfer Pippa to home ventilation if the alternative is withdrawal of life sustaining treatment? The answer is that the loss would be the continuing burdens to Pippa caused by maintaining a regime of ventilatory support and other life sustaining treatment to prolong her life, when to do so would bring her no benefit. Pippa's welfare is my paramount consideration and continued ventilation, whether in the PICU, a transition unit, or at home, is detrimental to her welfare. Even allowing for a very broad assessment of Pippa's medical and non-medical interests, the presumption that life should be preserved is rebutted in this case.
>
> 107. In my judgment, therefore, long term ventilation at home would be contrary to Pippa's best interests. In any event, I have already found that the chances of success of both a trial of portable ventilation, and then a transition process, are remote. Furthermore, the transition process is prolonged – it would take at least six months. During that time Pippa would continue to be ventilated and treated in a hospital setting. She would not therefore have any of the supposed benefits of home care during that process. Her life expectancy on long term ventilation once at home would be uncertain but the best evidence is that it would be for some months only. It might be as short as a matter of weeks. At any time she could suffer a complication from which she could not recover, and the means available to achieve her recovery in the community would be less effective than those available in the PICU. In my judgement, balancing all the relevant factors including the views and wishes set out above, the presumption that life should be preserved, the benefits and burdens to Pippa of long term ventilation at home, the fact that she would remain without conscious awareness and would have no hope of improvement, the remote chance of the goal of home care being achieved, her limited life expectancy on home ventilation, and the long process involving continued ventilation in a hospital setting that would be required before home care could begin, I have reached the firm conclusion that it is not in her best interests to embark on a trial of portable ventilation and the transition process towards home care."

55. The judge therefore made declarations reflecting his conclusions, including that it was lawful and in Pippa's best interests for mechanical ventilation to be withdrawn. He

added that the precise circumstances for that course were a matter for agreement but that it would not be contrary to her best interests to transfer her home for the purpose of withdrawal of ventilation, the Trust having indicated that extubation can be arranged to take place at home to be followed by appropriate palliative care.

The appeal

56. The appellant relies on four grounds of appeal.

(1) The judge erred in finding that medical treatment to prolong life constituted a physical harm to Pippa notwithstanding that she does not experience pain and has no conscious awareness.

(2) The judge erred in finding that there could be no non-medical benefit to Pippa by prolonging her life so that she could be cared for at home surrounded by her family due to her lack of awareness and young age.

(3) The court failed to give adequate weight to the views of Pippa's mother as to her best interests, in circumstances where her view was supported by reasonable body of medical opinion and Pippa did not experience pain from ongoing treatment.

(4) The judge's conclusion that it was not in Pippa's best interests to embark on a trial of portable ventilation was flawed for two reasons: (a) the court failed to analyse properly the prospects of success of a trial by failing to admit the evidence of Dr Chatwin that evidence given on behalf of the Trust was in some respects incorrect; (b) the court wrongly rejected the assessment of Dr Wallis that there was a significant chance of the trial of portable ventilation being successful and of Pippa being well enough to go home without making any finding about whether there were modifications to Pippa's regimen which had not yet been tried and which might improve the prospects of the trial succeeding.

Ground one

57. At paragraph 75 of his judgment, the judge recorded that it was a critical part of the mother's case that Pippa could not feel any pain and that her counsel had submitted that

> "by definition there is no physical harm caused by the provision of medical treatment to a person with no conscious awareness."

The judge, however, rejected this submission, and at paragraph 76 gave this explanation for doing so:

> "Any proper assessment of welfare in a case involving life sustaining treatment ought to take into account the nature and extent of the interventions necessary to keep the patient alive. Clearly much greater weight should be given to the harm caused by those interventions if the patient can feel pain or discomfort. If Pippa were able to experience pain and discomfort when undergoing the multiple invasive procedures she undergoes each day, that would be highly material to the assessment of her welfare. But her loss of conscious awareness

> does not mean that those interventions can now be wholly disregarded. In Pippa's own case she not only requires artificial ventilation, nutrition, and hydration, but, day and night, she requires other interventions including suctioning, bagging, proning, and use of the cough assist machine, as well as other less frequent interventions such as saline lavage. Both her ongoing condition and her necessary treatments in the PICU constitute burdens upon her person notwithstanding her lack of conscious awareness. In any event, the absence of pain is not the same as the absence of harm. The fact that a person has no conscious awareness does not give their clinicians, or anyone else, licence to perform procedures on them irrespective of their benefit. Compensation payments for "loss of amenity" have been made to patients who are in a coma because the law recognises that even the fully unconscious individual may experience a loss of function and a diminished quality of life even if they do not suffer pain – *Wise v. Kaye* [1962] 1 Q.B.638 and *H. West & Sons Ltd. v. Shephard* [1964] A.C.326, applied in *Lim Poh Choo v Camden & Islington Area Health Authority* [1980] AC 174.The losses of freedom, function, and ability to enjoy childhood, that severe disability, including severe brain damage, cause someone such as Pippa, are a form of harm which should be considered in assessing her welfare, whether or not they can feel pain and whether or not they have any conscious awareness."

58. At paragraph 77, he continued:

> "Accordingly, it would be an error to allow the absence of pain or of any sensation to prevent a wider consideration of welfare incorporating a consideration of physical and other harm or detriment to Pippa, from her condition, and from the treatments she needs to keep her alive."

In support of his approach, the judge cited observations of my Lady, King LJ, in *Re A (A Child)* [2016] EWCA Civ 759. In that case, this Court dismissed an appeal against a judge's declaration that it was lawful and in the best interests of a two-year-old child who had sustained catastrophic spinal cord and severe hypoxic brain injuries in a road accident to withdraw respiratory support and provide palliative care only. At paragraph 57, my Lady observed that in the evidence put before the judge at first instance there had been a disproportionate focus on the single issue of pain and a failure to stand back to consider the child's welfare "in its widest sense". The judge, however, had continued to maintain focus on the "overall picture" for the child, and my Lady endorsed her finding that

> "even if his life were pain-free, I would come to the conclusion that there is no measurable benefit to him to continue in his present condition and it is simply inhumane to permit it to continue. It is not in his best interest to continue treatment other than palliative care, and it is in his best interests for all other treatment to be withdrawn."

59. On the present appeal, Mr Sachdeva and Ms Butler-Cole submitted that the judge's finding that Pippa could experience physical harm from medical treatment notwithstanding that she has no capacity to feel pain and no conscious awareness was wrong for three reasons. First, it was wrong in principle, since by definition no physical harm could be caused by medical treatment in such circumstances. Secondly, it was at odds with the approach taken by MacDonald J in Raqeeb. Thirdly, the judge was wrong to rely on the authorities from the law of tort cited in paragraph 76 of the judgment and had wrongly relied on my Lady's observations in Re A, which were addressing the different point whether the best interests test should focus on a single issue rather than the child's welfare as a whole.

60. The proposition that no physical harm can be caused to a person with no conscious awareness seems to me to be plainly wrong. As I observed during the hearing, the law clearly recognises that physical harm can be caused to an unconscious person. In the criminal law, for example, an unconscious person can suffer actual or grievous bodily harm and it would be no defence to a charge under the Offences against the Person Act 1861 that the victim was unconscious. The judge was in my view entirely justified in citing examples from the law of tort in which it has been recognised that physical harm can be caused to an insensate person. As Mr Mylonas observed, if the proposition advanced on behalf of the appellant was correct, there would be no limit on a doctor's ability to perform any surgery upon any insensate patient. For my part, I fully endorse the judge's reasoning for rejecting the appellant's proposition at paragraph 76 of his judgment.

61. The judge's approach is entirely consistent with the observations of my Lady in Re A. By focussing on the presence or absence of pain and failing to recognise the physical harm which an insensate patient may suffer from her condition or treatment, a decision-maker may fail to consider the child's welfare in its widest sense. Furthermore, so far as I can see, there is no support for the appellant's proposition to be derived from the judgment in Raqeeb. That case was decided on very different facts. Unlike Pippa, Tafida retained a minimal awareness, was in a stable condition, was not suffering life-threatening episodes of desaturations, and had received ventilation for a significantly shorter period. The level of support required by Tafida was not of the same degree of complexity and there was unanimity amongst all the doctors, including the treating clinicians, that she could be ventilated at home. Her condition and the treatments she received for it did not give rise to physical harm on the scale endured by Pippa in this case. In cross-examination, Dr Wallis acknowledged that the treatments given to Pippa were "on a spectrum of burdens". Furthermore, as demonstrated in the passages cited above from MacDonald J's judgment, the arguments advanced on behalf of the hospital trust in that case to the effect that it would be detrimental for Tafida to undergo the treatment proposed by her parents notwithstanding the fact that she could feel no pain were expressed in terms of dignity. In the present case, the Trust has not presented its arguments in those terms and the judge concluded that it would not assist him in this case to adopt any supposedly objective concept of dignity. In any event, it is worth noting that the argument presented to MacDonald J, as quoted in paragraph 176 of the judgment in Raqeeb,

> "that even if Tafida feels no pain, further invasive treatment over an extended period of time will impose an unacceptable

> burden on her human dignity, which burden will be increased
> as she develops further debilitating physical symptoms"

acknowledged that there would be "physical symptoms" which would be "debilitating" even though she could feel no pain.

62. The judge was entitled to conclude Pippa could experience physical harm from her condition and medical treatment notwithstanding that she has no capacity to feel pain and no conscious awareness. There is no merit in the contrary proposition advanced on behalf of the appellant. I would refuse permission to appeal in respect of the first ground of appeal.

Ground 2

63. The second ground of appeal is that, having concluded that he ought to take into account the detriment to Pippa's welfare caused by her condition and the treatment provided for it, the judge then wrongly went on to find that she could derive no value or benefit from prolonging treatment. Mr Sachdeva and Ms Butler-Cole submitted that the judge erred in proceeding on the basis that a young child with no awareness can experience the burdens of prolonging life through continued medical treatment but no benefits.

64. On behalf of the appellant, it was submitted, first, that the judge adopted an approach that was wrong in principle. It does not follow that a person's interests only relate to pain or pleasure or only exist if the person has conscious awareness of them. As Baroness Hale said in the *Aintree* case, the decision-maker must look at welfare in its widest sense. In this case, it was common ground that Pippa has interests in the circumstances of her medical treatment and care even though she is not aware of them. Yet the judge concluded, at paragraph 88, that she could derive no palpable or impalpable benefit from prolonging her life. Secondly, it was contended that the judge's conclusion that there could be no benefit to Pippa from prolonging her life so that she could be cared for at home due to her lack of awareness was inconsistent with his earlier conclusion that he could consider the physical burdens of treatment notwithstanding her lack of awareness. Thirdly, it was said again that this approach is at odds with MacDonald J's judgment in *Raqeeb*.

65. The respondents do not accept the premise on which this ground of appeal is based. They contended that the judge did not conclude that there were no non-medical benefits to Pippa that were relevant to the assessment of whether it was in her best interests to undergo a trial of home ventilation. On behalf of the Trust, Mr Mylonas pointed out that the passages in the judgment on which the appellant relies as a basis for this second ground of appeal are found in the section of the judgment analysing whether it would be in Pippa's best interests to continue to receive long-term ventilation on the PICU, not in the subsequent section analysing whether it was in her best interests to embark on a trial of portable ventilation. When conducting the latter analysis, the judge carefully reassessed the benefits and burdens to Pippa by reference to the proposed trial before concluding that a trial was not in her best interests.

66. I have set out at some length the relevant parts of the judgment in which the judge analysed the two separate options – on the one hand, continuation of long-term ventilation in PICU and, on the other hand, a trial of portable ventilation. As already

stated, the judge carefully structured his judgment by addressing these two options separately. Although there was plainly an overlap in the evidence, law and argument, the options were different and discrete, and each option required a different and discrete balancing exercise. The fact that the judge concluded (at paragraph 90) that he was unable to identify any non-medical benefits to Pippa from continued ventilation on the PICU ("whether social, emotional, psychological, or otherwise") did not mean that he necessarily concluded that there could be no such benefit to be derived from a trial of home ventilation. On the contrary, a careful scrutiny of the judgment (in particular paragraphs 105 and 106(d)) demonstrates that he concluded that there were potential non-medical benefits to be derived from such a trial, in particular that "as a generality it is in a young child's interests to be cared for by a loving family, living with them at home, rather than away from home", but that they were outweighed by other factors. I do not accept the appellant's argument that the judge was saying that such benefits only arise if the patient has conscious awareness of them.

67. The appellant's submissions on this point elided discrete points made in the judge's separate analyses of the two options under consideration. With regard to the first option - continuation of ventilation on the PICU – the terms in which the judge framed the questions in paragraph 79 quoted above clearly demonstrate that he accepted that there could be non-medical benefits which should be considered as part of the best interests analysis. He concluded (at paragraphs 88 and 90) that on the facts of this case, having regard to the evidence and submissions presented to him, there was no such benefit for Pippa in continued care on the PICU.

68. With regard to the second option - the trial of portable ventilation leading to home care – in summarising what had been established by the close of the evidence about the proposed trial at paragraph 46, he recorded:

> "it has to be accepted that care at home will not be of the same clinical standard as care in the PICU. The care at home will not be optimal but it has to be "good enough". To embark on the process all have to agree that a lower standard of care is the price worth paying for the reward of caring for the child in a more nurturing environment, and one that suits the family."

Having analysed the evidence, he found (at paragraph 104) that he was "not satisfied that home care would confer any benefits to Pippa's welfare". At paragraph 105, "looking at the wider question of whether home care, as opposed to PICU care, would serve Pippa's best interests", he acknowledged that there were potential benefits, in particular that "as a generality it is in a young child's interests to be cared for by a loving family, living with them at home, rather than away from home". At paragraph 106, however, "standing back to consider and balance all welfare considerations and factors affecting best interests", he concluded that long-term ventilation at home would be detrimental. Taking paragraphs 105 and 106 together, it is in my judgment plain that, in conducting that balancing exercise, the judge did take into account the non-medical benefits to be derived from living at home alongside arguments in favour of a trial but concluded that they were outweighed by the other factors which indicated that such a trial would be contrary to her best interests.

69. As noted above, at some points in the judgment the judge seemed to draw a distinction between "welfare" and "best interests". In paragraph 78, 79 and 104, for example, he seems to regard "welfare" as a category or subset of "best interests". During the hearing in this Court, counsel were unable to enlighten us as to how this distinction came to drawn. Looking back at the earlier reported authorities, I can find no basis for distinguishing between the two concepts. On the contrary, the case law demonstrates that the terms are normally used interchangeably.

70. In *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199 at page 202, Lord Hailsham of St. Marylebone observed:

> "There is no doubt that, in the exercise of its wardship jurisdiction, the first and paramount consideration is the well being, welfare or interest (each expression occasionally used, but each, for this purpose, synonymous) of the … ward …."

In *Re F* [1990] 2 AC 1 at page 54, Lord Brandon of Oakbrook observed that, when exercising its wardship jurisdiction, a court

> "would be bound to treat the welfare, or use an expression with substantially the same meaning, the best interests of the minor, as the paramount consideration".

I have already cited paragraph 87 of this Court's judgment in *Wyatt v Portsmouth Hospital NHS Trust* in which it was stated that:

> "The judge must decide what is in the child's best interests. In making that decision, the welfare of the child is paramount … The term "best interests" encompasses medical, emotional, and all other welfare issues."

In addition, as I have already mentioned, in the *Aintree* case, Baroness Hale said that:

> "in considering the best interests of this particular patient … decision-makers must look at his welfare in the widest sense."

My Lady adopted precisely the same approach in *Re A*, supra, a case involving the withdrawal of treatment from a child.

71. Accordingly, in considering applications concerning the withdrawal or continuation of life-sustaining treatment, no substantial distinction is to be drawn between the two concepts of welfare and best interests. I am entirely satisfied, however, that insofar as the judge purported to draw such a distinction at some points in his judgment, this did not undermine his ultimate conclusions. In expressing his conclusion about the continuation of long-term ventilation on the PICU, the judge said (at paragraph 90):

> "Taking a broad view of Pippa's medical and non-medical interests, but with her welfare as the paramount consideration, I conclude that it is not in her best interests to continue to receive mechanical ventilation on the PICU."

Later, in expressing his ultimate conclusion on the proposed trial of home ventilation, the judge said (at paragraph 106):

> "Standing back to consider and balance all welfare considerations and factors affecting best interests, I am sure that it would be detrimental to Pippa's welfare and contrary to her best interests to receive long term ventilation at home, assuming that homecare is a feasible option."

72. Once again, I do not detect any material difference between the approach of the judge in this case to that adopted by MacDonald J in the *Raqeeb* case. The judicial approach to the balancing exercise was substantially the same in both cases, although the evidence adduced in each case and the outcomes which resulted from that evidence were significantly different.

73. Accordingly, whilst I would grant permission to appeal on the second ground, a careful reading of the judgment demonstrates that the judge did take into account the non-medical benefits to be derived from living at home. I would therefore dismiss this ground of appeal.

Ground 3

74. The third ground of appeal is that the court failed to give adequate weight to the views of Pippa's mother as to her best interests, in circumstances where her view was supported by a reasonable body of medical opinion and Pippa did not experience pain from ongoing treatment.

75. Mr Sachdeva and Ms Butler-Cole submitted that the correct approach to determining the weight to be attached to a parent's views when making a best interests evaluation was set out by Waite LJ in *Re T (Wardship: Medical Treatment)* [1997] 1 FLR 502 which, they say, was approved by this Court in *Yates* and followed by MacDonald J in *Raqeeb*. They acknowledged that the judge took the mother's views into account when considering both the option of continuation of long-term ventilation in the PICU and the option of a trial of ventilation at home. They submitted, however, that in conducting the latter balancing exercise, he gave insufficient weight to her view that the proposed trial was in Pippa's best interests and failed to explain his reasons. The mother's view was shared and supported by Dr Wallis and Dr Playfor, two highly reputable paediatricians with particular expertise in this field. In the light of those expert opinions, and the fact (as asserted on behalf of the appellant) that there were no medical burdens or benefits from ongoing treatment, the court's failure to accord proper weight to her view was inconsistent with the approach set out by Waite LJ in *Re T* and difficult to reconcile with that adopted by MacDonald J in *Raqeeb*.

76. In response, Mr Mylonas submitted that the approach to assessing the role of parental views in best interests cases is not controversial and is as set out by McFarlane LJ in *Yates*. He further submitted that the premise underlying the appellant's argument – that there are no medical burdens from ongoing treatment – was incorrect. He drew attention to the judge's detailed description of the mother's views at paragraphs 55 to 60 of the judgment, his consideration of the weight to be given to those views when considering the proposed trial of home ventilation at paragraphs 98 to 100, and his treatment of this factor in the ultimate balancing exercise at paragraph 106. It was

submitted that, in carrying out this assessment, the judge acted entirely properly and in accordance with authority and that the appellant's assertion that the judge did not explain why so little weight was afforded to the mother's views was wrong. On behalf of the guardian, Mr Davy accepted that, where there is really nothing to choose between the benefits and detriments of the treatment options, a court may look to the parents to make that choice. In this case, however, proper application of the best interests test did not lead to a finely-balanced result between the benefits and burdens of long-term ventilation.

77. In support of this third ground of appeal, the appellant relied heavily on the dicta of Waite LJ in *Re T*. The circumstances of that case, however, were very different. It concerned a baby born with a life-threatening liver defect. The unanimous opinion of the medical consultants was that he should undergo a liver transplant. His parents, who were both healthcare professionals experienced in the care of sick children, disagreed. Shortly after birth the baby had undergone the surgery which had been unsuccessful and caused much pain and distress. Thereafter, the father obtained a post abroad and, against medical advice, the mother took the baby out of the country to visit him. Before Connell J, the local authority successfully obtained declarations that it was in the baby's best interests to have the transplant and for permission to perform the operation notwithstanding the mother's refusal to consent, and an order for the child to be returned to the jurisdiction for the purposes of surgery. This Court allowed the mother's appeal and set aside the declarations and order.

78. All three of the judges in this Court delivered judgments. In the course of her judgment (at page 510), Butler-Sloss LJ noted:

> "The welfare of this child depends upon his mother. The practical considerations of her ability to cope with supporting the child in the face of her belief that this course is not right for him, the requirement to return probably for a long period to this country, either to leave the father behind and lose his support or to require him to give up his present job and seek one in England were not put by the judge into the balance when he made his decision."

Although she noted the "very strong presumption in favour of a course of action which will prolong life", Butler-Sloss LJ (at page 512) stressed that

> "on the most unusual facts of this case with the enormous significance of the close attachment between the mother and baby, the court is not concerned with the reasonableness of the mother's refusal to consent but with the consequences of that refusal and whether it is in the best interests of C for this court in effect to direct the mother to take on this total commitment where she does not agree with the course proposed …. The prospect of forcing the devoted mother of this young baby to the consequences of this major invasive surgery lead me to the conclusion, after much anxious deliberation, that it is not in the best interests of this child to give consent and require him to return to England for the purpose of undergoing liver transplantation. I believe that the best interests of this child

> require that his future treatment should be left in the hands of his devoted parents."

79. This was the context in which Waite LJ in his judgment (at page 513-4) made the observations to which counsel for the appellant in this case attached particular weight:

> "All these cases depend on their own facts and render generalisations – tempting though they may be to the legal or social analyst – wholly out of place. It can only be said safely that there is a scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course certainty) that the greater the scope for genuine debate between one view and another the stronger will be inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature."

80. In his judgment, Roch LJ made this observation:

> "The view of the parents in a liver transplant case has two aspects. First, if, as here, the parents are devoted and responsible and have the best interests of their child in mind, then their views are to be taken into account and accorded weight and respect by the court when reaching its decision. Secondly, the views of the parents have a clinical significance because in the absence of parental belief that a transplant is the right procedure for the child, the prospects of a successful outcome are diminished."

In the circumstances of that case, Roch LJ emphasised the "formidable practical difficulties" which stood in the way of implementing the judge's order.

81. It is clear from these citations that the circumstances of <u>*Re T*</u> were very different to those arising in the case with which we are concerned. It is important to bear in mind the caveat at the start of the passage from Waite LJ's judgment cited above – "all these cases depend on their own facts." In <u>*Yates*</u>, this Court was concerned with a factual matrix much closer to that of the present case – an application by a hospital trust for a declaration that it was lawful to withdraw artificial ventilation from a child. The parents opposed the application and proposed instead that the child should travel abroad for treatment, a course which the judge at first instance concluded on the evidence to be futile. In this Court, McFarlane LJ observed at paragraph 80:

> "Under the accepted approach to best interests cases the weight to be attached to the views of a child's parents may vary and, where there is real scope for debate as between two treatment options, the views of the parents may well be very important."

Having cited a number of authorities, including <u>*Re T*</u>, McFarlane LJ concluded:

> "94. …. Even if such a case may fall at the more favourable end of the spectrum described by Waite LJ, the court does not evaluate the reasonableness of the parents' case, or, as these authorities indicate, introduce any other factor or filter before it embarks upon deciding what is in the best interests of the child.
>
> 95. When thoughtful, caring, and responsible parents are putting forward a viable option for the care of their child, the court will look keenly at that option, in the same way that a court in family proceedings, when it gets to the welfare stage of any case, looks at the realistic options that are before it. The court evaluates the nitty-gritty detail of each option from the child's perspective. It does not prefer any particular option simply because it is put forward by a parent or by a local authority. The judge decides what is in the best interests of the child by looking at the case entirely through eyes focused on the child's welfare and focused upon the merits and drawbacks of the particular options that are being presented to the court.
>
> 96. If one option is favoured by a parent, that may give it weight, or as Waite LJ put it, incline the court to be 'influenced by reflection that in the last analysis, the best interests of every child, include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature'. Notwithstanding that that is the case, in the end it is the judge who has to choose the best course for a child."

82. In supporting the dismissal of the parents' appeal, McFarlane LJ added (at paragraph 112):

> "It goes without saying that in many cases, all other things being equal, the views of the parents will be respected and are likely to be determinative. Very many cases involving children with these tragic conditions never come to court because a way forward is agreed as a result of mutual respect between the family members and the hospital, but it is well recognised that parents in the appalling position that these and other parents can find themselves may lose their objectivity and be willing to "try anything", even if, when viewed objectively, their preferred option is not in a child's best interests. 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."

83. It is this authoritative statement by McFarlane LJ which encapsulates the approach to be adopted by courts deciding the weight to be attached to the views of a parent on an application for a declaration that it is lawful for life-sustaining treatment of a child to be withdrawn.

84. There may be cases in which the arguments are balanced in such a way that the views of a parent may be decisive. Waite LJ's dicta in *Re T* were cited by MacDonald J as part of his reasoning in *Raqeeb* when refusing the applicant NHS Trust's application for a declaration authorising the withdrawal of life-sustaining treatment. He found (at paragraph 182) that:

> "… in circumstances where Tafida is not in pain, where the burden of the treatment is low, where there is a responsible body of medical opinion that considers that she can and should be maintained on life support with a view to her being cared for at home on ventilation by her family in the same manner in which a number of children in a similar situation to Tafida are treated in this jurisdiction, where there is a funded care plan to this end, where Tafida can be safely transported to Italy, where the continuation of life-sustaining treatment is consistent with the religious and cultural tenets by which Tafida was being raised and having regard to the sanctity of Tafida's life, this case *does* in my judgment lie towards the end of the scale where the court should give weight to the reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of the child's life will be taken for the child by a parent in the exercise of their parental responsibility."

85. The case with which we are dealing is very different. At the time of the hearing before MacDonald J, Tafida Raqeeb had received only seven months of ventilation. In contrast, by the time of the first hearing in the present case, Pippa has been ventilated for nearly two years. Unlike Pippa, Tafida was in a stable condition and not subject to the regular life-threatening episodes of desaturation. The degree of specialist support required by Pippa is on a significantly greater scale that that needed by Tafida. All the experts agreed that Tafida could be ventilated at home. In the present case, the treating team are firmly of the view that this is not feasible, and Dr Wallis, whilst believing that it may be achievable, accepts that it is at the "absolute outer limits" of what can be managed at home. The judge noted that he had "no reassurance that her envisaged package of home care is practically achievable." In contrast to the position in *Raqeeb*, there is currently no funded plan in the present case to support the proposal for home ventilation. Although some of the experts supported the proposal of a trial of portable ventilation with a view to a return to home care, none of the clinicians or experts thought that such a course would lead to any improvement in Pippa's medical condition and the judge found that the proposed trial would increase Pippa's burdens.

86. Nonetheless, at paragraphs 55 to 60 the judge set out the mother's views in considerable detail and manifestly took those views into consideration when analysing

both the option of continuing ventilation in the PICU and the option of a trial of portable ventilation leading to home care. In my judgment, the weight he attached to the mother's views was carefully calibrated and justified on the evidence. I do not agree that he failed to provide a sufficient explanation for his reasons for not adopting the course proposed by the mother or for the weight he attached to her views. His analysis in paragraphs 91 to 108 is a comprehensive assessment and provides a clear explanation of the reasoning behind his decision. He took into account the fact that the mother's view was supported by Dr Wallis and Dr Playfor, although he did not attach weight to her view that home care would improve Pippa's condition because, as he explained at paragraph 106(e), that view was contrary to the unanimous opinion of the clinicians and medical experts. Unlike *Raqeeb,* this was not a case that fell within the category identified by Waite LJ in *Re T* where there is "genuine scope for a difference of view between parent and judge" and "an expectation that difficult decisions affecting the length and quality of [the child's] life will be taken for [her] by the parent to whom [her] care has been entrusted by nature." Rather, it was a case in which the judge properly followed the "sole principle" identified by McFarlane LJ in *Yates* 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".

87. For these reasons, I would refuse permission to appeal on the third ground.

Ground 4

88. Finally, the appellant argues that the judge's conclusion that it was not in Pippa's best interests to embark on a trial of portable ventilation was flawed for two reasons. First, it is said that the court failed to analyse properly the prospects of the success of a trial by failing to admit the evidence of Dr Chatwin that evidence given on behalf of the Trust was in some respects incorrect. Secondly, it is argued that the court wrongly rejected the assessment of Dr Wallis that there was a significant chance of the trial succeeding without making any finding about whether there were modifications to Pippa's regimen which had not yet been tried and which might improve the prospects of the trial succeeding.

89. The evidence of Dr Chatwin to which this submission is addressed was contained in a supplemental report dated 22 December 2020, four days after the hearing. In the report, the fourth that she had prepared in the proceedings, Dr Chatwin stated that, contrary to evidence given by Ms F in response to Dr Wallis's oral evidence, Pippa's medical records revealed no evidence to support the assertion that her oxygen saturation was being kept at 98 to 100% for the majority of the time. It was submitted on behalf of the appellant that the judge's decision to disregard the report revealed a failure to understand the relevance of Dr Wallis's evidence of the possible modifications to Pippa's regime. As to that evidence, it is submitted that the proposed modification was central to Dr Wallis's opinion about the prospects and that the judge therefore erred in law by failing to make detailed findings about whether those modifications were possible.

90. Mr Mylonas submitted that there is no merit in either of the complaints raised under this ground of appeal. He pointed out that Pippa's ventilatory status and her respiratory instability had been central features throughout the proceedings on which the served expert evidence was focused. Notwithstanding the extensive consideration given to those features in the expert discussions prior to the hearing, it was only

during Dr Wallis's oral evidence that he raised a number of further suggestions, none of which arose out of any change or development in Pippa's condition. Had any of his points been raised earlier, the Trust could and would have responded in writing, just as it had responded to Dr Wallis's earlier suggestions about the proposed trial of portable ventilation and a tracheostomy. In the circumstances, the judge's criticism at paragraph 44 of the judgment of the way Dr Wallis had introduced these suggestions was entirely justified. Notwithstanding that criticism, the judge (at paragraphs 51 and 52 of the judgment) duly considered Dr Wallis's evidence, including the additional proposed modifications to the treatment programme raised belatedly in his oral evidence, before reaching his decision. As Mr Davy pointed out, the judge (at paragraph 51(d)) accepted that "there may be several adjustments that could be made to optimise the chances of success of the trial and transition".

91. With regard to Dr Chatwin's fourth report Mr Mylonas reminded us of the very recent observation of Peter Jackson LJ in *Z, M, S, R v RS and University Hospitals Plymouth NHS Trust* [2021] EWCA Civ 22 when, in giving reasons for dismissing an appeal against a judge's refusal to allow the instruction of a further expert at paragraphs 20 and 22, he said:

> "Part 15 of the Court of Protection Rules 2017 provides that the court has the power to control the introduction of expert evidence and is under a duty to restrict expert evidence to what is necessary to assist the court to resolve the issues in the proceedings. A court-sanctioned expert has an overriding duty to the court. Respect for the procedural rules is of particular importance when the proceedings are of gravity. In the present case, the Court made appropriate directions for independent expert evidence …. These are not rolling proceedings which a dissatisfied party can continue at will. Far from there being any unfairness in the refusal to permit the instruction of a further unidentified expert, there is in my view a real risk of harm to the protected party and of unfairness to other parties if litigation is conducted in such an unprincipled way."

92. In the present case, four days after the conclusion of the hearing, the appellant's solicitor filed and served a fourth report from Dr Chatwin without notice and without the court's permission. Mr Mylonas submitted that this was an attempt to roll out new evidence in support of the appellant's case after the evidence had closed in precisely the manner deprecated by Peter Jackson LJ. It was submitted that this was particularly unfair to the Trust because the points addressed in the report had only been provided orally by the Trust in response to the matters raised for the first time by Dr Wallis in his oral evidence. In the circumstances, the judge was fully entitled in the exercise of his case management powers to refuse to admit the report.

93. Mr Davy draws attention to an email sent by the judge via his clerk to the parties on 23 December 2020 setting out his reasons for refusing to admit the report. In that email, included in the supplementary bundle for this appeal, the judge, having reminded himself of the overriding objective, stated *inter alia*:

> "The issues addressed by Dr Chatwin in this fourth report concern adjustments to Pippa's management which might

> affect a transition to home care, and whether and to what extent they have already been attempted or made. I have already received evidence from witnesses called by both the applicant and the second respondent in relation to those adjustments and the overall likelihood of transition being achieved. I have sufficient evidence on these matters to enable me determine the issues in this case, and to do so fairly …. It would be disproportionate to admit the evidence: to do so would lead to yet further evidence being adduced in response …. The issues addressed by Dr Chatwin in this fourth report are not, in my judgment, at all central to … the obviously very important issues that the court must determine."

Mr Davy submitted that, given the judge's conclusion that the chances of success of both a trial of portable ventilation followed by a transition process were remote and that long-term ventilation at home would be contrary to Pippa's best interests, the content of Dr Chatwin's fourth report was of no consequence to the judge's decision.

94. On this fourth ground of appeal, I again accept the submissions made on behalf of the respondents. I do not agree with the appellant's submission that the judge failed to grapple with the medical and expert evidence and to give reasons for departing from Dr Wallis's opinion. He clearly took into account Dr Wallis's oral evidence about potential modifications to the treatment programme, notwithstanding the unsatisfactory way in which that evidence had been adduced. Contrary to the assertion in the appellant's submissions, the judge acknowledged that there were modifications suggested by Dr Wallis which might affect the trial and transition plan but concluded on the basis of the totality of the evidence that the proposal was not in Pippa's best interests. The fact that he did not set out in full detail Dr Wallis's evidence about the proposed modifications does not mean that he failed to take that evidence into account.

95. As for Dr Chatwin's fourth report, the judge's decision to refuse to admit the report, as explained in his email dated 23 December 2020 and summarised in paragraph 44 of his judgment, was plainly within his case management powers and consistent with the principles in the court rules. In any event, he was entitled to conclude that the issue addressed in the report was not central to the evaluation of Pippa's best interests and the merits of the proposed trial of portable ventilation.

96. I would therefore refuse permission to appeal on the fourth ground.

97. Thus far, I have not considered the concept of dignity which featured in a number of the earlier judgments, including that of MacDonald J in *Raqeeb*. Although it was mentioned in the course of the judgment in this case, it was not a factor which the judge included as a reason for his decision.

98. On behalf of the appellant, Mr Sachdeva observed in oral submissions that dignity was not, as he put it, the touchstone. In his submissions on behalf of the guardian, however, Mr Davy made extensive submissions about the concept of dignity and its role in decisions concerning the withdrawal of life-sustaining treatment. It was his contention that, in addition to the principle of the sanctity of life and principle of self-determination, the court in these circumstances should take into account the principle

of the respect for the dignity of the individual. He submitted that the judge was correct to identify amongst the factors relevant to his decision both the burdens arising from the intensive and intrusive treatment required to keep Pippa alive and her grave loss of function and the potential benefits to be gained from treating her at home surrounded by her loving family rather than in hospital. Mr Davy submitted, however, that the real justification for including these burdens and benefits is that they are both aspects of the principle of respect for the dignity of the individual. He argued that this principle requires respect for an individual's value as a human being and encompasses both their psychological and physical integrity being deemed worthy of respect. Somebody who has no awareness of their circumstances can still be afforded dignity, or treated with indignity, by the manner in which they live and the way in which they are treated. Mr Davy submitted that, in Pippa's case, there is an innate indignity and burden associated with the intensive and intrusive treatment required to keep Pippa alive and her grave loss of function. Alternatively, if she were able to be cared for at home surrounded by her loving family, this would be a less undignified existence than her current care within the PICU. Notwithstanding these submissions, however, the guardian concluded that, when all the factors relevant to the decision are taken into account including the three principles of sanctity of life, self-determination and respect for the dignity of the individual, the potential benefit to Pippa from being cared for at home did not come close to tipping the best interests balance.

99. Mr Davy developed these arguments by reference to a number of reported authorities, in particular the decision of the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789. I commend him for the thought and care with which he has prepared those submissions and I intend no disrespect to him in saying that I do not think it necessary or appropriate on this occasion to embark upon a detailed analysis of the arguments he deployed. The judge declined to attach any weight to the concept of dignity in reaching a decision about Pippa's best interests, observing (at paragraph 86):

> "there is obviously a high degree of subjectivity involved in describing someone's life or death as having dignity"

and cited authorities in which the protection of dignity had been deployed to support decisions both to continue treatment and to withhold it. He concluded:

> "given the very different ideas expressed to the court about what would constitute dignity for Pippa in life and in her dying, I shall not presume to adopt some supposedly objective concept of dignity to determine her best interests."

Neither the appellant nor the Trust has sought to argue that he was wrong in adopting that course.

100. Other judges, dealing with cases involving different circumstances, have taken a different approach: see for example MacDonald J's decision in *Raqeeb*. In a future case, it may be necessary for this Court to address arguments akin to those put forward by Mr Davy about the role played by the concept of dignity in decisions of this sort. That necessity does not arise on this appeal.

101. Every parent dreads the prospect of their child contracting a terminal illness. No parent could have done more than Pippa's mother to care for her child or fight for her

future. As the judge observed at the end of his judgment, however, in this case the law vests responsibility for decisions in the court, not the parent. I am entirely satisfied that the judge was entitled to conclude and declare that it was lawful and in Pippa's best interests that life-sustaining treatment be withdrawn for the reasons he gave in his judgment.

ELISABETH LAING LJ

102. I agree.

KING LJ

103. I also agree.

Covid-19 Protocol: This hearing was conducted in public and in person, but this judgment was handed down at a remote hearing, in public and by circulation to the parties' representatives by email, and release to BAILII. 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 Applicant's witnesses and any individual having day-to-day care of or medical responsibility for the Child (the First Respondent) at the Applicant Trust 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.

Neutral Citation Number: [2021] EWHC 25

Case No: FD20P00135

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/01/2021

Before:

Mr Justice Poole

- -

Between:

GUY'S AND ST THOMAS' CHILDREN'S NHS FOUNDATION TRUST **Applicant**

and

(1) PIPPA KNIGHT
(By an officer of Cafcass and her Children's Guardian)

(2) MS PAULA PARFITT

Respondents

- -
- -

Michael Mylonas QC (instructed by **Hill Dickinson LLP**) for the **Applicant**
Neil Davy (instructed by **Cafcass Legal Services**) for the **First Respondent**
Vikram Sachdeva QC and Victoria Butler-Cole QC (instructed by **Sinclairs Law**) for the **Second Respondent**

Hearing dates: 14-18 December 2020

- -

APPROVED JUDGMENT

Mr Justice Poole:

Introduction

1. Pippa Knight is a much loved five year old girl. Her father died three years ago but she has the most dedicated and loving support of her mother, Paula Parfitt, her older brother, aged 7, and her maternal grandparents, uncle, and aunt. Together they form what Ms Parfitt describes as "powerful unit of strength for her and for each other."

2. That strength has been needed. Pippa is gravely unwell. She has severe brain damage and has been kept alive by mechanical ventilation through a nasal endotracheal tube in the paediatric intensive care unit at the Evelina London Children's Hospital since January 2019. Expert neurologists and intensivists agree that she probably feels no pain and experiences no pleasure, that she is not conscious of her environment, and that there is no prospect of improvement in her condition. The NHS Trust responsible for Pippa's care and treatment, whose doctors, nurses and therapists have exercised exceptional skill in looking after her, considers that she has been through enough. It asks this court to exercise its inherent jurisdiction to declare that it is lawful and in Pippa's best interests that:

    a. She should not be provided with a tracheostomy.
    b. Mechanical ventilation should be withdrawn.
    c. There be clearly defined limits on the treatment provided to Pippa after that withdrawal of ventilation, with the effect that she would be allowed to die.

3. Ms Parfitt opposes the Trust's application. The evidence shows that there have been many meetings between Ms Parfitt and the treating team. She is aware of all the expert medical opinions that have been given in this case, but unlike the Trust, she believes that Pippa has made some progress since January 2019, that she has awareness of her family and can derive pleasure from being with them and from touch and other sensations, and that it is in her best interests to continue on long term ventilation. In reliance on expert evidence, including from Dr Colin Wallis, Consultant Respiratory Physician, Ms Parfitt proposes that Pippa should now undergo a trial of portable ventilation, a tracheostomy, and management in a transition unit with a view to her being discharged from hospital, to be cared for at home.

4. Pippa is represented by her children's guardian, Lauren Doyle of the Cafcass High Court Team. After much careful consideration she supports the Trust's application.

5. Ms Parfitt does not seek anonymity for herself or for Pippa. The hearing before me was held in public and in person, with two witnesses giving evidence by video link. The parties and the court have had the benefit of experienced Counsel: Mr Mylonas QC for the Applicant, Mr Davy for the First Respondent, and Mr Sachdeva QC and Ms Butler-Cole QC for the Second Respondent. I am grateful to them and to their instructing solicitors for the care and skill they have exercised in presenting this case.

6. The dispute as to whether continuing ventilation should or should not be given to Pippa has been brought to the court for determination because Ms Parfitt and those who are treating Pippa have been unable to come to an agreement. The Trust has carried out best interest reviews. It has sought second opinions from independent consultants. Its Ethics Committee has given its opinion on whether long term ventilation is in Pippa's best interests. Mediation has taken place but was not successful. This case is of an

exceptional nature – very few children are in Pippa's condition – and it is the exceptional cases that tend to come before the courts. The Trust's application was made in March 2020 but it has taken several months to arrive at a final hearing. This is in part due to the Covid-19 pandemic, but also because of the nature and extent of the expert evidence in the case. On 22 July 2020, Judd J gave permission to the Second Respondent to rely on six expert witnesses. One of those, Dr Wallis, proposed a trial of portable ventilation with a view to transferring Pippa home. The feasibility of that proposal, and the conditions under which a trial should be conducted, have taken time to investigate.

7. Since the parties bring Pippa's case to court, the court must make a determination – it has a duty to do so. The court is independent of the Trust, of the NHS, and of Ms Parfitt. The court's power is to decide whether a course of treatment is lawful or unlawful. It has no power to require doctors to carry out a medical procedure against their professional judgment. The court's decisions are not based on what the particular judge would decide for themselves, or what outcome they would want for their own loved ones. Nor are the judge's own ethical or religious beliefs relevant. Rather, the court seeks to apply the law to the facts of the individual case. The question for the court is what is in Pippa's best interests.

8. On the first afternoon of the hearing, Ms Doyle and I visited Pippa on the PICU at the Evelina. Her mother was where she can usually be found: at her daughter's bedside. I had expected that any visit would be by a video link of some kind, given the current Covid-19 pandemic, but Ms Parfitt wanted me to attend in person and the Trust was happy to accommodate the visit with suitable safeguards being taken. The purpose of the visit was not to gather evidence, but to see Pippa in the environment in which she is cared for. The visit helped to connect the forensic process within the court room with the real circumstances in which Pippa and her mother find themselves.

9. In court, I heard powerful oral evidence from Ms Parfitt. I have been provided with written evidence from Ms Doyle, from a number of medical and nursing personnel at the hospital, and from the Head of Placements for Children and Young People at the Clinical Commissioning Group for Pippa's home location. I have also had the benefit of extensive expert evidence as follows:

    a. From Dr A, a Paediatric Intensive Care Consultant who is Pippa's lead consultant and who has been involved in her care throughout her time at the Trust's PICU, and from Dr Playfor, a Consultant Paediatric Intensivist instructed by the Second Respondent mother. They have produced a joint statement following discussion. I heard oral evidence by video link from them both.

    b. From Dr B, Consultant Paediatric Neurologist, who has been the lead Consultant Neurologist involved in Pippa's care at the hospital, and from Dr Spinty, Consultant Paediatric Neurologist instructed by the Second Respondent mother. Again, those two experts have produced a joint statement following discussion. Such is the extent of agreement between them that the parties did not need to call them to give oral evidence.

c. From Dr C, Respiratory Consultant, who has led Pippa's respiratory care at the hospital, and from Dr Wallis, Consultant Respiratory Paediatrician instructed by the Second Respondent mother. They too have produced a joint statement following discussion. I also heard their oral evidence.

d. Ms D, physiotherapist, and Ms E, occupational therapist from the Trust, and Ms Stevenson and Mr Chakraborty, respectively physiotherapist and neuro-rehabilitation occupational therapist instructed by the Second Respondent mother. These four witnesses produced a joint statement together following discussions. They did not give oral evidence.

e. Ms F, Clinical Specialist Paediatric Respiratory Physiotherapist employed by the Trust, and Dr Chatwin, Clinical Specialist Paediatric Respiratory Physiotherapist, instructed by the Second Respondent mother. They also have produced a joint statement following discussions. They also gave oral evidence.

The names of the medical and other personnel at the Trust have been anonymised following a reporting restrictions order made in July 2020. The volume of expert evidence reflects both the complexity of Pippa's care needs, and the depth of investigation that has been carried out to help the court to determine the difficult issues which it must now address.

Background

10. The background to this application is heart-rending. Pippa was born on 20 April 2015. As a very young child she was affectionate, reaching out to her parents and others for cuddles. She had a strong bond with her brother whom she idolised. She developed normally until December 2016 when her mother took her to Medway Hospital because she was unwell. She deteriorated overnight and began to suffer seizures. She was transferred to the Paediatric Intensive Care Unit ("PICU") at St George's Hospital, London, and was diagnosed with acute necrotising encephalopathy ("ANE"), a rare condition in which an acute febrile disease, usually a viral infection such as influenza, is followed rapidly by seizures, disturbance of consciousness, and ultimately brain damage (encephalopathy). Pippa remained on the PICU until 10 January 2017, when she was moved to the paediatric ward. A month later she was transferred back to Medway Hospital, and after another month she was transferred to a neuro-rehabilitation unit where she remained for a further three months. On discharge home Pippa was severely compromised. She had a four-limb motor disorder with a predominant dystonia. She required nasogastric tube feeding and was thought to have cognitive impairment.

11. Pippa went home on 9 June 2017 to be looked after by her mother. Her father had lost a young son from a previous relationship to meningitis. He found it difficult to cope with the fact that another of his children was suffering so grievously. A few days after Pippa's discharge home, he took his own life. Ms Parfitt had to cope not only with her own bereavement, but with two bereaved children, one of whom was newly discharged from rehabilitation and severely disabled.

12. In late February 2018 Pippa required in-patient care at Medway Hospital for 18 days following a viral infection, but she did not require intensive treatment and she was able to return home. She made progress under the care of her mother at home. She gradually regained some strength and could walk a few metres with a walking frame (her left leg was weaker and she had difficulties with balance). She regained the ability to crawl and she could ride a tricycle with support. She had limited verbal communication but was interactive in play.

13. Tragically, in January 2019 ANE struck again. On 14 January 2019 Pippa was admitted to Medway Hospital with a fever but she deteriorated. Her Glasgow Coma Score fell to 3/15 indicating a catastrophic loss of consciousness. She was transferred to the Applicant Trust's care on 15 January 2019 and admitted to its PICU where she was ventilated and given life support. Once again Pippa survived, but this time there has been no recovery of the kind she made after her first episode of ANE. She has remained on mechanical ventilation and is still a patient on the PICU at the Evelina nearly two years later.

14. Pippa's mother, Ms Parfitt, lives in hospital accommodation and spends as many as sixteen hours most days by Pippa's bedside. Pippa currently receives video calls from her brother and grandparents, and Ms Parfitt's brother and grandmother often sit with Pippa for long hours when Ms Parfitt is resting. The fact that Ms Parfitt has not been wholly ground down by her experiences is a tribute to her resilience and dedication. As Pippa's children's guardian Ms Doyle has said, she is "the most committed of mothers with a strength and mindset that I cannot comprehend."

Issues for the Court to Determine

15. The Trust seeks three declarations as set out above. Mr Mylonas QC for the Trust began his closing written submissions with the following:

> "There is one primary issue for the Court's determination – is it in Pippa's best interests (and therefore lawful) for life sustaining treatment to be withdrawn?"

In their opening position statement, Mr Sachdeva QC and Ms Butler-Cole QC for Ms Parfitt, contended that the choice for the court is "death now in hospital, or death in the future after a period at home." In fact, the questions for the court are about treatment and the withdrawal of treatment, not about choosing death, even if death is the inevitable consequence of withdrawal of ventilation. In *Airedale NHS Trust v Bland* [1993] AC 789, Lord Goff of Chieveley (with whose judgment Lord Keith of Kinkel and Lord Lowry expressly agreed) pointed out that,

> "the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment." [p 868]

The Second Respondent's case is not that it is in Pippa's best interests to be transferred home with a view to withdrawal of ventilation, but rather that steps should be taken to determine whether long term ventilation can be provided at home. As such, "death in the future after a period [of long term ventilation] at home" is not a choice currently available, because no-one yet knows whether Pippa can be given ventilation at home for anything beyond a few hours, or a few days at most. The Second Respondent's closing written submissions better reflect this fact. They began:

> "This case is about whether Pippa should be permitted to undergo a trial which will reveal whether she is sufficiently stable to be sent home to spend her last weeks or months in the company of her devoted mother and brother."

16. In my judgement, it is necessary to determine Pippa's best interests, and whether to make the declarations sought, in the context of three available options:

    A. Continuation of life-sustaining mechanical ventilatory support and treatment within a PICU setting.
    B. A trial of portable ventilation with a view to transition to long term ventilation and life sustaining treatment at home.
    C. Withdrawal of life sustaining mechanical ventilatory support.

Neither Counsel for the Second Respondent nor any of the clinical or expert witnesses have contended that option A would be in Pippa's best interests, but in my judgement it is necessary for me to consider it because,

(i) Pippa's mother made it clear in her evidence that she would prefer option A to option C.

(ii) Even if I determine that option B is in Pippa's best interests, the trial of portable ventilation might well fail, or the provision of home ventilation might otherwise become impossible to achieve. In that case, it is likely that the parties would remain in dispute about whether continued ventilation in the PICU was in Pippa's best interests. I should note that the likelihood of such a dispute may have reduced following the hearing. The evidence given was that the initial trial would take two weeks, but that the transition process before home care could be attempted could take at least six months. In closing submissions on behalf of Pippa's mother, Counsel stated,

> "Reflecting further since the conclusion of the oral evidence, Ms Parfitt has informed her solicitor that if Pippa passed the trial but in 6 months' time there was no real progress towards a return home or if Pippa's condition had stayed the same or deteriorated, she would consider consenting to withdrawal of ventilation."

Even given Ms Parfitt's new position - which is that she would consider consenting to withdrawal of ventilation, not that she would consent - it seems to me that there would remain the likelihood of a dispute about Pippa's best interests in the future. Ms Parfitt already disagrees with the healthcare professionals' views about the progress of Pippa's condition, and there would be ample room for further disagreement about Pippa's condition during the transition process, and whether "real progress" had been made towards a return home.

(iii) It would in principle be open to the court to find that neither option B nor option C were in Pippa's best interests, but that option A was. All agree that the quality of medical and nursing care that could be afforded to Pippa at home would be lower than could be given in a PICU setting. The court is not bound to accept the opinions of the medical experts and could in principle find that long term ventilation is in Pippa's best interests but only if provided in the optimal setting of the PICU.

17. As for option B, in my judgment I have to consider Pippa's best interests as they are now. I cannot know the outcome of a trial of portable ventilation or of the potentially long and detailed process of transition to home care. It is not possible to make multiple declarations about her best interests applicable to the many differing circumstances that might arise as the trial and then the transition process progressed. However, the evidence does allow me to consider:
    a. The nature of the end goal of long term ventilation and life sustaining treatment at home.
    b. The prospect that the trial and transition process would result in the end goal of home care being achieved.
    c. What that process would entail for Pippa: what would be the means by which the end would be achieved.

    By considering those factors, the court can make an assessment of whether it is in Pippa's best interests to embark upon the trial and transition process – option B. It would be wrong in my judgment to focus exclusively on the very first step in that process. The initial trial of portable ventilation is not an end in itself, it is a means to an end, or, more precisely, a necessary but not sufficient means to the end of providing Pippa with life sustaining treatment at home. If it would not be in Pippa's best interests to reach the destination, then it is unlikely to be in her best interests to embark on the journey.

18. Option A is not a hypothetical option, it is the ongoing reality. Option B is an available option and is urged upon the court by the Second Respondent. The Applicant and First Respondent submit that ongoing long term ventilation is not in Pippa's best interests, wherever it may be given, and that Option C is in her best interests. These are the options available that I should consider when assessing Pippa's best interests.

19. In the remainder of this judgment I shall consider the legal framework in which the court's determinations are to be made; summarise the evidence as to Pippa's condition and management; consider the steps that would need to be taken to discharge her into home care, the chances of those steps being successful, and what home care would comprise; and then examine Pippa's best interests in the context of the three options I have identified.

The Law

20. The law applicable to decisions of the kind this court is required to make in respect of a young child, has been set out in numerous cases. The key principles articulated by the Court of Appeal in *Portsmouth Hospitals NHS Trust v Wyatt and Anor* [2005] EWCA Civ 1181, and by Holman J in *An NHS Trust v MB* [2006] EWHC 507, continue to guide the courts today. They are that,

    i) The judge must decide what is in the best interests of the child.

    ii) In making that decision the welfare of the child is the paramount consideration.

    iii) The judge must look at the question from the assumed point of view of the child.

    iv) There is a strong presumption in favour of a course of action that will be likely to preserve life but that presumption is not irrebuttable.

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

    vi) The court must consider the views of the doctors and parents.

    vii) Each case will turn on its own facts.

    viii) The court must conduct a balancing exercise in which all relevant factors are weighed. This is not a mathematical exercise but it is an objective one.

21. More recently, in *Re A (A Child)* [2016] EWCA Civ 759, the Court of Appeal said at [31]:

> "Whilst its application requires sensitivity and care of the highest order, the law relating to applications to withdraw life sustaining treatment is now clear and well established. It can be summed up with economy by reference to two paragraphs from the speech of Baroness Hale in what is generally regarded as the leading case on the topic, notwithstanding that it related to an adult, against the backdrop of the Mental Capacity Act 2005. In *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67; [2014] AC 591 Baroness Hale said at paragraph 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."

> And from paragraph 39:-

> "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the 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."

22. In *An NHS Trust v MB*, Holman J said this of parental views,

> "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." [16]

To parents of a child whose life is in the balance, this may sound a harsh doctrine, but it seeks to emphasise that the child's welfare is paramount. When a child's parents and the medical personnel treating a child disagree about whether certain treatment is in a child's best interests, neither has a veto – the court, taking an independent and objective view of the evidence, is required to decide what is in the child's best interests. Nevertheless, authority from the European Court of Human Rights does suggest that parental wishes are a factor that should be taken into account. Pippa has a right to life under Article 2 of the European Convention on Human Rights. Art 2 imposes a positive obligation on the state to protect life but, although that is a fundamental right, withdrawal of life sustaining treatment is not a contravention of Art 2 if certain requirements are met. In *Gard and Others v. the United Kingdom* - 39793/17 (Decision [2017] ECHR 605 (27 June 2017) the ECtHR identified those requirements:

> "[80] In addressing the question of the administering or withdrawal of medical treatment … the Court has taken into account the following elements:
>
> - the existence in domestic law and practice of a regulatory framework compatible with the requirements of Article 2;
>
> - whether account had been taken of the applicant's previously expressed wishes and those of the persons close to him, as well as the opinions of other medical personnel;
>
> - the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests (Lambert and Others,[1] § 143)."

Reading the judgment as a whole, the ECtHR was not entirely clear, in my respectful view, as to whether decision-makers should have regard to the wishes of "persons close to" the individual, their evidence as to what the individual's wishes were or would be, and/or their views as to what is in the individual's best interests. However at [69] the ECHR did indicate, but did not determine, that in the case of a young child who had never been able to express views or wishes, their parents' "status" might be afforded greater weight, and at [80] the ECtHR expressly referred to need to take into account the wishes of those close to the individual concerned.

23. Pippa and Ms Parfitt each have Article 8 rights to family life, interference with which can only be justified if in accordance with the law and necessary in a democratic society for, amongst other things, the protection of the rights and freedoms of others.

24. The burden of proof is on the Applicant who seeks the declarations set out above, the standard of proof being the civil standard, on the balance of probabilities.

25. In cases where the individual concerned is in a permanent or persistent vegetative state, there are two strands of authority as to whether the court is able to, and should, engage in any balancing exercise of benefits and burdens when considering best interests. In *Airedale NHS Trust v Bland* [1993] AC 789, Lord Goff held at [868F]

> "… a distinction may be drawn between (1) cases in which, having regard to all the circumstances (including, for example, the intrusive nature of the treatment, the hazards involved in it, and the very poor quality of the life which may be prolonged for the patient if the treatment is successful), it may be judged not to be in the best interests of the patient to initiate or continue life-prolonging treatment, and (2) cases such as the present in which, so far as the living patient is concerned, the treatment is of no benefit to him because he is totally unconscious and there is no prospect of any improvement in his condition. In both classes of case, the decision whether or not to withhold treatment must be made in the best interests of the patient. In the first class,

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[1] Lambert and Others v. France [GC], no. 46043/14, ECHR 2015

> however, the decision has to be made by weighing the relevant considerations.
>
> … By contrast, in the latter class of case, of which the present case provides an example, there is in reality no weighing operation to be performed. Here the condition of the patient, who is totally unconscious and in whose condition there is no prospect of any improvement, is such that life-prolonging treatment is properly regarded as being, in medical terms, useless. …
>
> But for my part I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. It is reasonable also that account should be taken of the invasiveness of the treatment and of the indignity to which, as the present case shows, a person has to be subjected if his life is prolonged by artificial means, which must cause considerable distress to his family—a distress which reflects not only their own feelings but their perception of the situation of their relative who is being kept alive. But in the end, in a case such as the present, it is the futility of the treatment which justifies its termination."

26. The position that for a patient in a PVS, the futility of the treatment justifies its termination, and there is in reality "no weighing operation to be performed", was adopted by Hayden J in *M v N* [2015] EWCOP 76:

> "45. It is well established that if I conclude Mrs. N to be in MCS any evaluation of her best interests must involve a proper identification of the advantages and disadvantages of each proposed course. This approach is conveniently referred to as the 'balance sheet', a test articulated, in this context, by Thorpe LJ in *Re A (Male Sterilisation)* [2000] 1 FLR 549. …
>
> 47. By contrast, if I conclude that Mrs. N had no awareness at all, i.e. that she was in VS, the 'balance sheet' analysis does not apply, the diagnosis itself establishing the futility of further intervention. Definitive authority for this proposition is found in the judgment of Sir Mark Potter, in: *A Hospital v SW* [2007] Med LR 273 at [28]:
>
> "Whereas in most cases relating to the propriety or desirability of treatment for mentally incapacitated patients, it is requisite to draw up a balance sheet of the benefits and dis-benefits of providing medical treatment...it was made clear in the Airedale case that there is effectively no balancing operation to be performed where a person has a definite diagnosis of PVS, the futility of the treatment justifying its termination".

> 49. Were I to agree with Professor Wade that VS is the correct diagnosis here it would require me to endorse an opinion which steps outside the recently drafted and widely respected guidelines. …. I am bound to say, that for my part, where some level of awareness remains, however limited it may be, I instinctively consider that in such cases (whatever the label given to the condition) a decision to withdraw treatment should only be made after a full analysis of P's best interests. If I had accepted Professor Wade's conclusion it would have followed, inevitably, that no such analysis was required. It is, as I have stated, axiomatic that if P is in a vegetative state, treatment is futile."

27. An alternative strand of authority recognises that even for a patient in a PVS, for whom treatment is medically "futile" there are some considerations to be weighed in the balance when considering best interests. Lord Goff himself referred in *Bland* to the invasiveness of treatment, and the indignity caused to a patient. In the same case, in the Court of Appeal, Lord Hoffman said at [826F]

> "… the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person."

28. Lord Browne-Wilkinson in Bland advised some caution in weighing what he called "impalpable factors":

> "The position therefore, in my view, is that if the judges seek to develop new law to regulate the new circumstances, the law so laid down will of necessity reflect judges' views on the underlying ethical questions, questions on which there is a legitimate division of opinion. By way of example, although the Court of Appeal in this case, in reaching the conclusion that the withdrawal of food and Anthony Bland's subsequent death would be for his benefit, attach importance to impalpable factors such as personal dignity and the way Anthony Bland would wish to be remembered but do not take into account spiritual values which, for example, a member of the Roman Catholic church would regard as relevant in assessing such benefit. Where a case raises wholly new moral and social issues, in my judgment it is not for the judges to seek to develop new, all embracing,

> principles of law in a way which reflects the individual judges' moral stance when society as a whole is substantially divided on the relevant moral issues. Moreover, it is not legitimate for a judge in reaching a view as to what is for the benefit of the one individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources or the impact on third parties of altering the time at which death occurs.'[879H].

29. Notwithstanding this warning, judges have drawn "impalpable factors" into the balance. *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin), a case to which I shall return later in this judgment, concerned a five year old girl who was unable to feel pleasure or pain, but who had some minimal awareness. MacDonald J held that factors such as human dignity and the benefits of being cared for by a loving family as opposed to by hospital personnel in an intensive care unit, ought to be weighed in the balance even for a child with very limited conscious awareness.

Professional Guidance

RCP Guidance

30. The Royal College of Physicians published National Clinical Guidelines: "*Prolonged disorders of consciousness following sudden onset brain injury"*, the report of a working party, in 2020. The patient group comprised individuals aged 16 or over. Nevertheless, given that these guidelines are endorsed by a wide range of bodies including the Faculty of Intensive Medicine, it is helpful to have regard to them, and in particular the definitions used:

> "Vegetative state: a state of wakefulness without awareness in which there is preserved capacity for spontaneous or stimulus-induced arousal, evidenced by sleep–wake cycles and a range of reflexive and spontaneous behaviours. VS is characterised by complete absence of behavioural evidence for self or environmental awareness.
>
> Minimally Conscious State: a condition of severely altered consciousness in which minimal but clearly discernible behavioural evidence of self or environmental awareness is demonstrated'. MCS is characterised by inconsistent, but reproducible, responses above the level of spontaneous or reflexive behaviour, which indicate some degree of interaction with their surroundings."

VS or MCS can be continuing, chronic or permanent. A permanent VS, or MCS can only be diagnosed by a suitably qualified consultant physician who meets the criteria for an 'Expert PDOC Physician' and "after the patient has been in chronic VS or MCS for at least 6 months in the absence of any measurable trajectory of change."

RCPCH Guidance

31. The Royal College of Paediatrics and Child Healthcare published the document, "*Withholding and Withdrawing Life Saving Treatment in Children*" in 1997. In 2015 revised guidance was published under the title, "*Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice.*"[2] The authors issue a caution as follows:

> "We emphasise two important points so as to avoid confusion:
>
> 1. This document sets out circumstances under which withholding or withdrawing life sustaining treatment might be ethically permissible—NOT circumstances under which such treatment must certainly be withheld or withdrawn.
>
> 2. The document describes situations in which individual children should be spared inappropriate invasive procedures—NOT types of children to whom appropriate procedures should be denied."

The guidance then sets out three sets of circumstances in which the RCPCH advises that treatment limitation can be considered "because it is no longer in the child's best interests to continue, because treatments cannot provide overall benefit". They are:

> "I When life is limited in quantity
>
> If treatment is unable or unlikely to prolong life significantly it may not be in the child's best interests to provide it. These comprise:
>
> A. Brain stem death, as determined by agreed professional criteria appropriately applied
>
> B. Imminent death, where physiological deterioration is occurring irrespective of treatment
>
> C. Inevitable death, where death is not immediately imminent but will follow and where prolongation of life by LST confers no overall benefit.
>
> II When life is limited in quality
>
> This includes situations where treatment may be able to prolong life significantly but will not alleviate the burdens associated with illness or treatment itself. These comprise:

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[2] BMJ Larcher V, et al. Arch Dis Child 2015;100(Suppl 2):s1–s23

> A. Burdens of treatments, where the treatments themselves produce sufficient pain and suffering so as to outweigh any potential or actual benefits
>
> B. Burdens of the child's underlying condition. Here the severity and impact of the child's underlying condition is in itself sufficient to produce such pain and distress as to overcome any potential or actual benefits in sustaining life
>
> C. 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.
>
> III Informed competent refusal of treatment
>
> Adults, who have the capacity to make their own decisions, have the right to refuse LST and to have that refusal respected. So an older child with extensive experience of illness may repeatedly and competently consent to the withdrawal or withholding of LST. In these circumstances and where the child is supported by his or her parents and by the clinical team there is no ethical obligation to provide LST."

Although the terminology used is of "permanent" vegetative state, the witnesses in the present case have used the term "persistent" vegetative state. For the sake of consistency, I shall use "PVS" to refer to persistent vegetative state.

Pippa's Condition

32. Pippa's condition has been assessed at the Evelina over the nearly two years she has been a patient within its PICU. Longitudinal multi-disciplinary assessments have been performed to determine whether she is showing any signs of change. Numerous meetings have been held with Ms Parfitt, and with other family members to consider Pippa's condition. In 2019 the Trust made referrals for second opinions from a paediatric neurologist and paediatric intensivist at the Addenbrooke's Hospital in Cambridge. I have seen those opinions which largely accord with the expert opinions given to the court on behalf of the parties. All those experienced and highly qualified medical witnesses agree that, in summary:

   a. Pippa has suffered very severe brain damage as a result of ANE.
   b. She is in a persistent vegetative state ("PVS"). She has no conscious awareness of herself or her environment.
   c. On the balance of probabilities Pippa cannot experience pain or discomfort[3].
   d. On the balance of probabilities Pippa cannot derive any pleasure from her environment or interaction with others.

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[3] The paediatric neurologist from Cambridge did advise that children in Pippa's condition have the "capacity for pain" but he gave no evidence that Pippa herself could sense pain.

e. Pippa has random movements of her neck, head, and limbs. She has no purposeful movement. She shows no response to visual, auditory, or tactile stimulation.
f. She is wholly dependent on others for all her care.
g. She has no respiratory effort – she cannot breathe at all – and is wholly reliant on mechanical ventilation.
h. She has respiratory instability with frequent desaturations which require specialist nursing and physiotherapy interventions.
i. She is doubly incontinent.
j. She has cortical blindness.
k. Her condition has been static for well over a year and there is no prospect of any improvement.

Pippa's Neurological Condition

33. Dr G, Consultant neuroradiologist at the Trust says that MRI scanning in March 2019 reveals,

> "considerable brain tissue volume loss and shrinkage with mature (chronic) damage, chronic haemorrhagic damage and gliosis in the thalamus, basal ganglia and brainstem, including the widening of the cerebrospinal fluid (CSF) spaces around the brain."

EEG Telemetry has been performed, most recently over a 20 hour period at the end of September 2020. It revealed a wake-sleep pattern, but no evidence of any reactivity on visual, auditory, or painful stimulation.

34. Dr B and Dr Spinty agree the following evidence:

> "There are widespread destructive lesions of the brain including the brain stem, thalami and basal ganglia structures. These brain structures have a vital role in coordinating all neurological functions. There is also evidence of injury to the cortex. The injury has resulted in prolonged disorder of consciousness consistent with persistent vegetative state as defined in the RCP guidelines. She is totally dependent on the ventilator due to lack of respiratory drive and very abnormal brainstem function. We both agree that Pippa's neurological function is very severely impaired.
>
> …. Pippa has lost some vital parts of brain stem function due to the acquired injury. This is evident on clinical examination including the longitudinal multidisciplinary team assessments and on serial MRI brain scans. The acquired injuries have resulted in the need for lifelong ventilation and respiratory support. She will remain totally dependent on carers for the rest of her life. She has a four limb motor disorder and has lost

> multiple cranial nerve functions. We both agree that the brainstem functions will not recover."

They agree that,

> "Persistent vegetative state (PVS) is the correct description of Pippa's prolonged disorder of consciousness. She is not in a coma and we have no discernible behavioural evidence of self or environmental awareness to suggest that Pippa is in a minimally conscious state.
>
> … there are no viable treatments that would result in an improvement of her neurological status.
>
> … We agreed that long term ventilation will not change Pippa's neurological condition or long term prognosis. We agreed that there is no hope for a significant neurological recovery."
>
> "…. it is impossible to know at present whether Pippa is experiencing pleasure, discomfort, or pain. We have considered all the longitudinal investigations and reports including the latest from September 2020. We both agree that on the balance of probability, Pippa does not suffer discomfort, pain, or pleasure, but we are unable to exclude the possibility that she might experience discomfort, pain, or pleasure at some level.
>
> ... We both agree that Pippa's life is limited in quality with a severity of condition that is such that it is difficult or impossible for her to derive benefit from continued ventilatory support.

The Evidence of the Paediatric Intensivists

35. Dr A and Dr Playfor also agree on a great deal. They agree that:

    a. Pippa has made no progress since January 2019.
    b. There is no prospect at all of Pippa being able to survive in the future without ventilatory support and she would die very soon after extubation.
    c. "… on the balance of probabilities Pippa does not suffer any discomfort or pain from her current life – including the regular interventions that are required (such as deep suctioning of secretions)".
    d. "… on the balance of probabilities Pippa is not able to derive any pleasure from any source".
    e. Neither believes that "Pippa derives any personal benefit from prolonged ventilatory support".

36. Dr Playfor told the court that although he agreed that the possibility that Pippa could experience pain or pleasure could not be excluded, he would be very surprised if she had such capacity. He said in oral evidence that it was "difficult to think of circumstances where you could have more confidence that she cannot perceive pain or

discomfort – it is highly unlikely." It was also "extremely unlikely that she experiences any pleasure from interaction with those around her and her environment".

Agreed Evidence from Physiotherapists and Occupational Therapists

37. In their four-way joint statement, Ms D, Ms E, Ms Stevenson, and Mr Chakraborty recorded that they had made contact with Helen Gill-Thwaite and Karen Elliott, developers of the Sensory Modality Assessment and Rehabilitation Technique ("SMART") assessment of patients with prolonged disorders of consciousness. They responded that they could not offer an assessment of Pippa because they did not have specialism in paediatrics and,

> "as you are aware SMART is currently not validated with children. Whilst we have developed SMART version 3 to accommodate the needs of children with specialist guidance from the Children's Brain Injury Trust, Tadworth, it is not yet validated for this group. We have however, used this assessment in some medico legal cases, but only because the children have been older than 6 years old at the date of the index incident."

Contact was then made with Helle Mills at Tadworth who is the most experienced SMART assessor at Tadworth having been accredited for 10 years, and who uses SMART to assess children. She responded:

> "I do unfortunately not feel a SMART assessment would be appropriate due to the child's young age at time of index incident (even when considering the latest incident at 3.9 years old) and therefore lack of development and ability to engage in the assessment at pre injury stage… I am concerned the child will not have the pre injury skills to engage in the assessment even if there is awareness."

Nevertheless, the four witnesses agreed that,

> "Pippa has shown no consistent, repeatable, behaviour or purposeful movement to suggest that she has any conscious awareness to auditory, visual, tactile, proprioceptive or vestibular stimulation."

38. Whilst much of the focus of the oral evidence has been on Pippa's respiratory condition, these witnesses provide evidence in relation to some of Pippa's other long term therapeutic needs:

> "Maintenance of range of movement and provision of equipment to offer variety in seating and positioning is possible in the home setting, providing that there is availability of equipment and sufficient trained carers to carry out safe transfers and position

> changes. Pippa currently requires three trained carers for all transfers (two for hoisting and one to maintain her airway).
>
> Children with special needs, in the community routinely stand in standing frames at home or special school on a daily basis. This would be possible for Pippa to achieve but would necessitate three trained carers to hoist and move Pippa onto a tilt table or standing frame whilst maintaining her airway and then at least two trained carers to stay with her for the duration of the stand to maintain her airway and head alignment."

Pippa's Respiratory Condition

39. Pippa has no respiratory drive – she cannot breathe for herself at all. She has been ventilated on the PICU since admission in January 2019. Unusually she remains ventilated via an endotracheal tube ("ETT") rather than a tracheostomy tube. A tracheostomy was offered in February 2019, which was standard practice given that neurological improvement was then anticipated and there would be a likelihood of long term ventilation. Ms Parfitt declined a tracheostomy on behalf of her daughter and now says that she did not fully understand why it was being offered. By May 2019 the paediatric neurologist from Cambridge, who was contacted for a second opinion, was advising that a tracheostomy was not in Pippa's best interests, but he would not have anticipated that Pippa would have remained ventilated on the PICU as long as she has been. Pippa is attached to a standard ventilator and her respiratory support is described as modest with baseline settings at peak inspiratory pressure (PIP) 17, positive end-expiratory pressure (PEEP) 5, and SiO_2 30%. However, those baseline settings are adjusted several times a day according to her physiological need. Dr C explained that the particular challenges with Pippa's respiratory condition are not related to ventilation in itself, but to her tendency to desaturate, that is, for her oxygen saturation to fall. In the PICU, the target is oxygen saturation of at least 92%. About 10 to 20 times per day, on average, Pippa's saturations fall to between 80% and 90%. With careful monitoring those changes are noted and acted upon. The reason Pippa desaturates is that she has poor oxygen reserve and a tendency for her lungs to collapse ("atelectasis"), and that secretions and saliva accumulate in her airway. Secretions are produced by cells in the lung tissue, saliva is produced in the mouth. She cannot swallow, she has no gag reflex, she cannot cough, and she has little movement. These factors combine to allow both secretions and saliva to collect in Pippa's airway, causing blockages. Because she has poor reserve, the blockages quickly cause decline in her oxygenation.

40. Dr C and Ms F both told me of the regime used to counter the blockages and desaturations. Regular respiratory physiotherapy is required. Pippa is frequently moved from her back to her side and vice versa. She is also moved into a special "bee" chair on a daily basis. For at least two hours a day Pippa is turned into a prone position, a manoeuvre which takes two, sometimes three, individuals to complete. I was told that Ms Parfitt assists and has become particularly expert at helping to move Pippa onto her front. The object of "proning" is to remove pressure on the back of her lungs so that her alveoli, the tiny pleural sacs, can take up oxygen and so build up her reserve. A cough assist machine, called a Clearway, is used two to three times a day, and sometimes a

fourth time if needed. This machine administers saline under pressure and then reverses the flow, simulating a cough, so as to encourage secretions to move up the airway from where they can be suctioned. In addition, a risky process called saline lavage is undertaken by a suitably qualified respiratory physiotherapist. This involves instilling large amounts of saline into the lungs, giving large breaths with the oxygen bag, turning the patient, and using manual techniques alongside the bag breaths and suction to clear secretions. Mouth suctioning is also performed throughout the day and night.

41. Even with these interventions, Pippa desaturates every 1 to 4 hours. Generally, these episodes are addressed by deep suctioning (the suction tube goes to just above her vocal cords), adjustments to the ventilator pressures, and the use of anaesthetic bagging. Unlike with an Ambu bag, which can use air, or oxygen entrained from a connected cylinder or oxygen concentrator, anaesthetic bagging introduces oxygen into the patient under pressure in order to recruit the lungs. The specialist PICU nurses act swiftly to avoid further desaturation when these episodes occur because Pippa has a noted tendency to desaturate rapidly. Even so, notwithstanding the exceptional nursing care on the PICU, on an average of about once a week Pippa has a more significant loss of oxygen when her level drops significantly below 80%. It has been known to fall to as low as 40% as happened on one day during the hearing. In such cases a respiratory physiotherapist may have to be summoned urgently to add to the efforts to bring Pippa's oxygen levels back to an acceptable range. Again, specialist equipment such as the anaesthetic bag will be used.

42. Pippa receives excellent care on the Evelina PICU, but she is vulnerable to profound desaturations or some other complication that could take her life at any time. Predicting her life expectancy with continued long term ventilation on the PICU is difficult, but the balance of the evidence to me was that Pippa would live longer on the PICU than she would if on long term ventilation in a home setting, and whilst she could die at any time, she could live on the PICU for some years yet.

Trial of Portable Ventilation and Transition to Home Care

43. The notion that it might be possible to transfer Pippa home on long term ventilation first came from Dr Wallis. His proposal is supported, in general terms, by Dr Chatwin and Dr Playfor. This combination of expert voices, fully supported by Pippa's mother, introduces an important consideration for the court – is it in Pippa's best interests to embark on a process that might lead to her receiving long term ventilation and other life sustaining treatment at home? In order to answer that question, it is necessary to consider what the process of transition to home care would involve, and the prospects of that process succeeding.

44. The manner in which evidence about a trial of portable ventilation and transition to home care has been rolled out has not been very satisfactory. That is not a criticism of the legal representatives. I do however say that Dr Wallis ought to have recognised that his proposal of a trial and transition to home care would require considerably more detailed explanation than he had given prior to the hearing, particularly once he knew

that the treating team opposed it. For example, he gave very little further detail in his joint statement with Dr C, responding to some key questions merely by referring back to his first report. As a consequence, although Dr Chatwin had previously raised some issues about potential alterations to Pippa's regime, Dr Wallis gave a great deal of evidence about the process under questioning at the hearing, which he had not previously raised. Even in re-examination he introduced striking new evidence as to the nature of home care. This made it difficult for the Applicant to respond. When witnesses for the Trust were able to respond, their evidence, in turn, prompted further investigation by the Second Respondent, so that even after the hearing had concluded, a fourth report from Dr Chatwin was submitted. After representations by email I ruled against admission of Dr Chatwin's fourth report. It mainly concerned evidence of Pippa's oxygen saturation levels when not desaturating, and other aspects of her past respiratory management, and I do not find such further evidence to be necessary to my determination of the issues in this case.

45. Dr Wallis introduced the concept of a trial of home ventilation in his report of April 2020:

> "62. Home care may not be possible due to the high level of nursing and therapeutic input but this is currently not known with certainty. To explore the feasibility of this option, would require a tracheostomy and gastrostomy and the introduction of a package of management, tailored to Pippa's needs that can feasibly be provided by a team of home carers in a non-intensive care environment.
>
> 63. Although she is at the outer limits of possibility, living at home might be possible if shown that:
>
> a) A tracheostomy (possibly cuffed) provides a portal for ventilation, and airway clearance and bagging that is superior or equivalent to her current ETT;
>
> b) Her ventilatory needs can be provided by a home ventilator with the minimal of daily adjustments;
>
> c) Carers can achieve airway clearance and re-recruitment of lung if atelectasis occurs in the absence of regular physiotherapy input but with training in Pippa's care and physiotherapy needs;
>
> d) The family proceed with the discharge process aware that Pippa's high level of needs deems her vulnerable to complications that may lead to her death in the home environment despite her carers' best efforts.
>
> 64. It would be my suggestion that a tracheostomy should now be inserted and a package of care be trialled initially in the intensive care setting and, if successful, transferred to a step-down facility to determine whether home ventilation with current needs is feasible. It has to be recognised that there is an inherent risk to going home for Pippa but if the alternative is

> withdrawal of life-support, then this risk will have to be accepted by her therapeutic staff as well as mother. There is little to lose by exploring this option and is of no harm to the child."

Very helpfully, Dr Wallis has presented a flowchart demonstrating the steps towards home care. It is appended to this judgment at Appendix 1.

46. Dr Wallis has considerable experience at Great Ormond Street Hospital of transferring children from intensive care to a home setting. The same is true for the team at the Evelina. The Trust's witnesses responded with a number of concerns about this proposal but, whilst maintaining that the trial was not in Pippa's best interests, they produced a draft trial protocol which, in turn, received some criticism from Dr Wallis and Dr Playfor for being set up for failure. The thresholds for abandoning the trial were set too low in their opinion. In her oral evidence Dr A from the Evelina said she would be open to reviewing the protocol, the proposed ventilator settings, and the thresholds for abandoning the trial. Accordingly, the terms under which a trial would be carried out were explored in detail at the hearing. It is unnecessary for me to chart the course that this evidence took, but I shall set out what was established by the close of the evidence:

    a. The transition to home care is an iterative process involving a multi-disciplinary team working in conjunction with the family. There will be many obstacles and a positive approach to overcoming them is required if the goal is to be achieved.

    b. Every stage requires planning and risk assessment, but it has to be accepted that care at home will not be of the same clinical standard as care in the PICU. The care at home will not be optimal but it has to be "good enough". To embark on the process all have to agree that a lower standard of care is the price worth paying for the reward of caring for the child in a more nurturing environment, and one that suits the family.

    c. The first step would be to trial Pippa on a portable ventilator. She would remain in the PICU during this trial supported by the nurses and therapists who currently manage her, and all other equipment presently used.

    d. Although Dr Wallis initially maintained that it would be "pointless" to embark on the trial without first performing a tracheostomy, he relented at the hearing and said that the trial could be performed with the ETT still in situ.

    e. If, but only if, Pippa achieved stability during a two week period on a portable ventilator, which would include an absence of profound desaturations, she could then move to a non-PICU setting [to Box 8 in Appendix 1]. The initial trial stage might take more than two weeks if the view was taken that some of the settings on the ventilator could be altered, or other measures taken, to promote stability.

    f. If it had not already been performed, a tracheostomy would be performed soon after transfer to the transitional unit. At some stage thereafter Pippa would have to undergo a gastrostomy.

g. The non-PICU setting to which Pippa could be moved would still be within hospital and all equipment such as anaesthetic bagging and the cough assist machine, and therapies would be available. The next process is a lengthy one, lasting months. Pippa would remain on a portable ventilator barring any further setbacks. Step by step adjustments to her care would be made to replicate the care that would be available and needed at home. Plans for funding for her care, recruitment of a nursing team etc. could begin during this stage [Box 10, Appendix 1].

h. When home care has been replicated, and the home care package is assembled, Pippa would be ready to be transferred home [Box 11].

i. Although not mentioned in Box 11, were Pippa successfully transferred to home care, her life expectancy would be modest. She would be susceptible to complications including profound saturations that could not be as readily reversed in the community as they could in a PICU. When asked how long he would expect Pippa to survive if transferred to home care, Dr Playfor told me "many weeks …. some months".

47. Dr Wallis told me that the whole process of trial and transition would be likely to take at least six months. He said that overall there was a 1 in 4 chance of Pippa reaching the point of being discharged home with a full complex care package. However, if the initial trial were successful, he thought that there would then be about a 90% chance that Pippa would progress from the transition unit to home. As he told me, arrival at home is not the ultimate destination, it is the beginning of the next stage of her care. It would not be intended to discharge her home for palliative care, but to continue long term ventilation with a view to keeping her alive as long as possible. If, during the transition process, it became evident that home care was not achievable then the difficult discussion about withdrawal of ventilation would begin.

48. The treating team at the Applicant Trust does not believe that Pippa's condition warrants any attempt to transition her to home care. This is a process familiar to the team - the Trust has undertaken it with many other paediatric patients. Dr C told me that she is line manager for fifty patients who are ventilated in the community. Drs A and C and Ms F were perplexed at the suggestion that Pippa was at all suitable for home care. They have been looking after her for nearly two years in the PICU and with exceptional skill and high specification equipment have managed to keep her alive. Frankly, they believe there is no realistic chance that with less sophisticated equipment, and less specialist personnel, Pippa could survive more than a very short time at home. The treating team have stated that they would not be willing to perform a tracheostomy on Pippa for the purpose of the process Dr Wallis proposed and the Applicant seeks a declaration that it is not in Pippa's best interests to undergo a tracheostomy. It is not that the Trust is opposed to the use of tracheostomies for children on long term ventilation – nearly all such children in the Evelina PICU have undergone tracheostomies, and one was offered for Pippa in early 2019. Rather, their resistance to taking any steps towards a transfer home, in particular an invasive procedure such as a tracheostomy, is based on their belief that the exercise would be futile, and that the continuation of long term ventilation in any setting is contrary to Pippa's best interests.

49. The Trust's view is that Pippa's condition is such that she could not safely be cared for outside a PICU. The main reasons for that conviction are:

    a. Pippa needs a PICU ventilator which can be frequently adjusted as needed. A portable ventilator of the sort that would have to be used at home has a limited number of settings. Dr Wallis described to me how portable ventilators used by those of his patients who have been discharged home tend to have a "well" setting, a "sick" setting and perhaps one other setting for specific circumstances. In contrast the PICU ventilator can be operated with multiple adjustments during the day and night.

    b. As agreed by the respiratory physiotherapists Ms F and Dr Chatwin:
        i. An anaesthetic bag of the kind currently used to rescue Pippa when she desaturates cannot be used to administer oxygen in the community. Only an Ambu bag could be used, albeit with "entrained" oxygen rather than merely with air.
        ii. There are no community respiratory physicians in the area of Pippa's family home. In any event, even if there were, their role would only be to provide reviews of the care given. There would be no possibility of a respiratory physician visiting Pippa on a weekly or even monthly basis, let alone being on call in case of emergencies upon an episode of profound desaturation.
        iii. Saline lavage cannot be practised in the community – it is too risky.

    c. Proning would be potentially hazardous if practised in the community: if Pippa were to be cared for at home she would be ventilated through a tracheostomy. The advantage of such tubes is that they can easily be re-inserted, whereas an ETT requires re-insertion under general anaesthetic. However, when a child with a tracheostomy tube is in the prone position it is difficult to monitor whether the tube is still in situ. With Pippa's unpredictable head and neck movements, she could dislodge the tube without the disconnection being noted, with catastrophic results.

    d. Home care would involve a team of between 12 and 15 qualified nurses working in shifts and providing care 24 hours a day. Dr Wallis told me that half of the team could be health care assistants, but Dr Chatwin and the Trust's witnesses disagreed, advising that all staff would have to be qualified nurses. At least two nurses would be on duty at any one time. It would be very difficult to recruit such a team of nurses who could manage Pippa's respiratory condition.

    e. There is currently no funding in place for a sufficient package of home care, and no other Trust approached by the Applicant has yet agreed to undertake the transition process (the Trust itself being unwilling to perform a tracheostomy on Pippa, which would be an essential part of the transition).

50. All agreed that Pippa's life expectancy would be shorter if cared for at home than if she continued to receive long term ventilation and life sustaining treatment in the PICU. All agreed that there would be a risk of an unpredictable complication, such as a profound desaturation, which could prove fatal because of the limited resources available at home as compared with those in the PICU. Dr Playfor and Dr Wallis

emphasised that there are "ceilings of treatment" at home, and that families of children on ventilation at home, and the professional nursing team, have to accept the limits of provision and the consequent risks,. They have to be prepared for what to do as and when those risks materialise. As already noted, Dr Playfor considered that Pippa's life expectancy at home would be "some months" only.

51. Amongst the new evidence introduced by Dr Wallis at the hearing, were the following:

   a. During re-examination Dr Wallis made a surprising claim that in a home setting Pippa could "go out for walks". He meant that her portable ventilator could be positioned in a special wheelchair and she could be taken outside. He was the last witness to complete his evidence and there was no opportunity to explore this wholly new evidence with others. In particular, it was not clear to me what personnel and other equipment would have to be taken with Pippa in case she desaturated whilst outside. What is evident however, is that even at home Pippa would be permanently attached to a ventilator, she would require a tracheostomy and gastrostomy, and for most of the day, as now, she would be in a hospital bed, attended by nurses, undergoing suctioning and nurse led treatment and therapies.

   b. Further late evidence given by Dr Wallis during questioning was that failing home care, Pippa could be managed in some other form of community setting. The current position is that the relevant Clinical Commissioning Group has recently been made aware of Pippa's case but has not begun to investigate it, let alone to offer funding. There has been no assessment of the suitability of Pippa's family's home for accommodating her, her equipment, and the necessary care team. Hence, I have no reassurance that her envisaged package of home care is practically achievable. Whilst appreciating that the CCG will not address Pippa's needs and funding decisions until necessary, it does strike me as a gap in the evidence that no-one has made even a cursory assessment of the suitability of Pippa's family home as a venue for her long term care. The Second Respondent's case is focused on Pippa's best interests being served by her being cared for at her home, not in some other community setting but I have no evidence that her home is suitable to accommodate her, her mother and brother, all the equipment needed, and a team of nurses who would need space and facilities of their own in order to function effectively.

   c. He also suggested, in passing, that even if Pippa could not reach Box 11 of his flow chart at Appendix 1 – care at home - it would be in her best interests to reach Box 8, namely care in a transition unit. This is not part of the Second Respondent's case, no-one else suggested that the transition process was anything other than a means to an end, and Dr Wallis himself has said that in his view it would be contrary to Pippa's best interests to continue to be ventilated on the PICU. With respect to him it is difficult to see why placing Pippa in a different part of the hospital would change that assessment.

   d. Dr Wallis politely suggested during his oral evidence that the treating team might think about certain adjustments to Pippa's care, including the use of Glycopyrrolate and/or Scopolamine patches to reduce Pippa's secretions, Botox injections of her salivary glands to reduce the production of saliva, surgical removal of the salivary glands, a change in ventilator settings so that Pippa was on a higher setting, and super-oxygenation. These adjustments might, he said, optimise the chances of a successful trial of portable ventilation and transition to home care. Witnesses at the Trust who subsequently gave oral evidence sought to address these suggestions. I was told that one of the leading specialists in salivary glands works at the Applicant Trust, had been consulted in the past about the option of Botox injections, and had ruled it out on the basis that it might well thicken her saliva and cause worse blockages. When told of that, Dr Wallis suggested that they might wish to think about it again.

52. I do not think it necessary or appropriate for me to make detailed findings as to whether the proposed adjustments should be made to how Pippa is cared for now or in the future, how the trial and transition process should be managed, or how the prospects of transition to home care could be optimised. It is not the court's function to give detailed directions as to a patient's medical management. On the other hand, it is necessary for me to form a view on all the evidence of the prospects of success in transferring Pippa to home care. Dr Wallis proposed that such a transition should be attempted, and I take full account of his experience and his evidence to the court. I accept that there may be several adjustments that could be made to optimise the chances of success of the trial and transition, but the trial and transition could only succeed if Pippa's current tendency to suffer intermittent profound desaturations ceased or was significantly reduced. In his first report Dr Wallis wrote at para. 54:

> "It is my opinion that Pippa's clinical condition is at the absolute outer limits of what might be achievable at home. It is rare that a child with complete absence of ventilatory drive, failure to cope with secretions, absent cough and susceptibility to aspiration and atelectasis has, in the absence of consciousness, been put forward for home care. In one instance in which I am aware that this was provided, it was with the understanding that the child would have a limited life quantity and that palliative care provided at home with LTV support package was in the family's best interests. Pippa would require 2 trained carers at all time who have demonstrated the ability to cope with her respiratory needs."

In oral evidence Dr Wallis confirmed that that child, unlike Pippa, had some awareness of their environment. Dr Wallis knew of only two children with similar neurological conditions to Pippa's who had been transferred to home care, but they did not have the same severe respiratory problems that she has. When pressed during his oral evidence, Dr Wallis assessed the prospects of a successful trial of portable ventilation as being between 30% to 40%, and the overall chance that the trial and transition process would succeed in allowing Pippa to receive long term ventilation at home as being about 25%.

53. Dr Chatwin also thought it less than probable that Pippa would be able to transition to home care. Dr Playfor said that that there was a greater than 50% chance of portable ventilation being viable but did not express a view as to the overall chances of a transition to home care being completed. The weight of these experts' opinion evidence was that it is possible but unlikely that Pippa's management could be negotiated through

transition to home care. These experts did however acknowledge that their evidence was based on the notes, their experience of other patients, and relatively brief interactions with Pippa herself, whereas the Trust's witnesses had much more extensive experience of treating Pippa. Ms F for example told me that she had had direct dealings with Pippa on some 75 occasions. She has considerable hands-on experience of managing her desaturations. The Trust's clinicians are adamant that there is no realistic chance of Pippa transitioning to home care. A distinctive difference in attitude to transition emerged during the hearing. The Second Respondent's experts were more inclined to accept risk, to acknowledge that care at home could not and need not be optimal – it only had to be "good enough". If the alternative is withdrawal of ventilation in the PICU and death, then, they contended, it is worth taking the chance that transition to home care might work even if the chance is as low as 25%. In contrast the treating clinicians were adverse to giving Pippa less than optimal care and concerned that the proposed process was based on wishful thinking rather than the reality of Pippa's unstable respiratory condition.

54. I take into account the fact that the Second Respondent's expert witnesses might be able to form a more independent overview than those clinicians responsible for Pippa's ongoing care who were particularly anxious to keep up the very high standards of care they have offered to Pippa to date. Nevertheless, in my judgment Dr Wallis' assessment of a 25% chance of Pippa being successfully transferred to long term ventilation at home is too optimistic. It cannot easily be reconciled with his initial view that Pippa's condition was at the "absolute outer limits" of what can be managed at home. It is agreed that care of Pippa at the Evelina has been exceptional. She has had only a handful of respiratory infections during nearly two years on the PICU. Considerable thought, effort, and resources have been put into managing her complex respiratory problems. Even so, she has suffered numerous profound desaturations, and would have suffered more had her desaturations not been intensively and expertly managed. Against that background it is difficult to see how transfer to a less sophisticated ventilator and the removal of some of the interventions that have so far protected Pippa, could realistically alleviate her respiratory problems or lead to fewer or less profound desaturations, even with adjustments to her management. I give weight to the direct knowledge of managing Pippa that the Trust's witnesses have and which informs their pessimism about the prospects of a trial and transition to home care. I also take into account the chances of a fatal complication occurring during the transition period, and the practical difficulties in setting up a care regime at home. Weighing all the evidence I have read and heard, I am satisfied that the chances of Pippa being able to be transferred to long term ventilation at home are remote. There is only a remote possibility of the trial and transition succeeding such that she could be discharged home. It is more likely than not that the failure of the process would be known at an early stage, perhaps even within the first two weeks, but just as it cannot be known with certainty that the process would fail, it cannot be known in advance when any failure would occur.

The Views of Pippa's Family

55. No-one is closer to Pippa than her mother. She knows what Pippa was like as a child before ANE struck, and she has stayed beside her daughter throughout her time on the

PICU. Parental views do not determine what is in a child's best interests, otherwise there would be no role for the court in a case such as this, but they have significant value, as I shall consider more fully when conducting my assessment of Pippa's best interests. Albeit with some hesitation, given that I have no statements or other evidence from other members of Pippa's family, I proceed on the basis that Ms Parfitt speaks not only for herself but for the family as a whole.

56. Ms Parfitt's view, clearly expressed in her oral evidence, is that it is in Pippa's best interests to continue to receive life sustaining treatment because:

    a. It is "God's law" – by which I understand her to mean that there is a duty to preserve Pippa's God-given life. I received no other evidence to suggest that Ms Parfitt or her family actively practise within any faith, or hold other strong ethical views based on religious or secular teaching or values.

    b. Some patients recover from severe brain injury. Pippa made progress after her first episode of ANE, and she has made some recovery since January 2019. She has the basis from which further recovery could be made.

    c. The home environment and her mother's care are the contexts most likely to allow Pippa to achieve further recovery.

    d. Keeping Pippa alive would allow her to enjoy the benefits of any developments in medical science.

    e. Pippa will benefit from being in the warm embrace of her family in a familiar home. Her brother would return home – he is currently looked after by relatives in their own home - and Pippa would be reunited with him.

57. These views require some scrutiny. I accept without hesitation that the preservation of Pippa's life should be given considerable weight. As to Pippa's progress and level of functioning, Ms Parfitt says that Pippa has improved since January 2019, even after surviving the initial crisis. She says that Pippa was initially very static but began to move her fingers and then her whole limbs. In her second statement dated 3 November 2020, she says,

> "I believe Pippa has made good physical and cognitive progress in the 21 months since her initial arrival at the Evelina at a slow pace and continues to improve day by day. I believe my daughter has retained sufficient cognitive functioning that there is a base to build some form of cognitive recovery. I base this opinion on my unique intricate maternal knowledge of my daughter and the extent to which she is presently responding which I see daily."

On visiting Pippa in the PICU, I noticed that she was wearing her own, bright clothes and that her hair had been plaited. Her eyes were open and she moved her left arm up and down. She was surrounded by her soft toys. She has no dysmorphic features and normal head circumference. The Professor of Paediatric Neurology from

Addenbrooke's Hospital who was asked to give a second opinion in May 2019, advised that Pippa had suffered such severe brain damage that future treatment would be "considered futile", but "looking at Pippa I can entirely understand why any parent would find that hard to understand as she looks so normal in so many ways."

As for changes in Pippa's movements over time, Dr Playfor, on whose evidence the Second Respondent relies, says,

> "The pattern of Pippa's movements has changed since January 2019; initially she was described as being floppy and largely motionless but has gradually developed increasing, quite vigorous spontaneous movements. In my opinion this change represents the neurological evolution and maturation of the underlying brain injury rather than any form of improvement in her condition. I have seen no evidence to suggest that Pippa performs any purposeful movements."

58. Ms Parfitt's view is that Pippa will make further recovery if she is cared for at home, but none of the medical witnesses believe it likely that Pippa will make any form of recovery. Ms Parfitt's view is that at home Pippa would benefit from her mother's care such as being fed, but the undisputed medical evidence is that if Pippa were to go home she would require a gastrostomy to allow her to be tube fed. I have viewed twelve videos of Pippa submitted by Ms Parfitt. One has been given the title, "Pippa looking around the room", but the agreed neurological evidence is that Pippa has cortical blindness – her eyes roll but she cannot see. The videos show Pippa as I found her on my visit. The overwhelming weight of expert evidence is that Pippa has no awareness of her environment, that she has not regained any neurological function since January 2019, and that she will not do so in the future. Ms Parfitt's views on Pippa's best interests are based on her faith and determination that by committing herself to her care, she can help her daughter to enjoy some recovery. That is at odds with all the other evidence in this case, including the expert evidence on which she relies.

59. As to the general prospect of medical advances being made that would advantage Pippa in the future, it is clear to me that no court could sanction giving a child life-sustaining treatment merely because there might be some medical breakthrough from which they could benefit at some indefinable point in the future. That would clearly be the case where the child was suffering pain or discomfort due to ongoing treatment, but it is no less so in a case where the child does not experience pain.

60. The final benefit claimed for the provision of life-sustaining treatment at home, is that Pippa's welfare would be advanced by her being within the bosom of her family and in her own home. Even if Pippa had significantly less brain damage than she does, she might well not be able to remember her home, where she has not been for the last two years of her short life. As it is, her brain injury is much too severe to expect her even to be aware that she is in her family home. However, the key benefit being relied upon is not the house itself, but that Pippa would be living with her family. Pippa's brother would return home and so she would be living under the same roof as him as well as

with her mother and, I was told, the family dog. Other members of the family would be able to come and go from the home, rather than visiting Pippa in hospital.

The Views of the Medical Professionals on Pippa's Best Interests

61. The Trust relies on evidence from the clinicians who lead Pippa's treating team. The second respondent cannot do that and she has instructed independent experts. Expert medical evidence is permitted when it is necessary to help the court to determine the issues in a case. The medical expertise of Dr Playfor, Dr Wallis, Dr Chatwin, and others is of great assistance to this court, and their evidence on medical matters carries considerable weight, as does the evidence of the Trust's clinicians, all of whom also have considerable experience in treating extremely unwell children. It is well established that the court should take account of the views of a child's treating clinicians when assessing best interests, but how should the court treat the views of those clinicians, and of the independent medical experts, on the non-medical aspects of a child's best interests? Dr Playfor and Dr Wallis in particular expressed views on Pippa's best interests that went well beyond medical matters. Their views are relied upon by the Second Respondent and I address them in detail later in this judgment. In my view their opinions, and those of the treating clinicians on all matters touching on Pippa's best interests, are welcome because their experience in caring for very ill children gives them considerable insight into how children deal with adversity, how even very disabled children interact with their families, and what a child is like when at the very edge of life. In addition to their experience of such children generally, Pippa's treating clinicians have specific knowledge of Pippa, and have seen her with her mother and other members of her family. The views of all the medical witnesses on the non-medical aspects of best interests carry less weight than their views on medical matters, but I do take them into account.

62. Dr A and Dr Playfor agree that continued ventilatory support in the PICU is not in Pippa's best interests. This was also the view of the independent intensivist from Cambridge from whom the Applicant Trust obtained a second opinion in September 2019. Dr A's view that long term ventilation should be withdrawn is, she told me, shared by all of the 14 consultant intensivists working at the PICU at the Evelina Children's Hospital, and is a view which none of the 150 nurses on the unit have opposed, nearly all having been given the opportunity to do so. In contrast, Dr Playfor considers that it is in Pippa's best interests to continue with life sustaining treatment "in order to allow the steps identified at paragraphs 63 and 64 of Dr Wallis' report to be implemented, to ascertain the feasibility of a discharge home, pending a decision on it by the court." In his first report he wrote:

> "There is no doubt that Pippa's case arguably fulfils the criteria described the RCPCH where withdrawal of LST [life sustaining treatment] can be considered, specifically that the severity of her condition is such that it is difficult or impossible for her to derive benefit from continued life. Pippa's brain injury is so severe that there is no evidence that she is experiencing pain, but equally no objective evidence that she enjoys pleasurable experiences in her

> daily life. It is my opinion, by the finest of margins, that withdrawal of LST is not in Pippa's best interests."

In oral evidence he clarified, without hesitation, that in his view it would not be in Pippa's best interests to continue life sustaining treatment within a PICU setting, and that it would be in her best interests to withdraw life support if there were no other feasible option than continued ventilation on the PICU. For him, there is a material difference between prolonging life on the PICU and attempting to get Pippa home so that life can be prolonged there. To be clear, he did not contend that Pippa's best interests were to be sent home with a view to withdrawing treatment, but rather that it was in her best interests to attempt a trial of portable ventilation with a view to her being sent home to be ventilated and given life sustaining treatment.

63. Dr B and Dr Spinty, the two expert paediatric neurologists from whom I have received written evidence agree that it is not in Pippa's best interests to continue with life-sustaining treatment and that it is in her best interests to withdraw such treatment. That was also the view of the consultant paediatric neurologist at Addenbrooke's Hospital, Cambridge, who was asked to give a second opinion by the Trust in May 2019.

64. Dr C shares the view of the intensivists at the Trust that continued ventilation is not in Pippa's best interests. She is extremely sceptical about the feasibility of home care, and unconvinced that it would be safe for Pippa to be cared for at home, because her respiratory care needs can only safely be met on a PICU. Her respiratory needs are too complex even to be managed on a High Dependency Unit, let alone in the community. She does not think it in Pippa's best interests to be removed from the PICU setting for the purpose of providing long term ventilation elsewhere. The PICU is where she can be given optimal care. Dr Wallis encapsulated his view on best interests in two paragraphs of his first report:

> "60. Continued support in an intensive care environment is not a long-term viable option for Pippa and would not be in her best interests.
>
> 61. Ongoing support in her home environment surrounded by family and carers would give her the [chance] of an improvement in her life quality as well as enhancing the mutual life experiences with her wider family who continue to provide devotion and love."

Under questioning, Dr Wallis accepted that there would be no mutuality involving Pippa because she would not be aware of any life experiences. The "mutual life experiences" would be enjoyed by the wider family, not her. He also told the court that Pippa is capable of "giving and receiving love". Clearly, Pippa cannot communicate and she cannot reach out to touch in any purposeful way – she has no conscious awareness of her environment and she can derive no pleasure from life. I understand Dr Wallis to mean that Pippa is the focus of love, which is manifestly true whether she is kept alive on the PICU, in a transitional unit, or at home.

65. When asked at court, Dr Chatwin was reluctant to give her view on Pippa's best interests but supported the idea of a trial of portable ventilation. Ms F regarded the question of Pippa's best interests as outside the scope of her expertise. The physiotherapy and occupational therapy witnesses also chose not to express views on Pippa's best interests.

66. Notwithstanding their differing views as to Pippa's best interests, there was clearly considerable mutual respect amongst the medical professionals, and I understood them all to accept that each other's views on the question of best interests were within a reasonable range of opinion, albeit it appeared to me that some of Pippa's treating clinicians said so with significant reservation.

Pippa's Ascertainable Wishes, Feelings, Values and Beliefs

67. Pippa was 20 months old when she suffered the first episode of ANE. This left her significantly disabled and with cognitive impairment, but she was able to undergo rehabilitation and to be discharged home into the care of her mother. She remained at home for about eighteen months until ANE struck again, leaving her in a PVS. She was then 3 years, 8 months old. It is not possible to ascertain her current wishes and feelings. She is not "locked in" and she is almost certainly incapable of forming conscious wishes, let alone having any thoughts about her continued treatment. I take into account that before she lost her capacity for conscious awareness, Pippa knew that she had the unconditional love and dedication of her mother, her brother, and the rest of the family. She made progress at home in their care after the first episode of ANE. This showed that she responded positively to being cared for at home.

68. The evidence of Ms Parfitt does not assist the court in determining what Pippa's views about continued treatment would have been had they been capable of being ascertained. There can be little doubt that any young child who is loved and well cared for, would want to be at home with their family rather than in a hospital. However, it is not possible to know what Pippa's wishes and feelings would be in relation to the continuation of long term ventilation and other life sustaining treatment needed to allow her to attempt a transition to home care. Nor is it possible to impute to her any particular ethical, religious, or other values and beliefs. I would hesitate to do so for any five year old, let alone in Pippa's own case.

The Views of the Guardian

69. Ms Doyle is appointed to act on behalf of Pippa. She has produced two reports to the court. In the first, dated 27 October 2020, Ms Doyle supported a trial of portable ventilation taking place but with the significant caveat that she had not yet seen all the medical evidence relating to such a trial. In her second report dated 2 December 2020, having reviewed all the medical and other evidence then available, Ms Doyle concluded:

> "It is with great regret that having carefully considered Pippa's unique needs and individual circumstances I have come to the conclusion that it is not in Pippa's best interest to undergo the protocolised ventilator approach trial. Also, I cannot see how it accords with her best interest to continue receiving life-sustaining intervention. I recognise that the assessment which I have formed in this report will deeply upset her mother, brother, grandparents, and extended family members and if this is the decision of the court it will be difficult to accept.
>
> Having regard to Pippa's life experiences and considering Section 1 of the Children Act 1989, The Welfare Checklist, I do not find it in her best interest to receive treatment that is harmful or that is unable to meet her specialist needs. When thinking about the definition of harm, to mean 'ill treatment or the impairment of health or development', I find that a care environment outside of the PICU has now been established as unsuitable to care for Pippa's long standing, serious and life-threatening illness. Pippa cannot tell us about her experience of life, but it is evident that due to the most severe and debilitating of health conditions her day to day life is characterised by repeated life sustaining intervention and medical care. A final determination is now needed on whether it remains in her best interest for her life to be supported within the PICU."

On behalf of the Guardian, Mr Davy confirms in his closing submissions that she remains of the view that the court should make the declarations sought by the Applicant Trust.

Pippa's Best Interests

Continuation of Long Term Ventilation on the PICU

70. Fundamental to the Second Respondent's case is that it is in Pippa's best interests to be cared for at home rather than in the PICU. There is unanimity amongst the independent medical experts and treating clinicians that it is not in her best interests to be given long term ventilation in the PICU. Although Ms Parfitt would prefer that outcome if the only alternative were withdrawal of ventilation, her Counsel do not submit that long term ventilation on the PICU is in Pippa's best interests. Nevertheless, for reasons already given, it is necessary in my judgement first to consider what I have described as Option A – whether it is in Pippa's best interests to continue with long term ventilation on the PICU. A comparison can then be made with long term ventilation at home, which will help to determine whether steps should be taken to embark on a process that might lead to long term ventilation at home.

71. I give considerable weight to the preservation of life. Ms Parfitt also firmly believes in the principle that life should be preserved: she told me that it was "God's law". In the case of a child, the presumption that life should be preserved reflects common values

that children's lives should be protected and nurtured. This is an important factor weighing in favour of continuing the long term ventilation and other treatment that Pippa requires to keep her alive. However, there is, in law, no rule that life must be preserved in all circumstances and at whatever cost to the child. The presumption that life should be preserved is not a determinative factor and must be considered together with other factors relevant to Pippa's welfare and best interests.

72. The medical evidence overwhelmingly supports the conclusion that Pippa is in a persistent vegetative state with no prospect of improvement with time or with treatment. Pippa's disabilities are as grave as can be imagined. I have set them out earlier in this judgment, but, in short, she cannot see, breathe, or communicate, she has no awareness of her environment or of interactions with others, she has no purposeful movement, she is unresponsive to visual, auditory or tactile stimulation, she is doubly incontinent and she has to receive interventions throughout the day and night to prevent potentially fatal oxygen desaturations.

73. It is very rare for a child of her age to have been maintained in her current state for nearly two years in a PICU. The fact that she has not shown any sign of neurological improvement during that period leaves no reasonable doubt that she will remain in her current condition for as long as she lives. There is no hope of future improvement. Ms Parfitt's evidence stands alone in suggesting both that Pippa has shown some signs of progress to date, and that she will improve in the future. Ms Parfitt's care for Pippa after her first episode of ANE helped Pippa to improve and, as she told me, some patients may recover from brain injuries against medical expectations, but there is no evidence before me on which I could find that to be possible, let alone likely, now in Pippa's case. The suggested adjustments to her respiratory management would not be of any benefit to Pippa were she to remain on the PICU. I am bound to conclude, on the basis of the very clear medical evidence, that the second episode of ANE has left Pippa far more disabled than her first, and that she is in a PVS from which she will not enjoy any form of recovery.

74. Ms Parfitt spends about sixteen hours a day with Pippa. Her dedication to Pippa has moved and inspired members of her own family, staff at the Evelina, and many others. Very sadly however, the exceptional support from her loving family and the skilled and dedicated staff at the Evelina has not, and will not, confer any benefit to Pippa of which she can be aware. There is no subjective benefit to Pippa from being kept alive on the PICU.

75. On the other hand, Pippa cannot feel any pain, and this absence of awareness of pain is a critical aspect of the Second Respondent's case. Dr Wallis said, in relation to attempting transition to home care, that "there is little to lose by exploring this option and [it] is of no harm to the child". In their opening position statement, Counsel for Ms Parfitt contended that "by definition there is no physical harm caused by the provision of medical treatment to a person with no conscious awareness." If Pippa cannot suffer pain, should the court take into account her ongoing condition and treatment as disbenefits in the assessment of her welfare and her best interests?

76. I do not accept the Second Respondent's Counsels' submission that no physical harm can be caused by medical treatment to a person with no capacity to feel pain and no conscious awareness. Physical interventions to prolong life should not be regarded as

irrelevant to the consideration of welfare, just because the patient has no conscious awareness and cannot experience pain. Any proper assessment of welfare in a case involving life sustaining treatment ought to take into account the nature and extent of the interventions necessary to keep the patient alive. Clearly much greater weight should be given to the harm caused by those interventions if the patient can feel pain or discomfort. If Pippa were able to experience pain and discomfort when undergoing the multiple invasive procedures she undergoes each day, that would be highly material to the assessment of her welfare. But her loss of conscious awareness does not mean that those interventions can now be wholly disregarded. In Pippa's own case she not only requires artificial ventilation, nutrition, and hydration, but, day and night, she requires other interventions including suctioning, bagging, proning, and use of the cough assist machine, as well as other less frequent interventions such as saline lavage. Both her ongoing condition and her necessary treatments in the PICU constitute burdens upon her person notwithstanding her lack of conscious awareness. In any event, the absence of pain is not the same as the absence of harm. The fact that a person has no conscious awareness does not give their clinicians, or anyone else, licence to perform procedures on them irrespective of their benefit. Compensation payments for "loss of amenity" have been made to patients who are in a coma because the law recognises that even the fully unconscious individual may experience a loss of function and a diminished quality of life even if they do not suffer pain – *Wise v. Kaye* [1962] 1 Q.B.638 and *H. West & Sons Ltd. v. Shephard* [1964] A.C.326, applied in *Lim Poh Choo v Camden & Islington Area Health Authority* [1980] AC 174. The losses of freedom, function, and ability to enjoy childhood, that severe disability, including severe brain damage, cause someone such as Pippa, are a form of harm which should be considered in assessing her welfare, whether or not they can feel pain and whether or not they have any conscious awareness.

77. Accordingly, it would be an error to allow the absence of pain, or of any sensation, to prevent a wider consideration of welfare incorporating a consideration of physical and other harm or detriment to Pippa, from her condition, and from the treatments she needs to keep her alive. In Re *A (A Child)* [2016] EWCA Civ 759, King LJ concluded at [57]:

> "In the present case almost the entirety of the oral evidence and a substantial part of the judgment related to the issue of 'pain'. Although it is undoubtedly the case that a single factor can be of such overwhelming importance as to be determinative (for example where a child is in significant and unmanageable pain or distress) the emphasis here focused disproportionately on one item which, although relevant, did not in reality go to the heart of the decision. As a consequence, there was a real danger, repeated again before us, of a failure to stand back and consider A's welfare in its widest sense."

And at [58] King LJ approved the approach taken by Parker J,

> "… even if his life were completely pain free, I would come to the conclusion that there is no measurable benefit to him to continue in his present condition and it is simply inhumane to permit it to continue. It is not in his best interest to continue treatment other than palliative care, and it is in his best interests for all other treatment to be withdrawn."

78. In the light of these considerations, I do take into account the detriment to Pippa's welfare caused by her condition and the treatment for it, even though she is unaware of that detriment. She is a five year old girl who has lost virtually all her functioning. She is constantly subject to invasions of her person to keep her alive. It is insufficient to view her condition as depriving her of benefit. Her condition and the treatment it necessitates are significant burdens. Even if one discounted these factors in the welfare assessment, on the grounds that Pippa has no conscious awareness of them, they ought to be taken into account in the broad assessment of her interests. It must be relevant to any assessment of her interests that she has such grave loss of function and requires such intensive and intrusive treatment to preserve her life.

79. Pippa cannot derive any pleasure from life because she has no conscious awareness. Are there nevertheless other benefits to her, from the prolongation of her life, such as preserving her dignity, or allowing her to remain the focus of the love of her family, that the court should take into account? Or, if those are not benefits to her welfare, are they matters that should nevertheless be considered when assessing her best interests? The Second Respondent relies heavily on the decision of MacDonald J in *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin), in particular [168] to [177] and [186]. At [172] MacDonald J said,

> "Tafida is more than simply a patient who is the subject of medical treatment. Within this context, the benefits of life-sustaining treatment may extend beyond the merely medical. If the argument in *Bland* that Anthony Bland felt no pain or awareness and therefore had no interests which suffered from his being kept alive is demonstrated to be a fallacy because, in the words of Hoffman LJ (as he then was), "it assumes that we have no interests except in those things of which we have conscious experience", then the argument that a child who feels no pain and no or minimal awareness can derive no benefit from being kept alive is similarly fallacious in circumstances where, again to echo the words of Hoffman LJ, the foregoing assumption does not accord with many people's intuitive feelings about their lives, and particularly those people who have a strong religious faith."

At [176] to [177] he said,

> "[176] I have also paid careful regard to the Trust's submission that even if Tafida feels no pain, further invasive treatment over an extended period of time will impose an unacceptable burden on her human dignity, which burden will be increased as she develops further debilitating physical symptoms. Again, I accept that within the context of the frame of reference advanced by the Trust, namely continued invasive medical treatment over many years with little recuperative benefit may, for example in the manner articulated in Bland, reach the point of indignity for Tafida. The concept of human dignity as an element of the best interests analysis is however, not without difficulty. The term 'human dignity' does not lend itself to precise definition and

> there is no universal agreement as to its meaning. The concept of human dignity must, accordingly, contain a significant element of subjectivity and thus be influenced by, for example, the religious or cultural context in which the question is being considered. In *M v N* (2015) 148 BMLR 116, [2016] COPLR88 (at [72]) Hayden J observed that:
>
> 'There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who, for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life, prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected. But choice, where rational, informed and un-coerced, is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too.'
>
> [177] … the question of whether continued treatment would burden Tafida [Raqeeb] with indignity falls to be considered, once again, in the context of the agreed evidence that, ultimately, whilst moribund, with minimal awareness and entirely dependent on the care of others, it will be possible for Tafida to be cared for at home by a loving and dedicated family and consistent with the religious code and community values within which she had been raised. In the context of the concept of human dignity, although difficult to define, I am satisfied that this is a significantly different proposition to, for example, continued care over a period of years confined in a Tier 2 ICU unit."

80. I am currently considering whether continued ventilation in the PICU is in Pippa's best interests. Although MacDonald J found that dignity and receiving loving care in a home setting, rather than in the ICU, were benefits or factors that promoted the interests of the child, the fact is that he found such benefits or interests could exist. Dr Playfor has been involved in a number of cases involving decisions about life sustaining treatment for children, including *Raqeeb*, in which he gave evidence that continued ventilation would not be in the child's best interests. He told me that the *Raqeeb* judgment had changed his mind in relation to these extremely rare cases. I commend him for being open-minded, and for his frankness in accepting that his evidence in the present case is inconsistent with his evidence in *Raqeeb*, not because he relied on any particular difference on the facts, but because he has thought again, read around the subject, and come to a different view. In his written evidence he referred to the same passage from Hayden J's judgment in *M v N* that MacDonald J quoted at para. [176] of *Raqeeb.* He then observed, echoing MacDonald J's words at [169],

> "although severely disabled, with no demonstrable awareness of the environment and entirely dependent on the care of others, Pippa's life has inherent value; it is nurtured and precious to her mother, sibling and wider family. Pippa's existence can be said

> to add, admittedly in a modest manner, to the body of collective human experience."

81. I would respectfully agree with Dr Playfor except that I would replace the word "modest". With "significant". A child such as Pippa can contribute significantly to the lives of others and to the body of collective human experience. She is an exceptional child who has inspired exceptional behaviour from others: the selfless devotion of her mother, the sacrifices of her brother, the loving support of other family members, the dedication and skill of the PICU doctors, nurses, and therapists. Many people will have learned from Pippa's life and experiences: doctors, nurses, therapists, and other parents whose children have passed through the PICU at the Evelina.

82. I do, however, have difficulty in accepting Dr Playfor's analysis, not least because MacDonald J found that although it was likely that Tafida Raqeeb could not perceive pain in her resting or standard state [162], she had "retained a minimal level of awareness" [161]. As MacDonald J said, in medical cases like Pippa's and Tafida Raqeeb's, where there can be no absolute certainty as to their subjective experience, it is important to maintain fidelity to the standard of proof, particularly when the decisions for the court are so grave [175]. Applying the standard of proof, this court must assess Pippa's best interests on the basis that she has no conscious awareness, whereas MacDonald J assessed Tafida Raqeeb's best interests on the basis that she retained minimal awareness. In the present case there is a high degree of probability that Pippa has no conscious awareness. This distinction affects consideration of the benefits to Pippa of human interaction and loving care from the family.

83. Furthermore, the points that Dr Playfor makes would seem to me to apply even whilst Pippa is being kept alive on the PICU. Surely the "inherent value" of her life does not depend on whether she is cared for in a bed in a hospital or at home? Yet Dr Playfor does not believe it is in Pippa's best interests to be kept alive on the PICU.

84. Insofar as a plea to respect the "inherent value of life" or to the "innate dignity of life" directs the court's attention to the presumption that life should be preserved, it is uncontroversial. The law recognises the inherent value of Pippa's life by giving considerable weight to its preservation, but the fact that life has inherent value is not determinative of the best interests assessment. Lord Donaldson of Lymington said in *Re J (A minor) (Wardship: Medical Treatment)* [1991] Fam 33 at page 46:

> "There is without doubt a very strong presumption in favour of a course of action which will prolong life, but … it is not irrebuttable … Account has to be taken of the pain and suffering and quality of life which the child will experience if life is prolonged. Account has also to be taken of the pain and suffering involved in the proposed treatment… We know that the instinct and desire for survival is very strong … But in the end there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause it increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's, and mankind's desire to survive."

85. Insofar as Dr Playfor's view is that the value of Pippa's life can be seen in what she can bring to others, I am afraid that I do not accept that I should take that into account in an assessment of her welfare or her best interests. Her life does have worth and value which can be seen most clearly in what it brings to others, but the assessment of best interests has to be made from the point of view of the child. Pippa's condition renders her unaware of the benefits she brings to others. Not only is her welfare my paramount consideration, but it would be wrong, in my judgment, to take into account the welfare of others when determining her best interests.

86. The concept of "dignity" to which MacDonald J referred in *Raqeeb* at [176] to [177] (above) and which has influenced the view of Dr Playfor, is, I believe, problematic and does not assist me in identifying what is in Pippa's best interests. In an adult or older child the concept of dignity might be linked to their exercise of autonomy and be a crucial factor in determining what is in their best interests, but that factor does not apply in the case of a young child like Pippa, whose values, beliefs, and wishes cannot reliably be ascertained or inferred. Perhaps we all think we can recognise human dignity when we see it, but there is obviously a high degree of subjectivity involved in describing someone's life or death as having dignity. The protection of an individual's dignity has been deployed in support of decisions to continue life sustaining treatment – *Raqeeb* – and to withhold it - *Alder Hey Children's Foundation Trust v Evans* [2018] EWHC 308 (Fam) at [62]. For some, there is dignity in enduring suffering; for others, prolonged suffering constitutes a loss of dignity. There is a wide range of opinion as to what constitutes a dignified death. In the present case the Trust contends that the withdrawal of ventilation in a planned manner within the hospital and with appropriate palliative care, would allow Pippa to die peacefully with her family around her. Witnesses for the Trust told me of "chaotic" deaths they had witnessed, and which might occur if Pippa were at home, where a complication such as an uncontrollable desaturation could lead to her sudden death, perhaps without family members present. It might be said that Pippa's dignity would be protected in the former case and lost in the latter. Her mother would strongly disagree. She says, "I could not think of anything more undignified than Pippa's death being planned and for it to be carried out in the corner of the PICU when there is a procedure that can be done to potentially get her out of the ward and home." I take into account the views of Pippa's mother and of others about her best interests, but given the very different ideas expressed to the court about what would constitute dignity for Pippa in life and in her dying, I shall not presume to adopt some supposedly objective concept of dignity to determine her best interests.

87. I have already noted the important difference in level of awareness between Tafida Raqeeb and Pippa. There are other material differences. Pippa has spent nearly two years on ventilation in the PICU whereas Tafida had had seven months of ventilation prior to the hearing. This is not a small difference – MacDonald J placed some reliance at [176] on the impact of more prolonged ventilation and intensive care on best interests. There was no suggestion that Tafida Raqeeb was vulnerable to the multiple life threatening desaturations that Pippa suffers, requiring specialist assistance. There was a "fully thought out and funded care plan" to move Tafida to be cared for by her family at home on a ventilator and all the experts agreed that Tafida could be ventilated at home, whereas it is currently unknown whether home care is feasible for Pippa: Tafida's was "not a case where transport of the child remains simply a theoretical option…." [179f]. The court in *Raqeeb* heard "on the Trust's own evidence" that the proposal for home care was "consistent with the domestic approach in other areas to

children in a similar position to Tafida." In the present case no-one has experience of someone with Pippa's particular constellation of problems and needs being cared for at home.

88. So, what is the "impalpable factor" or other benefit that continuation of life will bring to Pippa beyond the prolongation of life itself, beyond the advantages or comfort it might bring to others, and beyond the subjective and malleable concept of dignity? Dr Wallis and Dr Playfor cannot find any benefit in continued care in the PICU, even though Pippa would continue to be the focus of the unconditional love of her mother and wider family, and to receive exceptional family, medical and nursing care. Counsel for Ms Parfitt do not point to any such benefits in their submissions. Likewise, I cannot find any palpable or impalpable benefit to Pippa from prolonging her life in the PICU. Is it inconsistent to find that a young child with no conscious awareness suffers burdens but enjoys no benefits from the prolongation of life? I do not believe so. The profound loss of function and the daily invasion of her bodily integrity necessary to prolong her life constitute objectively identifiable burdens on Pippa's person. Factors that might constitute some kind of benefit to an adult or young person, such as affirmation of deeply held values, or respect for autonomy, do not apply to a very young child such as Pippa.

89. I take into account the views of Pippa's family as to whether continued ventilation on the PICU is in Pippa's best interests, and the contrasting views of the treating team, the independent experts, and Pippa's guardian. As for Ms Parfitt, she wants Pippa to be kept alive, but has no wish for her to be kept on the PICU. I shall discuss the relevance of parental wishes in more detail in the context of the possibility of home care, but, following the ECtHR judgment in *Gard and Others v UK* (above), I do take into account Ms Parfitt's wishes in my assessment of Pippa's best interests. In any event Ms Parfitt does have an Art 8 right to a family life to which I have regard.

90. Considering the evidence as a whole and balancing all the relevant factors, I am satisfied that it is not in Pippa's best interests to continue to receive long term ventilation or other life sustaining treatment on the PICU. I have to consider Pippa's best interests from her perspective. Notwithstanding the presumption that life should be preserved, it is not in her best interests that her life should be prolonged. Her welfare is my paramount concern. Pippa is in a persistent vegetative state and has been for well over a year. She has no conscious awareness and she gains no benefit from life but she daily bears the dual burdens of her profoundly disabling condition and the intensive treatment she requires to prevent it from ending her life. The evidence drives me to conclude that Pippa has no awareness of her environment nor of interaction with others, including, I am very sorry to say, her family. She receives exceptional care from her mother, others in her family, and from the healthcare professionals at the Evelina, but as all the medical witnesses have advised the court, there is no hope of improvement in her condition and no medical benefit from prolonging her life on the PICU. I cannot identify any non-medical benefits to Pippa from continued ventilation on the PICU, whether social, emotional, psychological, or otherwise. Prolonging her life on the PICU will only prolong her burdens. Continued care on the PICU is not the primary wish of her family, although they would prefer her to live rather than to have ventilation withdrawn. I take into account their wishes and views. I also take into account the view of the treating team and the independent experts. Ultimately, however, the court has to take an objective view of Pippa's best interests. Taking a broad view of Pippa's medical

and non-medical interests, but with her welfare as the paramount consideration, I conclude that it is not in her best interests to continue to receive mechanical ventilation on the PICU.

Embarking on a Trial of Home Ventilation

91. In order to determine whether it is in Pippa's best interests to embark on a trial of portable ventilation with a view to transition to long term ventilation at home, I shall consider the end goal, the means by which that goal might be achieved, and the chances of those means succeeding. However, if the end goal would itself be contrary to Pippa's best interests, then even if there were certainty that it could be achieved, and with minimum of disruption to her care, it could not be considered to be in her best interests to embark on the process leading to it.

92. The starting point is my assessment that it is not in Pippa's best interests to continue with long term ventilation on the PICU. What then would be the differences between prolonging life on the PICU and prolonging life at home? Ms Parfitt submits, through Counsel, that long term ventilation at home would be in Pippa's best interests because it would place her in her home environment, surrounded by her loving family. Reliance is placed on the views of Dr Playfor and Dr Wallis:

> "In common with Dr Playfor, Dr Wallis felt there were benefits to leaving PICU, and that Pippa being cared for in a more suitable domestic setting surrounded by her family, her toys, and her personal objects, was a benefit. He said '*she is capable of receiving love and care, and she gives love and joy to her family. That is her worth'*. Later, he said it was unrealistic to separate mother and child when considering best interests – '*as so often is the case with severe disability and no ability to have a balance sheet, we end up looking at the unit. The mother and child are so enmeshed and tightly bound together that the interests of one affect the other.'*
>
> His view was that the question of where a child should die was '*very much parent-led. It is their right to determine the three most important things: when, how and where does death occur. If you can get those right, you have done well.'*"

93. I fully accept that for a clinician treating a child with severe impairments, it is vitally important to consider the family's wishes and to work, where at all possible, consensually with the family. However, this exceptional case comes to court precisely because that usual approach has broken down. The law is clear: in these cases it is not a parent's right to determine when, how and where death occurs, or whether life sustaining treatment should be prolonged. Nor do I accept that the court should consider Pippa's interests through the prism of her mother's interests: the court is concerned with Pippa's best interests which must be assessed from her perspective, not from anyone else's viewpoint. I referred earlier to Dr Wallis' statement that one of his own patients

was transferred home for palliative care because it was in the "family's best interests." For the court, the focus is entirely on the child's best interests.

94. I have considered very carefully whether, when assessing the best interests of a child with no conscious awareness, I should take any account of the parental view that home is where their child should be cared for, and the parental wish to bring their child home. Mr Sachdeva QC and Ms Butler-Cole QC direct my attention to three authorities: *Re G* [2012] EWCA Civ 1233, *Yates v Great Ormond Street Hospital For Children NHS Foundation Trust* [2017] EWCA Civ 410, and *Re T (Wardship: Medical Treatment)* 1997 1FLR 502.

95. In *Re G,* Munby LJ said:

> "30…The well-being of a child cannot be assessed in isolation. Human beings live within a network of relationships. Men and women are sociable beings. As John Donne famously remarked, "No man is an Island …" Blackstone observed that "Man was formed for society". And long ago Aristotle said that "He who is unable to live in society, or who has no need because he is sufficient for himself, must be either a beast or a god". As Herring and Foster comment, relationships are central to our sense and understanding of ourselves. Our characters and understandings of ourselves from the earliest days are charted by reference to our relationships with others. It is only by considering the child's network of relationships that their well-being can be properly considered. So a child's relationships, both within and without the family, are always relevant to the child's interests; often they will be determinative."

96. In *Yates v Great Ormond Street Hospital,* the Court of Appeal cited with approval the following passage from *Re Z (Identification: Restrictions of publication)* [1997] Fam 1, at page 32:

> "I understood the mother's counsel to advance two reasons why discretion could only be properly exercised to the effect contended for. The first was that the court should never override the decision of a devoted and reasonable parent, such as this mother was found to be. I would from my part accept without reservation that the decision of a devoted and responsible parent should be treated with respect. It should certainly not be disregarded or lightly set aside. But the role of the court is to exercise an independent and objective judgment. If that judgment is in accord with that of the devoted and responsible parent, well and good. If it is not, then it is the duty of the court, after giving due weight to the view of the devoted and responsible parent, to give effect to its own judgment. That is what it is there for. Its judgment may of course be wrong. So may that of the parent. But once the jurisdiction of the court is

> invoked its clear duty is to reach and express the best judgment it can."

97. The third authority is that of *Re T*, in which Waite LJ held,

> "All these cases depend on their own facts and render generalisations - tempting though they may be to the legal or social analyst - wholly out of place. It can only be said safely that there is a scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course a certainty) that the greater the scope for genuine debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature."

98. I accept that the views of a parent on what is in the best interests of their child should be given due respect and taken into account, but that does not mean that those views should avoid proper scrutiny, let alone that they should be determinative. It is clear to me that the court should also take into account evidence about the family unit and its ability to support a child when assessing best interests, because those matters may directly affect the child's welfare. Moreover, the court should have regard to a parent's evidence about the character, values and wishes of their child. However, I do not discern any support in these three authorities for the submission that the wishes of a parent, or any other person, are material to the determination of a child's best interests in a case of this kind. There is a distinction between the views of a parent as to their child's best interests or their child's own wishes, and the independent wishes of the parent. Counsel for Ms Parfitt submit that Holman J's "sweeping statement" in *An NHS Trust v MB* [see para. 22 above] that parental wishes are "wholly irrelevant" to the objective assessment of a child's best interests was "simply wrong". I am unaware of any authority in the fourteen years since his judgment that has expressly cast doubt on Holman J's view of the law, but I do take into account the judgment of the ECtHR in *Gard and others v UK* (above) to the effect that compliance with Art 2 of the European Convention on Human Rights does require the decision-maker to take into account the wishes of those close to the child when determining the child's best interests, perhaps all the more so in the case of a young child whose own wishes cannot be ascertained. I also bear in mind that Ms Parfitt has an Article 8 right to family life which ought to be considered. If so, parental wishes are not "wholly irrelevant". Nevertheless, an objective assessment of a child's best interests should not be confused with the satisfaction of a parent's wishes,

even if the wish to care for a child at home is wholly understandable. The child's best interests and parental wishes may coincide, but they may not. In *Re T*, Waite LJ said at page 254

> "when it comes to an assessment of the demands of the child patient's welfare, the starting point - and the finishing point too - must always be the judge's own independent assessment on the balance of advantage or disadvantage of the particular medical step under consideration. In striking that balance, the judge will of course take into account as a relevant, often highly-relevant factor, the attitude taken by a natural parent, and that may require examination of his or her motives. But the results of such an inquiry, must never be allowed to prove determinative. It is a mistake to view the issue as one in which the clinical advice of doctors is placed in one scale and the reasonableness of the parent in the other."

This approach applies, in my judgement, to all aspects of medical care, including where it should be given.

99. In *Yates v Great Ormond Street Hospital* [2017] EWCA Civ 410, [2018] 1 All ER 569, at [95] McFarlane LJ summarised the proper judicial approach,

> "When thoughtful, caring, and responsible parents are putting forward a viable option for the care of their child, the court will look keenly at that option, in the same way that a court in family proceedings, when it gets to the welfare stage of any case, looks at the realistic options that are before it. The court evaluates the nitty-gritty detail of each option from the child's perspective. It does not prefer any particular option simply because it is put forward by a parent or by a local authority. The judge decides what is in the best interests of the child by looking at the case entirely through eyes focused on the child's welfare and focused upon the merits and drawbacks of the particular options that are being presented to the court."

100. Accordingly, the court should take into account the wishes of those close to Pippa to care for her at home but only as part of the broad assessment of Pippa's best interests, and without detracting from the fundamental principles that Pippa's welfare is my paramount consideration and that the assessment of best interests is made from her perspective. If it would be contrary to Pippa's best interests to be cared for on long term ventilation at home, then it would be lawful not to accede to her family's wishes in that regard, and unlawful to do so. Their Article 8 rights would not be contravened. Dr Playfor, Dr Wallis, and many other people might think that when a child can feel no pain, the courts should seek a solution that gives the most comfort to the child's family, and that there is a cruelty in depriving them of that comfort and curtailing the life of the child they cherish. But the law seems to me to be clear that the benefits that Pippa has brought, and may continue to bring, to others, and the satisfaction of the wishes of a child's family, are not the focus of the court's attention. It is her welfare that is

paramount, not the welfare of others, and her best interests that are the court's concern. Commenting on the judgment in *Raqeeb*, Hayden J said in *Birmingham Women's and Children's NHS Foundation Trust v JB and KAB*, [2020] EWHC 2595 (Fam),

> "I am confident that Macdonald J, in *Barts Health NHS Trust v Raqeeb* [2019] EWHC 2530 (Fam) did not for a moment intend that a Trust should ever approach an evaluation of a child's best interests, in the context of medical treatment, as secondary to the wishes or religious beliefs of the parents. That would subvert the framework of the established law which preserves the interests of the child as paramount. Nor do I believe Macdonald J intended to sever medical 'best interests' from an overall evaluation of the child's interests. Such an approach would be artificial. A true and meaningful assessment of a child's best interests requires a conscientious survey of the wide canvas of his life, in which process the views of his parents concerning matters of faith, culture and more widely will be important but never a determinative factor."

101. Transfer to home care would not benefit Pippa's medical condition. Ms Parfitt's belief is that Pippa's condition will improve with home care, but I cannot accept that belief as a reasonable foundation for the proposition that it is in Pippa's best interests to receive long term ventilation at home. Extensive medical evidence has been adduced, and there is none which shows that changing Pippa's environment from hospital to home will lead to any improvement in her condition. She will remain unaware of her environment or of interactions with others. She would not be aware, therefore, of any change in her environment from the PICU to home and she would receive no benefit from such a change.

102. There would be some differences between the healthcare given in the PICU and any ongoing healthcare at home. The medical, nursing and physiotherapy care at home could not be of the exceptional standard it is in the PICU. Even if it is assumed that the very best care package could be funded and provided in Pippa's family home, a home ventilator cannot provide the same sophisticated level of finessed support as a PICU ventilator, there could be no use of anaesthetic bagging and more advanced respiratory physiotherapy techniques, and the immediate availability of a respiratory physiotherapist would not be guaranteed. Even assuming that a tracheostomy and transfer to home ventilation somehow improved Pippa's stability, there would be significant risk of a fatal complication occurring at home within weeks of transfer there, and without the immediate availability of the requisite equipment and skilled personnel effectively to help her. Pippa's home care could never replicate the exceptional standards of PICU care and in that sense transfer home would, if anything, be a detriment to her. However, if it is assumed that long term ventilation at home could safely be given without the need for anaesthetic (pressurised) bagging and saline lavage, Pippa would be at least spared those particular interventions which, I have found, are amongst the invasions of her bodily integrity that do constitute a detriment to her.

103. I cannot discern any non-medical benefit to Pippa's welfare from her care being at home rather than in a hospital. In his first report, Dr Wallis wrote,

> "If the clinical trial and move to a step-down unit was successful, I consider it would be in the child's best interests to then move home with a long term ventilation package of care, as this would give her a more appropriate environment in which to live and receive such life sustaining support and enjoy the daily benefits of close family life."

Dr Wallis and Dr Playfor each told me that they do not think it in Pippa's best interests to continue life sustaining treatment within a PICU. For both of them, the benefits of family life at home are what change the balance of best interests from withdrawing to continuing life sustaining treatment. Acknowledging their considerable experience in dealing with gravely ill children, I cannot agree with them.

a. I accept that there would be differences in the environment in which care were delivered to Pippa if she were transferred home. Attempts are made to personalise Pippa's environment on the PICU. As I saw on visiting her, she has her own clothes, and duvet. She is surrounded by her own toys, and coloured lights. She has music or videos played to her. Her mother is by the bedside sixteen hours a day and contributes very effectively to her nursing care. Nevertheless, inevitably there is a clinical sterility in the PICU. It is spacious but there are other children and parents in the vicinity. The PICU is a busy place with healthcare professionals constantly coming and going. At home the environment would be more personal, perhaps more peaceful.

b. It would be wrong, however, to imagine that Pippa's home would be anything like a normal home if she were returned there on long term ventilation. Much of her home would in effect become a mini-hospital with a large team of specialist nurses working shifts, and therapists visiting on a regular basis. Specialist equipment such as a hoist, tilting table, specialist chair, cough assist machine, ventilator, monitors and a hospital bed would be installed, and all manner of sterilised pieces of clinical paraphernalia stored. Two nurses would be on duty at all times. She would be attached to a ventilator and monitored using electronic equipment and she would continue to require suctioning, proning and other interventions, day and night. She would be fed through a gastrostomy. She would need hygiene care as now. Pippa's immediate environment would in many ways be similar to that at the PICU and, for her, home life would have many of the same features as life in the PICU.

c. It is agreed by all the medical witnesses that Pippa has no conscious awareness of her environment or interactions with others. Therefore, there would be no benefit to her from being in a home bedroom as opposed to a hospital unit. Family members may be able to spend more time with her at home in a more peaceful and welcoming environment, but she would not be aware of their visits or of the benefit to others. She would not be aware of any of the changes in her environment or in her care regime.

104. Pippa would continue to bear nearly all of the burdens of her condition and treatment that she has on the PICU were she to receive long term ventilation at home. Having regard to all the evidence, including the views of Ms Parfitt, I am not satisfied that home care would confer any benefits to Pippa's welfare. Any benefits of home care that do exist would fall to her family, rather than to Pippa because she has no conscious awareness and derives no benefit from interactions with others, including family members. That is not to say that Ms Parfitt's advocacy of home care is motivated by her own needs – no-one could have been more selfless in her devotion to her daughter. But I have to focus on Pippa's welfare and so it is necessary to be clear as to the benefits and burdens to her of home care, as opposed to PICU care. As to the benefits to the family, I proceed on the basis that Ms Parfitt speaks for the whole family, but I am not in a position, nor would it be appropriate, to take a view as to the other child involved in the decisions before the court, namely Pippa's seven year old brother.

105. Looking at the wider question of whether home care, as opposed to PICU care, would serve Pippa's best interests, I accept that I should take into account the wishes of Pippa's family to care for her at home, and that home care is a goal that, as a much loved five year old girl, Pippa would be likely to share. As a generality it is in a young child's interests to be cared for by a loving family, living with them at home, rather than away from home.

106. Standing back to consider and balance all welfare considerations and factors affecting best interests, I am sure that it would be detrimental to Pippa's welfare and contrary to her best interests to receive long term ventilation at home, assuming that home care is a feasible option.

a. The first matter I take into account is the preservation of Pippa's life. In fact, home care would be a less effective means of prolonging life than care in the PICU because the standard of care on the PICU could not be matched. However, that is an artificial comparison if the alternative to attempting a transfer to home care is to withdraw ventilation. Long term ventilation at home, if achievable, would at least serve to prolong Pippa's life, albeit only for "some months".

b. Weighed against the prolongation of life is the fact that long term ventilation at home would not improve Pippa's underlying neurological condition. She would remain unaware of her environment and interactions with others and remain unable to derive any pleasure from life. Prolonging her life at home would be no more beneficial to Pippa's welfare than prolonging her life in the PICU.

c. Pippa would continue to suffer the burdens of her condition and the treatment it requires. She might be spared some of the interventions currently performed on her in the PICU such as saline lavage, but she would need a tracheostomy and gastrostomy which she does not currently have. At home she would continue to receive artificial nutrition and hydration, therapies to protect her bones and muscles, 24 hour nursing care, ventilation, suction, cough assist, turning, proning, and bagging. Prolonging her life by long term ventilation at home would prolong those burdens.

d. I take into account the wishes of Pippa's mother to care for her at home, that Pippa would have been likely to have wanted to be at home rather than in hospital, and that there might be some benefits to Pippa's family from home care as opposed to hospital care, but Pippa would not be aware that her family were benefiting, their welfare is not the focus of the court's consideration, and although Pippa may well have wanted to be cared for at home, she would not be aware that she was at home.

e. I cannot give weight to Ms Parfitt's view that home care would improve Pippa's condition, because it is at odds with the unanimous view of the clinicians and medical experts.

Dr Wallis asks what is there to lose by trying to transfer Pippa to home ventilation if the alternative is withdrawal of life sustaining treatment? The answer is that the loss would be the continuing burdens to Pippa caused by maintaining a regime of ventilatory support and other life sustaining treatment to prolong her life, when to do so would bring her no benefit. Pippa's welfare is my paramount consideration and continued ventilation, whether in the PICU, a transition unit, or at home, is detrimental to her welfare. Even allowing for a very broad assessment of Pippa's medical and non-medical interests, the presumption that life should be preserved is rebutted in this case.

107. In my judgment, therefore, long term ventilation at home would be contrary to Pippa's best interests. In any event, I have already found that the chances of success of both a trial of portable ventilation, and then a transition process, are remote. Furthermore, the transition process is prolonged – it would take at least six months. During that time Pippa would continue to be ventilated and treated in a hospital setting. She would not therefore have any of the supposed benefits of home care during that process. Her life expectancy on long term ventilation once at home would be uncertain but the best evidence is that it would be for some months only. It might be as short as a matter of weeks. At any time she could suffer a complication from which she could not recover, and the means available to achieve her recovery in the community would be less effective than those available in the PICU. In my judgement, balancing all the relevant factors including the views and wishes set out above, the presumption that life should be preserved, the benefits and burdens to Pippa of long term ventilation at home, the fact that she would remain without conscious awareness and would have no hope of improvement, the remote chance of the goal of home care being achieved, her limited life expectancy on home ventilation, and the long process involving continued ventilation in a hospital setting that would be required before home care could begin, I have reached the firm conclusion that it is not in her best interests to embark on a trial of portable ventilation and the transition process towards home care.

108. I referred earlier to two strands of thought regarding the best interests assessment of a patient in a permanent or persistent vegetative state. In accordance with the submissions of all the parties in this case I have endeavoured to consider benefits and burdens to Pippa that go beyond those of which she is conscious, and to consider her interests in the broadest possible sense. The other view is that there is no balancing exercise of burdens and benefits because the individual has no conscious awareness. Had I taken that approach I would have reached the same conclusion that long term ventilation is not in Pippa's best interests, wherever she was cared for, and that it is not in her interests to embark on a trial of portable ventilation with a view to transferring her to long term ventilation at home.

Declarations

109. For the reasons given I am satisfied that it is in Pippa's best interests to withdraw mechanical ventilation, it being contrary to her best interests for it to be continued. On extubating Pippa it is likely that she will survive a very short time only. On withdrawal of ventilation there should be defined limits on the treatment provided to Pippa to allow her to die – those limits will be set out in the Court's Order following this judgment. If ventilation is to be withdrawn then it may be that Ms Parfitt will wish that to be done at home. The Trust has told me through Dr C that extubation can be arranged to take place at home with support from trained and experienced hospital personnel to transfer her home and then to undertake the extubation process and to provide such palliative care as may be necessary in the very short time that Pippa will remain alive. As I understand it the portable ventilation necessary for transporting her home would be expected to be used only for a matter of hours. I do not know if Ms Parfitt would want to bring Pippa home for that purpose but I very much hope that with the support of the Guardian and others she can work with the Trust to agree on the circumstances of withdrawal of ventilation.

110. I am satisfied that it is not in Pippa's best interests to undergo a tracheostomy. It would serve no useful purpose, provide no benefit to her, and it would be an unnecessary intervention. By the conclusion of the evidence it was accepted by Dr Wallis that the two week trial of portable ventilation could be done without performing a tracheostomy. Thus, the prospect is put before the court of a supposedly "harmless" two week trial of portable ventilation which would be likely to fail but which it is claimed would at least give Ms Parfitt the peace of mind that everything had been tried that could be tried. The Second Respondent proposes that the court makes a declaration that it is lawful and in Pippa's best interests to undergo a trial of portable ventilation at the Evelina in a two-stage process, "starting with a trial without a tracheostomy".

111. Having given the matter careful consideration, I am not prepared to adjust the declarations I make to accommodate that suggestion. Most importantly, I have already concluded that continuing ventilation is contrary to Pippa's best interests. A trial of portable ventilation might not involve a tracheostomy but it would involve continuing ventilation on the PICU albeit for a short period. The trial would confer no benefit on Pippa. Furthermore, I am concerned that such an attempt to give Ms Parfitt some comfort would be ill-judged. Firstly, there are ongoing disagreements about how the trial should be conducted and failure of the trial could well lead to further disagreements about the merits of a re-trial with further adjustments. Secondly, Ms Parfitt does not agree that Pippa has made no progress to date and may well take a different view from the clinicians about whether Pippa had responded to the trial and whether everything had been done that could have been done. Thirdly, for the reasons I have set out in detail in this judgment, it would remain in Pippa's best interests to withdraw ventilation even after a successful trial of portable ventilation. Withdrawal after a successful trial might, if anything, aggravate the distress to Pippa's family.

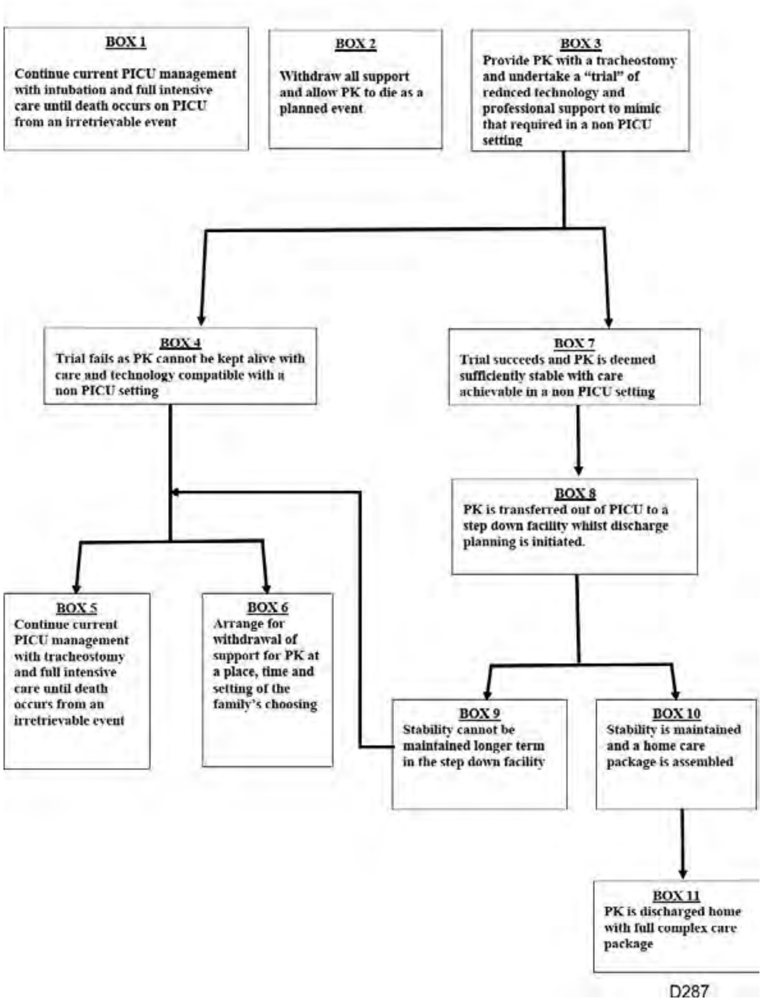
112. Ms Parfitt has fought as hard for Pippa as any parent could. Responsibility for the decisions in this case lies with the court not with her. My conclusion is that continued

mechanical ventilation is contrary to Pippa's best interests. The declarations sought, and which I shall make, are not in contravention of Pippa's Art 2 right to life and constitute necessary and lawful interference with her and her mother's Art 8 rights to family life. The declarations include a declaration that it would be lawful and in Pippa's best interests for mechanical ventilation to be withdrawn. The precise circumstances in which mechanical ventilation is withdrawn are a matter now for agreement but it would not be contrary to Pippa's best interests to transfer her to her family home for the purpose of withdrawal of ventilation.

113. The declarations I make are that it is lawful and in Pippa's best interests that:

(a) She should not be provided with a tracheostomy.
(b) Mechanical ventilation should be withdrawn.
(c) There be clearly defined limits on the treatment provided to Pippa after that withdrawal of ventilation, with the effect that she would be allowed to die.

Appendix 1



Possible options and outcomes for PK:

BOX 1
Continue current PICU management with intubation and full intensive care until death occurs on PICU from an irretrievable event

BOX 2
Withdraw all support and allow PK to die as a planned event

BOX 3
Provide PK with a tracheostomy and undertake a "trial" of reduced technology and professional support to mimic that required in a non PICU setting

BOX 4
Trial fails as PK cannot be kept alive with care and technology compatible with a non PICU setting

BOX 7
Trial succeeds and PK is deemed sufficiently stable with care achievable in a non PICU setting

BOX 8
PK is transferred out of PICU to a step down facility whilst discharge planning is initiated.

BOX 5
Continue current PICU management with tracheostomy and full intensive care until death occurs from an irretrievable event

BOX 6
Arrange for withdrawal of support for PK at a place, time and setting of the family's choosing

BOX 9
Stability cannot be maintained longer term in the step down facility

BOX 10
Stability is maintained and a home care package is assembled

BOX 11
PK is discharged home with full complex care package

D287

Neutral Citation Number: [2021] EWCOP 59

Case No: 1375980T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/11/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

NORTH WEST LONDON CLINICAL COMMISSIONING GROUP	**Applicant**
- and -	
GU **(By his Litigation Friend, the Official Solicitor)**	**Respondent**

- -
- -

Mr Mungo Wenban-Smith (instructed by **Capsticks Solicitor**) for the **Applicant**
Ms Debra Powell QC (instructed by **the Official Solicitor**) for the **Respondent**
Ms Amelia Walker (instructed by **RPC Solicitors**) for the **Royal Hospital for Neuro-disability**

Hearing dates: 15th July 2021

- -

Approved Judgment

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

....

THE HONOURABLE MR JUSTICE HAYDEN, VICE PRESIDENT OF THE COURT OF PROTECTION

This judgment was delivered following a remote hearing conducted on a video conferencing platform and was attended by members of the public and the press. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. In April 2014 GU was enjoying his retirement in Thailand with his wife. He had been a very respected airline pilot and had achieved considerable distinction in his profession. He was 63 years old. On 14th April 2014 he decided to clean his pond. In the course of that task he began to examine the pump. Tragically, he had forgotten to switch off the electricity and he suffered an electrocution accident, possibly complicated by drowning. He sustained a cardiorespiratory arrest with a significant delay before cardiopulmonary resuscitation was started. He was admitted to a local hospital where a CT brain scan was undertaken which revealed no other intracranial lesion. GU was placed on a ventilator and remained there until 12th May 2014 until he had been gradually weaned off his ventilator. On that date he was transferred to a hospital in Bangkok, effectively as a staging post, to enable him to be transferred to the United Kingdom and eventually to the Royal Hospital for Neuro- disability (RHND). The transfer took place on 1st September 2014. It is important to emphasise that for the whole of this period GU had been unconscious with no behavioural signs indicating any awareness either of himself or his environment.

2. On admission to the RHND, GU was initially suffering with respiratory and chest problems, related to a long-standing history of chronic obstructive pulmonary disease, in consequence of heavy smoking. For the last five years GU has been medically stable. He was assessed by use of conventional standardised assessments. GU has been consistently observed and monitored by a highly specialist team of nurses and therapists. There was no evidence of awareness. All responses were either automatic or reflexive. There was no perceptible change.

3. In August 2018 a request was made, by GU's brother E, for a Best Interest decision concerning his Clinically Assisted Nutrition and Hydration (CANH). A meeting was held with the family on 16th March 2017, following which GU was referred, on the same day, to the palliative care team. The records reveal that there was discussion concerning *"ceilings of care"* and a *"possible end of life plan"*. A care plan drafted in 2021 contains the following account:

> "*16th of August [year not stated but presumed to be 2018] regarding end-of-life care with the participation of brother [E], palliative care team and locum GP. The brother expressed that under new laws for palliative care, the life should not be sustained and all hydration, nutrition and medications should be stopped. The rest of the family does not agree with this new decision and therefore [GU] will continue to be cared by nursing staff. An advance care planning form was requested by the brother according to the plan in medical notes from palliative consultant."*

4. This note is not consistent with the evidence I have heard, nor the statements I have read. There is, in fact, only one family member, GU's son (A), who did not agree with the plan and for very particular reasons, which I will return to in detail. In any event, the apparent assumption that in the face of family disagreement *"therefore [GU] will continue to be cared for by nursing staff"* is a troubling non sequitur. Family dissent to a medical consensus should never stand in the way of an incapacitated patient's best interests being properly identified. A difference of view between the doctors and a

family member should not be permitted to subjugate this best interest investigation. The differing views are facets of a broad canvas which requires to be considered in their totality and, where necessary, by a Judge. To do otherwise is to risk silencing the voice of the vulnerable individual at the centre of the process. There can be no mediation of these issues where the needs of the protected person (P) are neither properly identified nor given the priority they require. Autonomy does not evaporate with loss of capacity. It may become harder to identify and evaluate but that is a challenge to be confronted not avoided. All this has concerned me and the Official Solicitor who represents GU by counsel, Ms Debra Powell QC. I requested that it be further investigated. What does seem to be clear is that GU's treating clinicians had come to the clear conclusion by August 2018, that GU was in a prolonged disorder of consciousness for which there had been no change or any prospect of future change. Treatment was both futile and, at least potentially, burdensome.

5. No formal best interest decision has ever taken place. On 14th December 2020 Professor Derek Wade, a consultant in neurological rehabilitation, was approached to provide an opinion to see whether he agreed with RHND that it would not be in GU's best interest to continue with CANH. Professor Wade understood that there was some dispute within the family and that litigation seemed to be likely. Unfortunately, the assessment was derailed by the Covid-19 pandemic. Whether the ensuant delay was unnecessarily protracted is properly queried by the Official Solicitor.

6. It was not until 19th March 2021, that it was possible for Professor Wade to visit. Professor Wade reviewed the notes, assessed GU thoroughly, and was also careful to speak to staff members who have treated GU for a number of years. Various family members also prepared statements and Professor Wade read them. In his report, dated 3rd May 2021, he expressed agreement with the opinions of the treating clinicians and set out his conclusions in unambiguous terms:

> *"I have concluded that he has been unaware of himself or his environment from the outset, and that there is no prospect of any recovery. He may live in this state for up to 10 years. I have reviewed the evidence from family members, which show convincingly that his past wishes would have been that he should not continue with life-sustaining medical treatment.* ***I have reviewed the statement from the dissenting eldest son, and this shows that he has a moral objection, personally, to the withdrawal of food and fluid from his father. He is not disputing any of the factual evidence.*** *(my emphasis)*
>
> *On this basis I have concluded that it is not in the best interests of [GU] to continue with clinically assisted nutrition and hydration. I am satisfied that the local team has the necessary expertise to provide all appropriate palliative end-of-life care."*

7. GU's medical history since his cardiac arrest has been carefully reviewed. There have been a number of infections, including hospital acquired pneumonia. His body has shown resilience. Paradoxically, the fact that he can no longer smoke led to a mild improvement in his lungs. On one occasion morphine was required for respiratory distress. It is not necessary for me further to extend this judgment with any greater detail concerning GU's general health. It is important, however, that I record the observations

as to GU's level of awareness. Professor Wade confirms the view of the hospital that from the outset i.e. following the accident, GU has never been reported as showing any kind of behaviour which could be construed as an indication of possible awareness.

8. There was a formal review undertaken on 29th October 2017. Preceding this, GU had been assessed applying the well-recognised criteria within the Wessex Head Injury Matrix. Additionally, he was assessed clinically during sessions in a sensory art group. Clinical observations were made during therapy sessions. The highest score on the Wessex head injury matrix was four i.e. attention held momentarily by dominant stimulus. The remainder of his responses were entirely automatic or reflex. He showed a low level of arousal, and usually required multiple prompts even to remain awake with his eyes open.

9. Formal assessment of GU's ability to communicate is stated as follows in the medical records:

> *"[GU] demonstrated a profound disorder of communication and did not show evidence of communicative intent verbally or nonverbally. [GU] was unable to comprehend, express himself by any means, and remains fully dependent on others to anticipate his needs and act in his best interests."*

10. It was summarised thus:

> *"[GU] demonstrated overall low responses to sensory stimuli. He demonstrated mainly reflexive responses to auditory stimuli, such as opening eyes and shoulder elevation when sound presented on both sides. He has demonstrated no response to visual stimuli on three out of four occasions and reflexive on one occasion. He demonstrated reflexive responses to tactile stimuli on two occasions. Also, he demonstrated a withdrawal response on one occasion. [GU] demonstrated no functional communication or functional use of his arms within the art group sessions.*"

11. Between 1stApril and 10th May 2019, GU underwent a further period of review. He was assessed five times, again deploying the Wessex Head Injury Matrix, and the highest recorded score was 22. However, this only occurred on one occasion, otherwise his score was never higher than four. A score of 22, I am told, equates to *"tracks a source of sound"*. This described as "*he was observed to move pupils towards the left in response to music being played on this side. This was difficult to interpret due to resting spontaneous movements of the pupils. He did not appear to localise to the right side or in response to other sounds.*"

12. A yet further period of assessment was undertaken between 26th October and 4th December 2020. This included four assessments, once again deploying the Wessex

Head Injury Matrix and again GU's highest score was four. His arousal levels were "low". The overall summary was that he "*demonstrated mainly reflexive, non-meaningful responses to auditory, tactile and visual stimuli in keeping with his presentation in a low-level Prolonged Disorder of Consciousness*."

13. The original score summary sheet for the observations made on the Wessex Head Injury Matrix, record a total of 13 assessments between 30th August 2017 and 19th November 2020, by a variety of different staff members, with individual assessments lasting between 20 minutes and one hour. On one occasion seven behaviours were noted, but otherwise no more than four behaviours and on all occasions bar one, the highest score was four.

14. All the staff on the ward see GU on a regular basis and in many different circumstances, none has ever noticed any suggestion of awareness. To this I would add that at least two of the nurses, one of whom is senior, have cared for GU for between 3 – 5 years. They have also been caring for him during the course of a pandemic where family members have not been able to enter the hospital. GU's family are scattered across the world and face the additional challenges of international travel in difficult times. When I visited, at the conclusion of the evidence, the two nurses caring for him described themselves as having been GU's family in his isolation. The nursing staff observations have to be placed in this intimate context.

15. Finally, Professor Wade added his own observations which confirmed GU's complete lack of awareness. Further, Professor Wade considered GU *"showed minimal responses"*. That led him to the following conclusion:

> *"I conclude that, beyond all reasonable doubt, [GU] has no awareness of himself or his environment."*

That conclusion could not be bleaker nor less equivocal. There is nobody involved in GU's care who disagrees with it. The family also accept it. E goes further and roundly endorses it. Nobody has suggested that there should be further investigations. The primary diagnosis is severe hypoxic brain damage. There is no alternative treatable diagnosis. There is no secondary subsequently developing complication that obscures the nature and extent of the brain damage.

16. GU is now 70 years old. It is common ground amongst the professionals that, at least statistically, he might live for another 10 years. It is equally possible that he might not fight off his next infection or perhaps suffer a sudden cardiac event. Professor Wade pays tribute to GU's medical and nursing care:

> *"His current medical and nursing management is clearly first class in that he has been kept alive, he is no longer suffering chest infections, he has not had any skin breakdown or other complications, he is not experiencing worsening contractures, and his weight has been kept steady and he looks not unwell."*

17. As I shall relate further below, I attended at the RHND to visit GU. Though I do not bring any expertise to bear, it struck me that GU was extremely well cared for.

18. It is also pertinent to note that it has already been agreed by everybody that there should be no cardiopulmonary resuscitation in the event of collapse nor treatment, in the event of any acute life-threatening illness. The sole decision requiring to be made is whether CANH, via GU's gastrostomy feeding tube is in his best interests.

19. The only individual who challenges the consensus is his son (A). His objections were powerfully articulated and moving both to read and to listen to. They are views which reflect a strong, deeply rooted and instinctive filial love. This is a father and son who were easy, open and spontaneous in each other's company. They would seek each other out and socialise together. I have heard that their conversations were hearty, broad ranging and sometimes liberally lubricated by whisky. GU embraced life to the full. All the family communicated this to me. Quite literally *"a highflier"*, he enjoyed nothing more than being amongst family and friends without formality or pomposity and chatting generally about life and, occasionally, football. I sensed there were more than a few late nights. It is this relationship that cast light on A's opposition to the prevailing view. A was asked to reduce his views to writing. It is obvious that he found that to be a valuable opportunity properly to process his thoughts and beliefs. I propose to set these out in some detail

> *"My view on the removal of my father's feeding and hydration tube has not changed since it was first raised in August 2018. I did not agree then and will not agree now to such a decision. There is nothing that will change my mind on this…"*

20. A cites the universal declaration of Human Rights to support the proposition that *"everyone has the right to adequate food, housing and medical care"*. He states:

> *"To deprive my father from this right is unbearable to accept. I believe if the situation was turned around, and one of his children was in hospital in his condition, my father will fight this as well. He would still have faith and hope, and forbid this. I am holding onto to the fact that my father has the right, which is being fulfilled at the moment, and that should be accepted by all. Being in the state that he is in, being cared for in a hospital and by nurses, he is not being a burden on anyone. When my father's time is up, he will go, but on his own terms, not ours to decide."*

21. He characterises his relationship with his father in moving terms:

> *"My dad was this really cool guy, a pilot who was very loyal to his company and to Jordan. He could have worked anywhere but he stayed with the company (Royal Jordanian) for 30 years. He was my best friend and my superhero. He gave us unconditional love with his family being his number one priority. We, his children always came first."*

22. In so far as GU and his son had discussed death A told me that he had always assumed, as a pilot, he would *"go out with a bang at 36,000 feet"*. His present circumstances are the polar opposite of what he contemplated. A puts it thus:

> "*Dad never discussed death with me, even when I was with him and he'd downed a bottle of whisky and was crying over his father's death. He didn't discuss the sort of state he's in now either. He always thought he'd die in a plane crash at 36,000 feet – go with a bang as you would say. I guess this sort of thing; you think it never happens to you but to someone else. The only time he said anything was when he was in a car crash in Thailand and his car rolled a few times, and he said to me, 'that he was ok. It could have been worse, but my time was not up."*

23. A has reflected on his position, in language which communicates both the intensity of his grief and depth of his loss:

> *"Maybe I'm being selfish and want to hang on to whatever is left of my dad. I don't know who would want to live like this? I'd love to pick up the phone and ask him, "I'm in this situation, what shall I do?', but I can't."*

24. Though A's position has not always been entirely consistent, he distils the core reasoning of his position in the following paragraph:

> *"When it came to not resuscitating him if his heart stops, that I had no issue with and I backed it 100%. If he was on a life support machine, I'd be the first to pull the plug. If my dad was on a machine keeping his heart and lungs going he would say 'pull the plug'. He is not on any machine or anything that is supporting him to stay alive. What he is being given, food and water, are the basics and right to have. I have been told there would be really good palliative care and that it can be peaceful and that I could talk to a palliative consultant, but it is not just that I worry that he would suffer. I've worked over in Africa, you can see a child there walking for miles to get a glass of water and here, in the UK, we'd deny water to my dad? People in the world are starving because they don't have enough money, and here, in the UK, you are going to starve my dad? Starving someone to death will take a long time, the body has to shut down. A vet would put a sick pet down quick and painless. Maybe he did say to some people 'If I'm ever like that shoot me' but ok shoot him, don't starve him."*

25. To my mind this is an instinctive, human and visceral reaction to what is perceived to be depriving food and water from a human being who is, in this case, *"a best friend and superhero"*.

26. It is, however, a mistake to equate CANH with the consumption of food and drink in the ordinary sense, where it is an intrinsic part of life, integral to health and survival. Nutrition and hydration which is "clinically assisted" is properly identified as 'medical treatment' (see: **Airedale NHS Trust v Bland [1993] AC 789**). It requires to be emphasised that the incapacitous patient receiving CANH is deprived of the choice to eat or drink. There is no exercise of autonomy. By contrast, in daily life, the consumption of food and drink frequently involves pleasure and conviviality. Not

uncommonly it is an expression of love. There is no mutuality, pleasure or love where nutrition and hydration are delivered by a gastrostomy feeding tube. CANH incorporates intravenous feeding by nasogastric tube, by percutaneous endoscopic gastrostomy (PEG) and radiologically inserted gastrostomy feeding tubes through the abdominal wall. It can be provided by intravenous or subcutaneous infusion of fluids through a 'drip'. All this can provide symptom relief or prolong or improve the quality of the patient's life, but equally, it may become burdensome or futile and serve only to extend life in its most vestigial sense, failing to achieve anything that might properly be identified as 'quality of life' for a patient in a prolonged disorder of consciousness. With equal legitimacy, to my mind, this can be viewed as protracting death.

27. A decision to stop eating and drinking often reflects a feeling of powerlessness. This may, for example, be a child using food to exercise tyranny or an individual facing dementia or terminal illness who simply decides to 'turn their face to the wall'. To impose nutrition and hydration on those who would not wish to receive it, particularly for those in the circumstances in which GU finds himself, is to risk suborning autonomy and compromising human dignity.

28. GU has been unaware of himself or the outside world for 7 years. No decision was taken as to his "best interests". His voice remained unheard for what many in this case regard as an unconscionable period. I regret to say, I agree with that view. Respecting human dignity in these circumstances can prove to be challenging and has been the subject of judicial discussion in a number of cases in recent years. The striking facts of this case require me to confront whether GU's dignity has been avoidably compromised and, more generally, how dignity may be evaluated.

29. Sometimes it is difficult to ascertain what a protected party (P) would have wanted, should he or she have found themselves in a prolonged disorder of consciousness, from which there could be no prospect of recovery. Family members, friends and work colleagues are often able to help cast light on P's likely wishes and feelings but sometimes, perhaps for reasons of P's temperament or convictions, no clues have been left. Happily, in this case, GU left nobody in any doubt at all that he would not want to continue in the parlous circumstances in which he finds himself. His views have been communicated consistently, volubly and unambiguously. They require to be recorded, not least because they lay unheeded for too long.

30. I heard evidence from E, GU's brother. He has also filed a statement in the proceedings. He emphasised: *"I do not believe he [my brother] would want ongoing life-sustaining interventions in his situation.*"

He stated:

> "*when my mother had Alzheimer's, towards the end, he expressed very strong views. He said things like: "for God's sake, if ever I get like this, take me out and shoot me"."*

He then goes on to record that they visited their mother on another occasion where:

> "*he again talked to a lot of us saying he would not wish to live like that totally dependent on others. He would say it was no life I would*

> *never forgive anyone who let me be like mum is now. He was like our dad in that way who also had strong views. [GU] understood what our dad did. A few years earlier, when our dad had a terminal problem, he basically opened all the windows in the lounge closed the doors, it was snowing outside and lay down naked on the sofa to die. [GU] was called the next day by my mom to deal with my dad dead naked on the sofa.*"

Later in the same paragraph he records:

> "*[GU] said I hope I have the courage of dad to do as he did if ever I was like that, facing slow debilitating death or worse loss of independence."*

31. He recalls another instance *"when [GU] was around 17 years and [E] was around 14 years"* visiting their grandmother who was bedridden and in a nursing home when "*we both agreed we would never wish to live like that and be dependent."* Much of the rest of the statement reviews the history of GU's management and a failure to consider his best interest at many points.

32. I have read the statement of RB (sister). This is dated 9th February 2020. It starts by stating "*[GU] would not want to be kept alive in his condition*." She explains this by stating "*I believe this because of the type of man my brother was.*" She described him as being somebody who liked to be talking to people, and that:

> *"he was an out-and-about the sort of person. His life was getting in the car, going into town, being on a beach, seeing things, going places*." She also states "*when [GU] came over in 2013 to England because of my mum's dementia we were talking about things – he was very clear that he would not want to be around if he had dementia. He said things like "if I do not have my mental facilities there is no reason for me to be here".*

She also stated:

> *"if he could have his say now, he would be arguing with anyone who said he had to be kept alive. He would be saying, "we need to talk about it. No, it cannot happen, it is not fair on me"."*

33. Statement of NU, first wife. She was married to him for 17 years. She states:

> "*during that time, we had long, and deep conversations and I know that how he is now is not what he would want in any shape or form. He would want all life-sustaining treatment to stop*."

She continued:

> "*we often had conversations about death, and he would always say that his greatest fear would to be in a vegetative state. He would make me promise to "pull the switch" so as to end his life rather than be a vegetable. It was a fear of his.*"

34. I have seen an email from PU, his third wife. She was contacted by E, concerning the possibility of withdrawing life sustaining treatment, she replied thus:

> *"Dear [E] and [R]*
>
> *I am very sad that we are having to think about helping [GU] this way but I want to tell you that for me as long as all the family agree I think it is what [GU] would want*
> *us to do. You have my support and anything I can do to help make it easier for you please let me know.*
>
> *I now realize after four years that [GU] will not be coming back and it's not good for him to stay like this for much more time. I want to come and see [GU] before anything happens and I hope we can arrange it so*
> *that I can say goodbye to him.*
>
> *Love to you both and the family*
>
> *I miss you all very much*
> *[P]"*

35. A statement was filed by Captain H, a work colleague and friend. This statement, within an email dated 9th February 2020, makes it clear that they were very close friends. He was best man to GU at his second marriage. Captain H referred to himself as "*his [GU's] proxy younger brother*". They had discussed death in the context of the death of parents. In his statement Captain H recounts:

> "*my father who was a doctor and professor did not believe in life prolonging interventions just to appease families, and strangely the three of us had conversations about this when family members, friends and colleagues were diagnosed with terminal illness. I remember these conversations as ones in which [GU] took the same view as my father and I.*"

Later he said:

> "*we both agreed that prolonged suffering to the individual and their families was redundant and unnecessary…*"
> *"…he would not want this for himself languishing through clinically assisted nutrition in my opinion."*

36. There are further statements filed, all of which serve to reinforce my clear impression of GU as a man who lived life to the full and embraced the opportunities he was presented with. Each witness and each statement revealed GU's personality with both clarity and perception. I was left with no doubt at all that he would have recoiled from his present circumstances. I emphasise that nobody, son, brother, friend, sister, wife had any ambivalence about what he would have wanted.

37. Ms Powell has made the following submissions on behalf of the Official Solicitor:

> *"3. When Professor Wade assessed GU in April 2021, he concluded that GU was unlikely to be having any experiences, but that if he was, they would generally be unpleasant. At the hearing on 10-11 June 2021 the Court concluded that it was not in GU's best interests to continue to receive CANH.*
>
> *4. The Official Solicitor submits that it is highly likely that this had been the case for some considerable time and that, had the question of GU's best interests been properly addressed in August 2018, when a dispute between family members was clearly apparent, the same decision would have been made then as now.*
>
> *5. It is submitted that there was* **inordinate and inexcusable delay** *(my emphasis) on the part of RHND, in giving consideration to the issue of whether continued treatment was in GU's best interests, and in taking steps to enable the Court to determine that issue in the absence of family agreement. This was compounded by further delay on the part of the CCG."*

38. Later, Ms Powell identifies *"a complete abrogation of responsibility to consider properly or at all, and to determine whether it was in GU's best interests and therefore lawful to continue to give him an invasive medical treatment, CANH."*

39. This submission, advanced on behalf of the Official Solicitor, is expressed in uncompromising and trenchant language. The CCG is also criticised for compounding the delay, a complaint which, it seems to me, it broadly accepts. Ms Powell invited me to consider whether the continued treatment given to GU might, at some point, have become unlawful. However, as will become clear later in the judgment, following the death of GU, the Official Solicitor properly recognised that her role had ceased and it was no longer necessary to consider this point. At the end of the June hearing I made declarations confirming that it was not in GU's interests to receive nutrition and hydration. Treatment was withdrawn and GU died peacefully on 26th June 2021.

40. I do not consider it necessary or indeed appropriate for the Court of Protection posthumously to review the lawfulness of GU's past treatment. I do, however, regard it as necessary, as I have foreshadowed above, to evaluate whether GU's dignity was properly protected and, if not, why not. The hearing on 15th July 2021, was specifically convened to afford the RHND an opportunity carefully to review their approach to

GU's treatment and to assist this court in understanding what the Official Solicitor rightly, in my judgement, identifies as the 'inordinate and inexcusable delay' in determining GU's best interests.

41. The RHND is recognised, internationally, as a centre of excellence in the provision of treatment, rehabilitation and long-term care for people who have suffered significant neurological damage. As mentioned above, at the conclusion of the evidence in the June hearing, I visited GU in hospital. When I met him, he was sitting in his wheelchair, accompanied by two nurses who knew him well, overlooking a large rose garden in full and resplendent bloom on a strikingly beautiful morning. The compelling and uncontested evidence is that he appreciated nothing of his circumstances. That he was being cared for physically, to a high standard, was obvious. It was equally clear that he received nursing care that was sensitive, respectful and kind.

Dignity

42. In the, admittedly extensive, passages which follow, I do not purport to provide an exegesis of the law or to review all the international texts, instruments and documents which address the concept of human dignity. I do, however, wish to signal and analyse the emphasis given to human dignity, in order to evaluate its application to this case and more widely to the many challenging decisions that the Court of Protection is required to take.

43. **Bouyid v Belgium (App No. 23380/09)** provides a starting point in identifying the international perspective:

> *"45. The Preamble to the 26 June 1945 Charter of the United Nations affirms the determination of the peoples of the United Nations "**to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small"**.*

44. The concept of dignity is also mentioned in the Universal Declaration of Human Rights of 10 December 1948, the Preamble to which states that **"recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world"**, and Article 1 of which provides that **"all human beings are born free and equal in dignity and rights"**. (my emphasis)

45. Both the above Charter and the Universal Declaration were written in the immediate shadow of the Second World War. It is important to recognise that the events of the first half of that century still constituted lived experience. Thus, the slaughter of the Somme, the insidious and corrosive rise of fascism in Europe and the awful abomination of the Holocaust provide the backdrop to both documents. This was a period when the world had real cause to confront and analyse the importance of human dignity. What is most striking is that dignity does not appear as a mere facet of fundamental human rights but is emphasised as entirely central and integral to them. As is clear from the respective preambles to both instruments, human dignity is afforded paramount status.

46. It is useful to trace the subsequent international human rights texts and instruments which incorporate the concept of dignity. In particular:

i. the **UN Declaration on the Elimination of All Forms of Racial Discrimination, 20th November 1963**, which *"solemnly affirms the necessity of speedily eliminating racial discrimination throughout the world, in all its forms and manifestations, and of securing understanding of and respect for the dignity of the human person"*. The International Convention on the Elimination of All Forms of Racial Discrimination, 21st December 1965, the Preamble to which refers to that Declaration;
ii. the **International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights**, 16th December 1966, the Preamble to which states that the equal and inalienable rights of all members of the human family *"derive from the inherent dignity of the human person"*. Furthermore, Article 10 of the former provides that *"all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person"*, and Article 13 of the latter states that the *"States Parties ... recognize the right of everyone to education ... [and] agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms ..."*;
iii. the **Convention on the Elimination of All Forms of Discrimination against Women**, 18th December 1979, the Preamble to which emphasises in particular that discrimination against women *"violates the principles of equality of rights and respect for human dignity"*;
iv. the **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**, 10th December 1984, the Preamble to which points out that the *"equal and inalienable rights of all members of the human family ... derive from the inherent dignity of the human person"*;
v. the **Convention on the Rights of the Child**, 20th November 1989, the Preamble to which states that *"the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the UN Charter, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity"* (see also Articles 23 § 1, 28 § 2, 37, 39 and 40 § 1);
vi. the **International Convention for the Protection of All Persons from Enforced Disappearance** (Articles 19 § 2 and 24 § 5 (c));
vii. the **Convention on the Rights of Persons with Disabilities**, the Preamble to which states that *"discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person"*, and the aims of which include promoting respect for the *"inherent dignity"* of persons with disabilities (Article 1), this being also one of its general principles (Article 3 (a)) (see also Articles 8 (a), 16 § 4, 24 § 1 and 25);

viii. the **Second Optional Protocol to the International Covenant on Civil and Political Rights on the abolition of the death penalty**, 15th December 1989, the Preamble to which expresses the conviction that **"abolition of the death penalty contributes to enhancement of human dignity and progressive development of human rights"**;

ix. the **Optional Protocol to the Convention on the Rights of the Child on a communications procedure**, 19th December 2011, the Preamble to which reaffirms *"the status of the child as a subject of rights and as a human being with dignity and with evolving capacities"*;

x. the **Optional Protocol to the International Covenant on Economic, Social and Cultural Rights**, 10th December 2008 and the **Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women**, 6th October 1999.

47. The importance afforded to human dignity resonates throughout the world:

i. the **American Convention on Human Rights**, 22nd November 1969 (Articles 5 § 2, 6 § 2 and 11 § 1);

ii. the **Final Act of the Helsinki Conference on Security and Cooperation in Europe**, 1st August 1975, which stipulates that the States *"will promote and encourage the effective exercise of civil, political, economic, social, cultural and other rights and freedoms all of which derive from the inherent dignity of the human person and are essential for his free and full development"* (Principle VII);

iii. the **African Charter on Human and Peoples' Rights of 27 June 1981, Article 5** ,which lays down that *"[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status"*;

iv. the **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine**, 4th April 1997, the Preamble to which affirms, inter alia, "*the need to respect the human being both as an individual and as a member of the human species and ... the importance of ensuring [his] dignity"*;

v. the **Charter of Fundamental Rights of the European Union of 7 December 2000, the Preamble**, which affirms that being *"[c]onscious of its spiritual and moral heritage, the Union is founded on the indivisible, universal values of human dignity, freedom, equality and solidarity"*, and Article 1 of which states that *"human dignity is inviolable [and] must be respected and protected"* (see also Article 31 on "*Fair and just working conditions"*);

vi. Protocol No. 13 to the **European Convention on Human Rights concerning the abolition of the death penalty in all circumstances**, 3rd May 2002, the Preamble to which points out that the abolition of the death penalty is essential for the protection of everyone's right to life and for the full recognition of the *"inherent dignity of all human beings"*;

vii. the **Council of Europe Convention on Action against Trafficking in Human Beings**, 16th May 2005, the Preamble to which emphasises that *"trafficking in human beings constitutes a violation of human rights and an offence to the dignity and the integrity of the human being"* (see also Articles 6 and 16).

48. It is notable in the above texts that human dignity is frequently recognised to constitute a permanent, essential or characteristic attribute e.g. *"the dignity inherent in a human being"*, *"the inherent dignity of all human beings"*, *"the indivisible, universal values of human dignity…"*

49. The Council of Europe has also delivered recommendations and reports which incorporate the concept of dignity e.g. **Convention of the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine** (https://rm.coe.int/168007cf98).

50. Alongside the Preamble (referred to above), Article 1 reaffirms that:

> *"Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine"*.

51. The Convention considers how to protect dignity in a number of identified circumstances, e.g. taking part in medical research, uses of the human genome etc. Of note is the emphasis placed on the importance of consent (Article 5); what to do if the patient is not able to consent (Article 6) and on previously expressed wishes (Article 9).

52. Article 6 requires that any intervention is only carried out for the person's *"direct benefit"* (Article 6(1)) and that it *"may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The individual concerned shall as far as possible take part in the authorisation procedure."* (Article 6(3)). Any authorisation *"may be withdrawn at any time in the best interests of the person concerned"* (Article 6(5)). *"The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."* (Article 9).

All this resonates clearly with the central philosophy of the framework of the Mental Capacity Act 2005.

53. In the context of "end of life", it is useful to consider: **Parliamentary Assembly, Protection of the human rights and dignity of the terminally ill and the dying, Recommendation 1418 (1999).** Again, in what has become a demonstrably clear pattern, human dignity is afforded absolute priority. Paragraph 1 provides:

> *"The vocation of the Council of Europe is to protect the dignity of all human beings and the rights which stem therefrom."*

54. Paragraph 5 expands the above:

> *"The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their expression in the provision of an appropriate environment, enabling a human being to die in dignity."*

55. Atypically, in the context of the other texts considered above, Recommendation 1418 (supra) identifies a variety of particular scenarios likely to compromise a person's dignity. These trigger the obligations of the state:

> 7. "Fundamental rights deriving from the dignity of the terminally ill or dying person are threatened today by a variety of factors:
>
> 7.1. insufficient access to palliative care and good pain management;
>
> 7.2. often lacking treatment of physical suffering and a failure to take into account psychological, social and spiritual needs;
>
> 7.3. **artificial prolongation of the dying process by either using disproportionate medical measures or by continuing treatment without a patient's consent**; (my emphasis)
>
> 7.4. **the lack of continuing education and psychological support for health-care professionals working in palliative medicine**; (my emphasis)
>
> 7.5. insufficient care and support for relatives and friends of terminally ill or dying patients, which otherwise could alleviate human suffering in its various dimensions;
>
> 7.6. patients' fear of losing their autonomy and becoming a burden to, and totally dependent upon, their relatives or institutions;
>
> 7.7. the lack or inadequacy of a social as well as institutional environment in which someone may take leave of his or her relatives and friends peacefully;
>
> 7.8. insufficient allocation of funds and resources for the care and support of the terminally ill or dying;
>
> 7.9. the social discrimination inherent in weakness, dying and death.

56. The Assembly calls upon member states to provide, in domestic law, the necessary legal and social protection against these specific dangers and fears which a terminally ill or dying person may be faced with in domestic law, and in particular against:

> 7.10. dying exposed to unbearable symptoms (for example, pain, suffocation, etc.);
>
> 7.11. **prolongation of the dying process of a terminally ill or dying person against his or her will**; (my emphasis)
>
> 7.12. dying alone and neglected;
>
> 7.13. dying under the fear of being a social burden;
>
> 7.14. limitation of life-sustaining treatment due to economic reasons;
>
> 7.15. insufficient provision of funds and resources for adequate supportive care of the terminally ill or dying."

57. For completeness, I identify three further Council of Europe documents which contemplate the concept of dignity: **Parliamentary Assembly, Protecting human rights and dignity by taking into account previously expressed wishes of patients**(https://pace.coe.int/en/files/18063#trace-4); **Parliamentary Assembly, Ethics in science and technology, Report Doc 13141 (2013)** (https://pace.coe.int/en/files/19501/html); Importantly, this latter document identifies that *"notions such as "human life", "person" and "dignity" will be understood in different ways, resulting in diverging opinions whether priority should be given to individual interests over the interests of the community"* (paragraph 67) and which may require "*re-questioning of even basic assumptions, such as the definition of "human identity" or "human dignity"."* (paragraph 69). All this reflects the challenge the Court of Protection faces when different perspectives on human dignity arise within families or amongst professionals.

58. In **Parliamentary Assembly, Rights of the sick and dying, Report Doc 3699 (1976)** (https://pace.coe.int/en/files/3937/html), amplifying *'Rights defined'*, the document states, at paragraph 16:

> *"Right to personal dignity and integrity. This right implies that medical premises should be so arranged that examinations can be carried out and treatment given without a patient suffering any loss of dignity vis-à-vis other patients, physicians, hospital staff or the outside world.* ***A patient may demand that no information be revealed regarding his presence at the hospital or his state of health***"

59. The above point also has tangential significance in the context of Transparency Orders. The document continues thus:

> "*he may refuse visits from persons he does not wish to see. It should not be forgotten that a patient's human dignity generally implies a right to the truth, which is therefore closely linked to a patient's right*

> *to information. An individual is entitled to respect for the integrity of his being as a whole (body and mind). Naturally, physicians may not violate this integrity, even at the request of the person concerned, unless this is required by the latter's treatment. The law has in fact had to be adjusted to give doctors a say, as it is sometimes difficult to judge whether medical intervention is necessary. This too is a matter for a physician's own conscience."*

60. **Convention on the Rights of Persons with Disabilities**

(https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx). Here, in addition to the wording in the Preamble, dignity is also referred to under the "general principles" provision which includes *"Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;"* (Article 3(1)).

61. Finally, at 'General Comment No 1', an important link is made between the concept of dignity and autonomy:

> "33. Freedom from discrimination in the recognition of legal capacity restores autonomy and respects the human dignity of the person in accordance with the principles enshrined in article 3 (a) of the Convention. Freedom to make one's own choices most often requires legal capacity. Independence and autonomy include the power to have one's decisions legally respected. The need for support and reasonable accommodation in making decisions shall not be used to question a person's legal capacity. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity (art. 3 (d)) is incompatible with granting legal capacity on an assimilationist basis."

62. Whilst it is undoubtedly true that freedom to make one's own choices will usually arise in the context of those who are capacitous, this is not universally the case. I reiterate, the decisions, choices, wishes and feelings of those who have lost capacity may be harvested in a variety of ways in order to assert their autonomy. Friends, colleagues, family members may be able to bring the voice of P into the decision-making process. This will require evidence to be carefully garnered but may also be available by way of written advanced decisions relating to treatment.

63. Though it is an ambitious objective to seek to draw from the above texts, drafted in differing jurisdictions and in a variety of contexts, unifying principles underpinning the concept of human dignity, there is a striking thematic consistency. The following is a non-exhaustive summary of what emerges:

i. human dignity is predicated on a universal understanding that human beings possess a unique value which is intrinsic to the human condition;

ii. an individual has an inviolable right to be valued, respected and treated ethically, solely because he/she is a human being;

iii. human dignity should not be regarded merely as a facet of human rights but as the foundation for them. Logically, it both establishes and substantiates the construction of human rights;

iv. thus, the protection of human dignity and the rights that flow therefrom is to be regarded as an indispensable priority;

v. the inherent dignity of a human being imposes an obligation on the State actively to protect the dignity of all human beings. This involves guaranteeing respect for human integrity, fundamental rights and freedoms. Axiomatically, this prescribes the avoidance of discrimination;

vi. compliance with these principles may result in legitimately diverging opinions as to how best to preserve or promote human dignity, but it does not alter the nature of it nor will it ever obviate the need for rigorous enquiry.

64. Thus, whilst there is and can be no defining characteristic of human dignity, it is clear that respect for personal autonomy is afforded pre-eminence. Each case will be both situational and person specific. In this respect there is a striking resonance both with the framework of the Mental Capacity Act 2005 and the jurisprudence which underpins it. The forensic approach is 'subjective', in the sense that it requires all involved, family members, treating clinicians, the Courts to conduct an intense focus on the individual at the centre of the process. Frequently, it will involve drilling down into the person's life, considering what he or she may have said or written and a more general evaluation of the code and values by which they have lived their life.

65. The case law of the Court of Protection reveals this exercise, in my judgement, to be receptive to a structured, investigative, non-adversarial enquiry which, as here, frequently establishes a secure evidential base, illuminating P's wishes and feelings. This investigation requires sensitivity, intellectual integrity and compassion on the part of all those involved. The beliefs and/or prejudices of others are entirely extraneous to the question of what P would want in the circumstances which he or she finds themselves in. Sometimes, where P has become isolated and alone the investigation may be inconclusive but experience shows and the case law reveals, that many of us leave a mark on those around us and closest to us which is clearer, stronger and more enduring than perhaps we might anticipate (See: **N, Re [2015] EWCOP 76; Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor [2014] EWCOP 4**). The outcome of this investigation will, of course, never achieve the same evidential weight as a strong, clearly expressed wish by a capacitous individual. But, the evidence of the code by which P has lived his life and the views he has expressed (which cast light on the decision to be taken) frequently provide powerful evidence when evaluated against the broad canvas of the other forensic material.

66. Although it is not an issue in this instant case, evaluating the codes and values by which an individual has lived his life will, in many cases, involve taking account of both religious and cultural beliefs. This is not to be equated with a superficial assumption that because a person is a member of an identified faith, he will inevitably have wanted a particular medical decision to be taken. It must be recognised that within any faith or culture there will exist a diversity of interpretation and practices, some of which will be extra-doctrinal and not easily reconcilable with the theological strictures of the faith.

Thus, for example, some Roman Catholics whilst having a clear religious identity may nonetheless choose to practice birth control; some Jews may not adhere to prescribed dietary requirements; some Muslims may not observe Ramadan. Even those who do not regard themselves as having a faith may have grown up in countries or families where faith-based beliefs have migrated into more general cultural values. All this is in sharp focus when considering what is often referred to as the 'sanctity of life', a phrase which is rooted in religious lexicon, though it has developed a broader meaning in the law (e.g. sanctity of contract). When considering what P would want, it is his own religious views and practices that need to be focused upon and not the received doctrine of the faith to which he subscribes. The latter approach risks unintentionally subverting rather than promoting the autonomy that is integral to human dignity.

67. It is important to highlight that there is a recognition within many faiths that effective surgery or other medical intervention is not synonymous with beneficial treatment; sustaining vital functioning is not the same as promoting health. Intervention which may have a powerful effect on the body may be antagonistic to the integral well-being of the patient. Once treatment is identified as both burdensome and futile and where death becomes inevitable, the prolongation of death is recognised as disproportionate.

68. It is instructive to consider both the domestic and European case law (ECHR).

ECHR case law

The concept of dignity engages both Article 8 and Article 3. In the Fourth Section judgment of **Pretty v UK (app no. 2346/02)**, the court held that an undignified death may fall within the ambit of Article 8:

> *"65.* ***The very essence of the Convention is respect for human dignity and human freedom.*** (my emphasis) *Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.*
>
> *66. In Rodriguez v. the Attorney General of Canada ([1994] 2 Law Reports of Canada 136), which concerned a not dissimilar situation to the present, the majority opinion of the Supreme Court considered that the prohibition on the appellant in that case receiving assistance in suicide contributed to her distress and prevented her from managing her death. This deprived her of autonomy and required justification under principles of fundamental justice. Although the Canadian court was considering a provision of the Canadian Charter framed in different terms from those of Article 8 of the Convention, comparable concerns arose regarding the principle of personal autonomy in the sense of the right to make choices about one's own body.*

> *67. The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8 § 1 of the Convention. It considers below whether this interference conforms with the requirements of the second paragraph of Article 8."*

69. The court in **Haas v Switzerland (App no. 31322/07)** drew on **Pretty** (supra) stating at paragraph 51 that: *"In the light of this case-law, the Court considers that an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."* The court concluded at paragraph 61 that "*even assuming that the States have a positive obligation to adopt measures to facilitate the act of suicide with dignity, the Swiss authorities have not failed to comply with this obligation in the instant case."*

70. The objections articulated by A in this case found expression in **Lambert v France (App no. 46043/14)**, where the dissenting opinion placed emphasis on the fact that food and water are intimately linked to human dignity (drawing on General Comments No. 12 and 15 of UN Committee on Economic, Social and Cultural Rights): *"What, we therefore ask, can justify a State in allowing a doctor ... in this case not so much to "pull the plug" (Vincent Lambert is not on any life-support machine) as to withdraw or discontinue feeding and hydration so as to, in effect, starve Vincent Lambert to death?"* (paragraph 4 of dissenting opinion).

Article 3

71. In **D v United Kingdom (App no. 30240/96)**, the court held that removing the applicant from the UK, who was in the advanced stages of a terminal illness, *"would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment"* paragraph 53. This case law has been interpreted by domestic courts to mean that Article 3 includes *"the right to die with dignity" (***A National Health Service Trust v D [2000] 2 FLR 677**, at 695).

72. In the ECtHR jurisprudence, dignity is inevitably scrutinised in the context of claims of inhuman and degrading treatment. For example, in **Bouyid v Belgium (App No. 23380/09**) the court held that:

> *"81. Article 3 of the Convention enshrines one of the most fundamental values of democratic societies... Indeed, the prohibition of torture and inhuman or degrading treatment or punishment is a value of civilisation closely bound up with respect for human dignity.*
> ...

> *87. Ill-treatment that attains such a minimum level of severity usually involves actual bodily injury or intense physical or mental suffering. However, even in the absence of these aspects, where treatment humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition set forth in Article 3 (see, among other authorities, Vasyukov v. Russia, no. 2974/05, § 59, 5 April 2011; Gäfgen, cited above, § 89; Svinarenko and Slyadnev, cited above, § 114; and Georgia v. Russia (I), cited above, § 192). It should also be pointed out that it may well suffice that the victim is humiliated in his own eyes, even if not in the eyes of others (see, among other authorities, Tyrer v. the United Kingdom, 25 April 1978, § 32, Series A no. 26, and M.S.S. v. Belgium and Greece [GC], no. 30696/09, § 220, ECHR 2011).*
>
> *…*
>
> *89. The word "dignity" appears in many international and regional texts and instruments (see paragraphs 45-47 above). Although the Convention does not mention that concept – which nevertheless appears in the Preamble to Protocol No. 13 to the Convention, concerning the abolition of the death penalty in all circumstances – the Court has emphasised that respect for human dignity forms part of the very essence of the Convention (see Svinarenko and Slyadnev, cited above, § 118), alongside human freedom (see C.R. v. the United Kingdom, 22 November 1995, § 42, Series A no. 335-C, and S.W. v. the United Kingdom, 22 November 1995, § 44, Series A no. 335-B; see also, among other authorities, Pretty v. the United Kingdom, no. 2346/02, § 65, ECHR 2002-III).*
>
> *90. Moreover, there is a particularly strong link between the concepts of "degrading" treatment or punishment within the meaning of Article 3 of the Convention and respect for "dignity". In 1973 the European Commission of Human Rights stressed that in the context of Article 3 of the Convention the expression "degrading treatment" showed that the general purpose of that provision was to prevent particularly serious interferences with human dignity (see East African Asians v. the United Kingdom, nos. 4403/70 and 30 others, Commission's report of 14 December 1973, Decisions and Reports 78-A, p. 56, § 192). The Court, for its part, made its first explicit reference to this concept in the judgment in Tyrer (cited above), concerning not "degrading treatment" but "degrading punishment". In finding that the punishment in question was degrading within the meaning of Article 3 of the Convention, the Court had regard to the fact that "although the applicant did not suffer any severe or long-lasting physical effects, his punishment — whereby he was treated as an object in the power of the authorities – constituted an assault on precisely that which it is one of the main purposes of Article 3 to protect, namely a person's dignity and physical integrity" (ibid., § 33). Many subsequent judgments have highlighted the close link*

> *between the concepts of "degrading treatment" and respect for "dignity" (see, for example, Kudła v. Poland [GC], no. 30210/96, § 94, ECHR 2000□XI; Valašinas v. Lithuania, no. 44558/98, § 102, ECHR 2001□VIII; Yankov v. Bulgaria, no. 39084/97, § 114, ECHR 2003□XII; and Svinarenko and Slyadnev, cited above, § 138)."*

73. In **Svinarenko and Slyadnev (App no. 32541/08)**, the court considered the *objective* notion of degrading treatment and once again analysed human dignity as *"the very essence of the convention"*, extrapolating that the object and purpose of the convention requires that its provisions be interpreted in a manner which makes its safeguards both practical and effective:

> *"138. Regardless of the concrete circumstances in the present case, the Court reiterates that the very essence of the Convention is respect for human dignity and that the object and purpose of the Convention as an instrument for the protection of individual human beings require that its provisions be interpreted and applied so as to make its safeguards practical and effective. It is therefore of the view that holding a person in a metal cage during a trial constitutes in itself – having regard to its objectively degrading nature which is incompatible with the standards of civilised behaviour that are the hallmark of a democratic society – an affront to human dignity in breach of Article 3."*

74. Further, in **Campbell and Cosans v United Kingdom (App No. 7511/76)**, the court is clear that the subjective element (*"humiliated in his own eyes"*) is not the only consideration:

> *"a threat directed to an exceptionally insensitive person may have no significant effect on him but nevertheless be incontrovertibly degrading; and conversely, an exceptionally sensitive person might be deeply affected by a threat that could be described as degrading only by a distortion of the ordinary and usual meaning of the word."* [paragraph 30].

Domestic case law

75. The leading case in this area and one which has been subject to most scrutiny is **Airedale NHS Trust v Bland [1993] AC 789** Sir Thomas Bingham held that

> *"account may be taken of wider and less tangible considerations. An objective assessment of Mr. Bland's best interests, viewed through his eyes would in my opinion give weight to the constant invasions and humiliations to which his inert body is subject; to the desire he would naturally have to be remembered as a cheerful, carefree, gregarious teenager and not an object of pity; to the prolonged ordeal imposed on all members of his family, but particularly on his parents; even, perhaps, if altruism still lives, to a belief that finite resources are*

> *better devoted to enhancing life than simply averting death."* (Page 813)

76. Lord Hoffman identifies dignity as an *"ethical principle"*:

> *"But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular, for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person."* (page 826)

77. Further,

> *"Similarly, it is possible to qualify the meaning of the sanctity of life by including, as some cultures do, concepts of dignity and fulfilment as part of the essence of life. In this way one could argue that, properly understood, Anthony Bland's death would not offend against the sanctity of life."* (page 827).

78. Lord Hoffman also recognised that which is now imbedded in the jurisprudence of the Court of Protection, namely the dignity abides even where consciousness is lost and indeed, beyond death:

> *"I think that the fallacy in this argument is that it assumes that we have no interests except in those things of which we have conscious experience. But this does not accord with most people's intuitive feelings about their lives and deaths. At least a part of the reason why we honour the wishes of the dead about the distribution of their property is that we think it would wrong them not to do so, despite the fact that we believe that they will never know that their will has been ignored. Most people would like an honourable and dignified death and we think it wrong to dishonour their deaths, even when they are unconscious that this is happening. We pay respect to their dead bodies and to their memory because we think it an offence against the dead themselves if we do not. Once again, I am not concerned to analyse the rationality of these feelings. It is enough that they are deeply rooted in our ways of thinking and that the law cannot possibly ignore them. Thus, I think that counsel for the Official Solicitor offers a seriously incomplete picture of Anthony Bland's interests when he*

> *confines them to animal feelings of pain or pleasure. It is demeaning to the human spirit to say that, being unconscious, he can have no interest in his personal privacy and dignity, in how he lives or dies."* (Page 829)

79. In a dissenting judgment, Lord Browne-Wilkinson considered *"personal dignity"* to be an *"impalpable factor"* which could only be evaluated in a way which reflected the moral stance of an individual judge and as such had no legitimacy:

> *"The position therefore, in my view, is that if the judges seek to develop new law to regulate the new circumstances, the law so laid down will of necessity reflect judges' views on the underlying ethical questions, questions on which there is a legitimate division of opinion. By way of example, although the Court of Appeal in this case, in reaching the conclusion that the withdrawal of food and Anthony Bland's subsequent death would be for his benefit, attach importance to impalpable factors such as personal dignity and the way Anthony Bland would wish to be remembered but do not take into account spiritual values which, for example, a member of the Roman Catholic church would regard as relevant in assessing such benefit. Where a case raises wholly new moral and social issues, in my judgment it is not for the judges to seek to develop new, all embracing, principles of law in a way which reflects the individual judges' moral stance when society as a whole is substantially divided on the relevant moral issues. Moreover, it is not legitimate for a judge in reaching a view as to what is for the benefit of the one individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources or the impact on third parties of altering the time at which death occurs."* (pages 879 – 880).

80. Though the case law in the decades that have followed has eschewed Lord Browne-Wilkinson's analysis, it is, to my mind, always helpful to keep this passage in mind when evaluating whether that which is identified as human dignity is genuinely attributable to P's humanity and not to the moral and ethical judgements of others. Lord Mustill noted that:

> *"...it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none."* (page 897)

81. In **A and others v East Sussex County Council and another [2003] EWHC 167 (Admin)**, when considering the idea of "physical and psychological integrity" founded in Article 8 (citing **Botta v Italy (App No. 21439/93)**), the court commented that it

embraced two important concepts: dignity and the right of disabled individuals to participate in the life of the community. In relation to dignity, the court stated:

> *"86. The first is human dignity. True it is that the phrase is not used in the Convention but it is surely immanent in article 8, indeed in almost every one of the Convention's provisions.* ***The recognition and protection of human dignity is one of the core values -in truth the core value - of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value of the common law, long pre-dating the Convention and the Charter.*** (my emphasis) *The invocation of the dignity of the patient in the form of declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law's and of society's recognition of our humanity and of human dignity as something fundamental. Not surprisingly, human dignity is extolled in article 1 of the Charter, just as it is in article 1 of the Universal Declaration. And the latter's call to us to "act towards one another in a spirit of brotherhood" is nothing new. It reflects the fourth Earl of Chesterfield's injunction, "Do as you would be done by" and, for the Christian, the biblical call (Matthew ch 7, v 12): "all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets".*
>
> *Further, the court highlighted at [94] - [95] that "the demands of human dignity fall to be evaluated in the particular context – not merely of place but also of time ... As Lord Hoffmann said, "The content may change but the concept remains the same", reflecting Professor Ronald Dworkin's distinction between the "concept" which does not change and changing "conceptions of the concept": see R (ota Smeaton on behalf of the Society for the protection of unborn children) v Secretary of State for Health [2002] EWHC 610 (Admin), [2002] 2 FLR 146 at 226 (paras [324]-[325])."*

82. The court at [121] also distinguished between *'dignified ends'* and '*undignified means'* in the context of dignity. The analysis here illuminates the difficult balance that may require to be struck. However, it is also important to note that in the intervening years (i.e. approaching 20 years), palliative medicine has evolved to such a degree that the hypothesis posited in the judgment is rarely likely to arise in modern medicine:

> *"But, and this is the first point, insistence on the use of dignified means cannot be allowed to obstruct more important ends. On occasions our very humanity and dignity may itself demand that we be subjected to a certain amount - sometimes a very great deal - of indignity. Dignified ends may sometimes demand the use of undignified means ... But this does not mean that means must be allowed to triumph over*

> *ends. There is a balance to be held—and it is often a very difficult balance to strike. It is difficult enough to balance the utility or possible futility of means against the utility or possible futility of ends: it is all the more difficult when one has to assess in addition the dignity or possible indignity of the means against the end in view. Modern medical law and ethics illustrate the excruciating difficulty we often have in achieving the right balance between using undignified means in striving to achieve dignified ends."*

83. In **Sheffield Teaching Hospitals NHS Foundation Trust v TH and another [2014] All ER (D) 209 (May)**, the court observed as follows:

> *"53. If ever a court heard a holistic account of a man's character, life, talents and priorities it is this court in this case. Each of the witnesses has contributed to the overall picture and I include in that the treating clinicians, whose view of TH seems to me to accord very much with that communicated by his friends. I am left in no doubt at all that TH would wish to determine what remains of his life in his own way not least because that is the strategy he has always both expressed and adopted. I have no doubt that he would wish to leave the hospital and go to the home of his ex-wife and his mate's Spud and end his days quietly there and with dignity as he sees it. Privacy, personal autonomy and dignity have not only been features of TH's life, they have been the creed by which he has lived it. He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation. I have given this judgment at this stage so that I can record my findings in relation to TH's views. Mr Spencer on behalf of the Trust does not argue against this analysis, he agrees that nobody having listened to the evidence in this case could be in any real doubt what TH would want."*

84. In **M v N [2015] EWCOP 76**, I made the following observations:

> *"[71] As I have already set out and at some length, I am entirely satisfied that Mrs. N's views find real and authoritative expression through her family in this courtroom. I start with the assumption that an instinct for life beats strongly in all human beings. However, I am entirely satisfied that Mrs. N would have found her circumstances to be profoundly humiliating and that she would have been acutely alert to the distress caused to her family, which she would very much have wanted to avoid. LR told me that Mrs. N would not have wanted to have been a burden; that I also believe to be entirely reliable.*

> *[72] There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected. But choice where rational, informed and un-coerced is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too."*

85. I also, at [76] referred to the following passage from **R (Purdy) v DPP [2009] UKHL 45**:

> *"66 ... If we are serious about protecting autonomy we have to accept that autonomous individuals have different views about what makes their lives worth living. There are many, many people who can live with terminal illness; there are many, many people who can live with a permanent disability at least as grave as that which afflicted Daniel James; but those same people might find it impossible to live with the loss of a much-loved partner or child, or with permanent disgrace, or even with financial ruin."*

86. In **Tafida Raqeeb v Barts NHS Foundation Trust and others [2020] 3 All ER 663**, Macdonald J considered that the *"concept of human dignity"* must contain *"a significant element of subjectivity"* and thus be influenced by, for example, *"the religious or cultural context in which the question is being considered"*. Whilst identifying what constitutes human dignity for a particular individual in a given situation will inevitably be subjective, the *"concept of human dignity"* is not. Rather, it is objectively predicated on what emerges as a universal understanding of a unique value intrinsic to the human condition.

87. When considering the likely wishes of an incapacitated adult, the religious codes and community values within which he or she has lived will be an important facet of the subjective evaluation of best interests. These are however, for the reasons considered at para 59 above, essentially extraneous and contextual factors which can never be permitted to occlude the far more rigorous exercise of identifying what P most likely believed and what he or she would have wanted in circumstances where medical treatment had become burdensome and futile.

88. In **Guy's and St Thomas' Children's NHS Foundation Trust v Pippa Knight [2021] EWHC 25 (Fam)** Poole J held at [86] that:

> *"The concept of "dignity" to which MacDonald J referred in Raqeeb at [176] to [177] (above) and which has influenced the view of Dr B, is, I believe, problematic and does not assist me in identifying what is in Pippa's best interests. In an adult or older child the concept of dignity might be linked to their exercise of autonomy and be a crucial factor in determining what is in their best interests, but that factor*

> *does not apply in the case of a young child like Pippa, whose values, beliefs, and wishes cannot reliably be ascertained or inferred. Perhaps we all think we can recognise human dignity when we see it, but there is obviously a high degree of subjectivity involved in describing someone's life or death as having dignity The protection of an individual's dignity has been deployed in support of decisions to continue life sustaining treatment – Raqeeb – and to withhold it - Alder Hey Children's Foundation Trust v Evans [2018] EWHC 308 (Fam) at [62]. For some, there is dignity in enduring suffering; for others, prolonged suffering constitutes a loss of dignity. There is a wide range of opinion as to what constitutes a dignified death. In the present case the Trust contends that the withdrawal of ventilation in a planned manner within the hospital and with appropriate palliative care, would allow Pippa to die peacefully with her family around her. Witnesses for the Trust told me of "chaotic" deaths they had witnessed, and which might occur if Pippa were at home, where a complication such as an uncontrollable desaturation could lead to her sudden death, perhaps without family members present. It might be said that Pippa's dignity would be protected in the former case and lost in the latter. Her mother would strongly disagree. She says, "I could not think of anything more undignified than Pippa's death being planned and for it to be carried out in the corner of the PICU when there is a procedure that can be done to potentially get her out of the ward and home." I take into account the views of Pippa's mother and of others about her best interests, but given the very different ideas expressed to the court about what would constitute dignity for Pippa in life and in her dying, I shall not presume to adopt some supposedly objective concept of dignity to determine her best interests."*

89. Lord Justice Baker found himself confronted with the question of how the Court should address the question of human dignity in **Parfitt v Guy's and St Thomas' Children's NHS Foundation Trust [2021] EWCA Civ 362**. However, as it was not identified as a ground of appeal by either the Appellant or the Trust, Baker LJ was not required to address it:

> *"[99] ... I commend him for the thought and care with which [the counsel for the Guardian] has prepared those submissions and I intend no disrespect to him in saying that I do not think it necessary or appropriate on this occasion to embark upon a detailed analysis of the arguments he deployed [about the concept of dignity]. The judge [of the High Court] declined to attach any weight to the concept of dignity in reaching a decision about Pippa's best interests…Neither the appellant nor the Trust has sought to argue that he was wrong in adopting that course.*
>
> *[100] Other judges, dealing with cases involving different circumstances, have taken a different approach: see for example MacDonald J's decision in Raqeeb. In a future case, it may be*

> *necessary for this Court to address arguments akin to those put forward by Mr Davy about the role played by the concept of dignity in decisions of this sort. That necessity does not arise on this appeal."*

90. In **Manchester University NHS Foundation Trust v Alta Fisher and others [2021] EWHC 1426 (Fam)**, the court having reviewed the history of the case law starting with *Raqeeb* and the two judgments in *Knight*, stated:

> *"[70] Within this context, the judgment of this court in Raqeeb sought to recognise that some of the wide range of considerations relevant to the evaluation of best interests, such as the role of religious belief, futility (in its non-technical sense), dignity, the meaning of life and the principle of the sanctity of life, will be ones that admit, as the best interests principle itself can admit, of more than one "right" answer capable of driving the best interests decision of the court, particularly in the absence of factors which tend to attract societal consensus, such as the undesirability of pain and suffering. However, and consistent with the long-established process of evaluation conducted by the court with respect to best interests, whether, in a given case, those more subjective or value laden factors will drive the best interests decision will depend on the totality of the welfare factors that fall to be considered in that case."*

91. In **Alder Hey Children's NHS Foundation Trust v Evans & Anor [2018] EWHC 308 (Fam)** I made the following observations which I do not consider need amplification:

> *"54. In her evidence the Guardian expressed her clear support for the Trust's application. Her view had been foreshadowed in her report. The evidence, she told me, had served ultimately to confirm her recommendation. She stated that in her view Alfie's life now lacks dignity and his best interests can only be met by withdrawing ventilation. This evidence from an experienced children's guardian requires to be considered very carefully. I have done so. With great respect to her I disagree with her view on Alfie's dignity. As I had promised the family I attended the PICU at Alder Hey to meet Alfie. I was greeted not merely with courtesy by the parents and a number of aunts and uncles but with a sincere and genuine warmth. I was and remain grateful to them. Alfie's pod in the unit is large, comfortable and he is surrounded by some of the world's most up-to-date technology. F was, in my presence, assiduous to Alfie's care. He is entirely besotted with his son. M, both parents agree, is far less involved in Alfie's practical care and less confident. Her contribution, in my assessment, is of an entirely different complexion. She has, if I may say so, a zany and delightful sense of humour entirely free from self-regard or pomposity. Her love for her partner and her son was obvious. The atmosphere around Alfie was peaceful, dignified and*

> *though some might find it surprising for me to say so, very happy. The primary engine for all this is Alfie's mum.*
>
> *55. Alfie's bed is festooned with toys. His walls are plastered with photographs and his many supporters have delivered a variety of football shirts to him. One, in particular, was signed by the entire Everton squad specifically for him.*
>
> *56. Supporting all this is the diligent professionalism of some truly remarkable doctors and the warm and compassionate energy of the nurses whose concern and compassion is almost tangible. All this creates an environment which inherently conveys dignity to Alfie himself. In my judgment his life has true dignity. The far more challenging question is whether and if so how that can be maintained."*

Lessons to be learned

92. I have gone to such lengths to review the concept of human dignity in this case because from my first reading of the papers, I was alarmed to discover the extraordinary delay that had occurred in addressing GU's best interests and the profoundly perturbing period in which he had been in a prolonged disorder of consciousness. In the 7 years since his dreadful accident it is regarded as highly unlikely that he had any experience at all but that if he did, it would have *"generally been unpleasant"*. Having concluded that it was not in GU's best interests to continue to receive CANH at the hearing on 11th June 2021, I considered it was necessary to afford RHND the opportunity of explaining what had happened. On 11th June 2021, I delivered an extempore judgment in which I indicated why the continued provision of nutrition and hydration to GU, in the manner outlined above, was contrary to GU's interests. The Court could not compound the delay. It was also important that the family, who were all present, could understand the reasons supporting my decision. I have repeated that judgment here in broadly similar language, though I have refined some of the concepts. Because it was contended by the Official Solicitor that GU's dignity had been so seriously compromised, I invited a response from RHND. I wanted to ensure that delays of this magnitude were not repeated in cases of this kind, or indeed, at all. I also wanted better to understand how the failure to identify GU's best interests had occurred.

93. Ms Walker, on behalf of RHND, has not sought to justify the delay in referring the question of withdrawal of CANH to the court. It seems to me she could not have done so. She makes a number of submissions which I record:

> *"RHND considers it important to emphasise at the outset of this part of the submissions that it is a charity, it is not a Trust, this has clear resourcing implications which are addressed further below. The charity was set up with the aim of giving "permanent relief to such persons as are hopelessly disqualified for the duties of life by disease, accident or deformity," (originally called the Hospital for Incurables). RHND has always taken seriously its approach to ensuring a strong ethical position on the end of life care, and as*

> *explained at F1, this has involved the appointment until April 2018 as chair of the Ethics Committee of Laurence Oates CB (former Official Solicitor to the Supreme Court). Without diverging too far from the specifics of GU's case, RHND does consider it important to emphasise that its ethos is to provide rehabilitation and long-term care for its patients and that this coupled with the more limited experience of staff in withdrawing life sustaining treatment had an impact on its approach to CANH withdrawal cases."*

94. Whilst I recognise the commitment and professionalism of all involved in the RHND, I regret to say that the failure of the hospital to ensure that its ethos evolved to incorporate the very clear guidance of the Royal College of Physicians and the British Medical Association is troubling. Ms Walker amplifies her above submission thus:

> *"The Official Solicitor has been critical of RHND's reliance on its ethos in its representations. RHND understands why this criticism is being made, but is simply and honestly reflecting the cultural factors within RHND which meant that its policy in 2017 and 2018 did contain gaps which could lead to the sorts of delays experienced in GU's case. The policy produced by RHND in 2017 referred to the guidance produced by the Royal College of Physicians in 2013. However, RHND's policy then (and to the same extent as produced in October 2018) was a reactive one in the sense that it indicated that when it was appropriate to do so there would be discussions with the family about what options are open to them but the policy was not specific as to the processes that needed to be followed if it were not possible to obtain agreement. It is important to acknowledge this past practice and to acknowledge that RHND has been and will continue to take steps to ensure that there are no obstructions to RHND taking action. It should also be noted that a detailed Guidance and governance process (based on the prevailing National Guidance) was developed under the Policy, adopted by the RHN in October 2018 and revised in the light of experience in March 2019. This shows a firm commitment by the RHN to properly considering and progressing cases where this was appropriate."*

95. It is trite to say that medicine has progressed very significantly since the establishment of the charitable Hospital for Incurables. It is manifest that the identified aim of providing *"permanent relief"* to those *"hopelessly disqualified for the duties of life"* requires to be interpreted in the context of good, contemporary medical practice. Underpinning the original aims of the hospital is a clear recognition of the importance of human dignity. It does not strain even this now antiquated language to identify that the objective is to provide "relief" to those who have lost the capacity to assert their own autonomy. GU was not provided with relief; he should have been. His treatment became both burdensome and futile and entirely contrary to what he would have wanted. His dignity was avoidably compromised. Even the most summary assessment of his best interests would have revealed this many years ago.

96. The obligation to review a patient's best interests falls upon the treating clinical team. In this case any consideration of a best interests meeting was triggered by E who had

discovered the judgment of the Supreme Court in **NHS Trust v Y [2018] UKSC 46**. The following passage in that judgment by Lady Black, with whom the majority agreed, is apposite here:

> *"125. If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application* **can and should be made** *(my emphaisis). As the decisions of the ECtHR underline, this possibility of approaching a court in the event of doubts as to the best interests of the patient is an essential part of the protection of human rights. The assessments, evaluations and opinions assembled as part of the medical process will then form the core of the material available to the judge, together with such further expert and other evidence as may need to be placed before the court at that stage."*

97. This judgment finds clear expression in the guidance of the Royal College of Physicians **"Clinically – Assisted Nutrition and Hydration (CANH) and adults who lack the capacity to consent"** (2018). Further guidance can be found in the document published by this court, **Serious Medical Treatment, Guidance [2020] EWCOP 2**.

98. I accept the submission, on behalf of the Official Solicitor, that there was *"a wealth of professional guidance"* available to the RHND and certainly by 2018. Moreover, I think it is fair to say that the judgment in the Supreme Court in re: Y (supra) and the available guidance make it pellucidly clear that the person responsible for making decisions in this sphere, where P lacks capacity, is the individual with overall responsibility for the patient's care, as part of their clinical responsibility to ensure that treatment provided is in the patient's best interests. This will usually be a consultant or general practitioner. This is reflected, almost verbatim within the Royal College's guidance and it does not permit of any ambiguity. To the extent that the RHND have suggested that there is any lack of clarity on this point, I disagree.

99. After what I strongly suspect were years of real distress and concern, the pressure to convene a best interests meeting was, ultimately, generated by E (GU's brother). Even a moment's reflection will reveal that this puts a family member in a highly invidious position. The RHND's failure to act led to a situation in which E had to press for the discontinuance of treatment in order that his own brother (GU) might be permitted to die with dignity. Many in E's situation might have found themselves unable or unwilling to take this course. They should not have to do so.

100. The guidance emphasises that the central point to keep in mind is that the decision-making process is about the best interests of the individual patient not what is best for those who are close to, or around them. I was told by the CEO of RHND that the discontinuance of life sustaining treatment in the kind of circumstances arising here causes distress to staff, other patients and their families. It was clearly intended to signal that this was, in some way, a reason to delay the best interests decision-making process. I have no doubt that these cases cause deep distress to others in the hospital. Indeed, it would be concerning if they did not. I have equally no doubt that these considerations

have no place at all in evaluating GU's best interests. Factoring these matters into the decision process is both poor practice and ethically misconceived.

101. Ms Walker has drafted a number of suggestions as to how guidance might need to be updated. Within those suggestions is an observation that the experience of the pandemic has revealed how the use of technology can be very effective in achieving easier access to key individuals and the wider recognition that best interests meetings can be entirely effective when conducted 'remotely'. This may well be right, but it is a distraction from the central issue in this case.

102. I am not persuaded that there is a need for further guidance, beyond that which is folded into the analysis of this judgment. Indeed, I have come to the conclusion that the existing guidance must be restated and emphatically so. This Court's guidance (supra) was released as recently as 17th January 2020 and is condensed into five pages. It is intended to be an easily accessible document. I am aware that it is widely consulted. It is, I hope, a convenient gateway to the wider case law and to the other available professional guidance.

103. What does require to be spelt out, though it ought to be regarded as obvious, is that where the treating hospital is, for whatever reason, unable to bring an application to the court itself, it should recognise a clear and compelling duty to take timely and effective measures to bring the issue to the attention of the NHS commissioning body with overall responsibility for the patient.

104. Ms Powell has emphasised the Royal College of Physicians PDOC Guidelines:

> *"Annual review should include a consideration and discussion of best interests. Appropriate ceiling of treatment arrangements should be discussed and agreed at each annual review. Treating teams and commissioners should not simply continue treatment because it is the easiest option. Family members must be given ongoing opportunities to discuss withdrawal of life-sustaining treatment, including the practical, legal and emotional aspects"*

It is submitted, on behalf of the Official Solicitor, that:

> *"as soon as there is any doubt over whether it is in the patient's best interests to continue to receive CANH, appropriate steps must be taken in every case to ensure that a timely decision is made on that issue, one way or the other. If it is not possible to achieve unanimity amongst the treating team and all those with an interest in the patient's welfare, or if it is considered that the decision is finely balanced, then steps must be taken to bring the matter before the Court, in a timely way, for a determination."*

105. This latter point is an important one. The Royal College has issued guidelines, they are to be treated as such and not regarded as set in stone. Consideration of a patient's best interests arises in response to clinically identified need. The need for an assessment is driven by what the patient requires and not confined to the structure of annual review. In simple terms, it requires to be kept in constant and unswerving focus. (see e.g.; **Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious**

Medical Treatment) [2021] EWCOP 51). Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed quite suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance.

C. United States Authorities

The original text of reference for the following note could not be located

FEINMAN | 10/13/2022 14:43:35
Child Custody76Dk809Wrongful retention or removal To determine if a removal or retention of a child was wrongful under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), courts ask four questions: (1) when did the removal or retention of the child occur; (2) in what State was the child habitually resident immediately prior to the removal or retention; (3) was the removal or retention in breach of the custody rights of the petitioning parent under the law of the State of the child's habitual residence; and (4) was the petitioning parent exercising those rights at the time of the unlawful removal or retention. 22 U.S.C.A. § 9001 et seq.

Thad would ... visit Jennie every holiday and the entire summer. If bday was mid-October, then by mid-April/May, would it be summer?

122 F.Supp.3d 765
United States District Court, N.D. Illinois, Eastern Division.

Raul Salazar GARCIA, Petitioner,
v.
Emely Galvan PINELO, Respondent.

No. 14 C 09644
|
Signed August 16, 2015

Synopsis
Background: Father filed petition seeking return of son to Mexico pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA). Father moved for summary judgment.

Holdings: The District Court, Edmond E. Chang, J., held that:

[1] father was exercising his custody rights;

[2] genuine issue of material fact existed as to son's habitual residence;

[3] district court would reserve issue of whether father had rights of custody as to son;

[4] genuine issue of material fact existed as to whether father consented to son's retention in the United States; and

[5] district court would exercise its discretion in declining to apply the mature-child defense.

Motion granted in part, denied in part, and reserved in part.

Procedural Posture(s): Motion for Summary Judgment.

West Headnotes (27)

[1] **Child Custody** 🔑 International Issues

Although the federal courts normally have nothing to do with child custody issues, there is an exception for cases that arise under International Child Abduction Remedies Act (ICARA), which implements the Hague Convention on Civil Aspects of International Child Abduction. 22 U.S.C.A. § 9001 et seq.

[2] **Child Custody** 🔑 Return of child

Child Custody 🔑 Wrongful retention or removal

The Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), employs a remedy of return, which entitles a person whose child has wrongfully been removed to the United States in violation of the Convention to petition for return of the child to the child's country of habitual residence. 22 U.S.C.A. § 9001 et seq.

[3] **Child Custody** 🔑 Wrongful retention or removal

A court's role in enforcing the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), is not to settle a custody dispute between the parties, but rather to restore the status quo prior to any wrongful removal or retention; the court's task is to simply determine which country is the proper forum for that custody determination. 22 U.S.C.A. § 9001 et seq.

[4] **Child Custody** 🔑 Return of child

Child Custody 🔑 Wrongful retention or removal

The central question in any petition seeking the return of a child under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), is whether the child who is the subject of the petition has been wrongfully removed or retained within the meaning of the Convention. 22 U.S.C.A. § 9001 et seq.

[5] **Child Custody** 🔑 Wrongful retention or removal

To determine if a removal or retention of a child was wrongful under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), courts ask four questions: (1) when did the removal or retention of the child occur; (2) in what State was the child habitually resident immediately prior to the removal or retention; (3) was the removal or retention in breach of the custody rights of the petitioning parent under the law of the State of the child's habitual residence; and (4) was the petitioning parent exercising those rights at the time of the unlawful removal or retention. 22 U.S.C.A. § 9001 et seq.

[6] **Child Custody** 🔑 Wrongful retention or removal

Father was exercising his custody rights at time mother retained their son in the United States, as required to find retention was wrongful for father's petition seeking return of child to Mexico under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA); father regularly spoke to son over using social media and Internet video calling, and son visited father in Mexico for a week. 22 U.S.C.A. § 9001 et seq.

[7] **Child Custody** 🔑 Abandonment

Under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), the standard for finding that a parent was exercising his custody rights is a liberal one, and courts will generally find exercise whenever a parent with de jure custody rights keeps, or seeks to keep, any sort of regular contact with his or her child; put another way, a person cannot fail to exercise his custody rights under the Hague Convention short of acts that constitute clear and unequivocal abandonment of the child. 22 U.S.C.A. § 9001 et seq.

[8] **Child Custody** 🔑 Return of child

In a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), a court must evaluate whether the petitioner was exercising his custody rights at the time of retention. 22 U.S.C.A. § 9001 et seq.

1 Cases that cite this headnote

[9] **Child Custody** 🔑 Return of child

In a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), once a court has concluded that a parent exercised custody rights in any manner, the court should stop, completely avoiding the question whether the parent exercised the custody rights well or badly. 22 U.S.C.A. § 9001 et seq.

[10] **Child Custody** 🔑 Habitual residence

Under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), the determination of habitual residence is to be based on the everyday meaning of these words rather than on the legal meaning that a particular jurisdiction attaches to them; habitual residence is a question of fact to be decided by reference to all the circumstances of any particular case and courts must consider the unique circumstances of each case when inquiring into a child's habitual residence. 22 U.S.C.A. § 9001 et seq.

[11] **Federal Civil Procedure** 🔑 Particular Cases

Genuine issue of material fact existed as to child's habitual residence, precluding summary judgment in father's petition pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), seeking return of child to Mexico after mother allegedly wrongfully retained child in the United States. 22 U.S.C.A. § 9001 et seq.

[12] **Child Custody** ⊶ Habitual residence

For purposes of a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), habitual residence is intended to be a description of a factual state of affairs, and a child can lose its habitual attachment to a place even without a parent's consent. 22 U.S.C.A. § 9001 et seq.

[13] **Child Custody** ⊶ Habitual residence

Ultimately, the question of habitual residence in a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), is whether courts can say with confidence that the child's relative attachments to the two countries have changed to the point where requiring return to the original forum would now be tantamount to taking the child out of the family and social environment which its life has developed. 22 U.S.C.A. § 9001 et seq.

[14] **Child Custody** ⊶ Return of child

Child Custody ⊶ Wrongful retention or removal

For purposes of a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), a parent cannot create a new habitual residence by the wrongful removal and sequestering of a child, but where the parent's initial removal of the child was not wrongful, a court can give weight to the duration of the child's residence in the United States. 22 U.S.C.A. § 9001 et seq.

[15] **Child Custody** ⊶ Wrongful retention or removal

A removal or retention is only wrongful under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), if it is in violation of the rights of custody of the petitioning parent. 22 U.S.C.A. § 9001 et seq.

[16] **Child Custody** ⊶ Return of child

There is no return remedy under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), for a violation of a petitioner's rights of access to a child. 22 U.S.C.A. § 9001 et seq.

1 Cases that cite this headnote

[17] **Child Custody** ⊶ Proceedings in general

On motion for summary judgment in father's petition under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), seeking return of his son to Mexico after mother allegedly wrongfully retained son in the United States, district court would reserve issue of whether father had rights of custody as to son; Mexican law potentially governed father's parental rights, a custody order existed between the parents, and an English translation was necessary to determine if order extinguished father's rights of patria potestas. 22 U.S.C.A. § 9001 et seq.

[18] **Child Custody** ⊶ Return of child

Child Custody ⊶ Wrongful retention or removal

A court's determination that a child was wrongfully removed or retained does not automatically result in the return of the child to his or her habitual residence under the Hague

Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA). 22 U.S.C.A. § 9001 et seq.

[19] **Child Custody** 🔑 Acquiescence to removal

Child Custody 🔑 Return of child

Consent and acquiescence are separate defenses to a petition seeking return of a child pursuant to the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA). 22 U.S.C.A. § 9001 et seq.

1 Cases that cite this headnote

[20] **Child Custody** 🔑 Acquiescence to removal

Child Custody 🔑 Wrongful retention or removal

Under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), the consent exception to return of a wrongfully removed or retained child applies when a petitioning parent, either expressly or through his conduct, agrees to a removal or retention before it takes place; a parent's consent need not be formal, but it is important to consider what the petitioner actually contemplated and agreed to in allowing the child to travel outside its home country. 22 U.S.C.A. § 9001 et seq.

[21] **Child Custody** 🔑 Acquiescence to removal

Under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), acquiescence, as a defense to return of a wrongfully removed or rained child, is more formal than consent and might require evidence such as testimony in a judicial proceeding, a convincing written renunciation of rights, or a consistent attitude of acquiescence over a significant period of time. 22 U.S.C.A. § 9001 et seq.

[22] **Federal Civil Procedure** 🔑 Particular Cases

Genuine issue of material fact existed as to whether father consented to son's retention in the United States, precluding summary judgment in father's petition under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), seeking return of son after mother allegedly wrongfully retained child. 22 U.S.C.A. § 9001 et seq.

[23] **Child Custody** 🔑 Return of child

Although the objection of a mature child can form the basis of a court's decision not to return a child under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), a court must apply a stricter standard in considering a child's wishes when those wishes are the sole reason underlying a repatriation decision and not part of some broader analysis; even if the court determines that the exception applies, it can nonetheless order return of the child if return would further the aims of the Convention. 22 U.S.C.A. § 9001 et seq.

[24] **Child Custody** 🔑 Grounds and factors in general

But even if a child objects to returning, and even if the child is of an age and degree of maturity at which it is appropriate to consider his views, the child's objection to being returned may be accorded little if any weight in proceedings under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), if the court believes that the child's preference is the product of the abductor parent's undue influence over the child. 22 U.S.C.A. § 9001 et seq.

[25] **Child Custody** 🔑 Grounds and factors in general

Assuming mother wrongfully retained son in the United States and that mature-child defense to return was established, district court would exercise its discretion in declining to apply the exception in father's petition under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), seeking return of the child to Mexico; son's objection to return was premised on concern about his or his mother's ability to travel to and from Mexico. 22 U.S.C.A. § 9001 et seq.

[26] **Child Custody** 🔑 Defenses

Equitable defenses, such as waiver, estoppel, laches, ratification, and unclean hands, do not apply in proceedings seeking return of a child under the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA). 22 U.S.C.A. § 9001 et seq.

[27] **Child Custody** 🔑 Habitual residence

Child Custody 🔑 Return of child

The language of the Hague Convention on Civil Aspects of International Child Abduction, as implemented by the International Child Abduction Remedies Act (ICARA), is focused on returning a wrongfully removed or retained child to the habitual residence so that State can decide the custody dispute; it is not a determination of the merits of the custody dispute. 22 U.S.C.A. § 9001 et seq.

Attorneys and Law Firms

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***770** Soledad O'Donnell, Joseph M. Callaghan, Marc Richard Kadish, Mayer Brown LLP, Sean Michael Hamann, Lake Toback, Chicago, IL, for Respondent.

MEMORANDUM OPINION AND ORDER

Honorable Edmond E. Chang, United States District Judge

Petitioner Raul Salazar Garcia, a resident of Mexico, filed this petition against Respondent Emely Galvan Pinelo, a resident of Chicago, for return of the parties' minor son, D.S., to Mexico.[1] R. 30, Am. Petition. The parents, who were never married, agreed to allow D.S. to attend school in Chicago for one school year (though they disagree as to the scope of that agreement, as detailed later). But after that year, the parents disagreed as to whether D.S. would remain in Chicago or return to Mexico. In July 2014, Galvan refused to allow D.S. to travel back to Mexico with Salazar. Salazar then filed this petition for wrongful retention under the Hague Convention on Civil Aspects of International Child Abduction, Oct. 25, 1980, T.I.A.S. No. 11670, 1343 U.N.T.S. 89, and its implementing legislation, the International Child Abduction Remedies Act (ICARA), 22 U.S.C. § 9001 *et seq.*[2]

Salazar has moved for summary judgment on his petition. R. 54, Mot. Summ. J. For the reasons discussed below, Petitioner's motion is granted in part, denied in part, and reserved in part. An evidentiary hearing—basically, a bench trial—is needed on one narrow factual issue, described more fully below. As discussed when setting the briefing schedule on this motion, the hearing will be held on Friday, August 21, 2015 at 10:15 a.m. R. 53, July 6, 2015 Minute Entry. There is also one open legal issue that requires a translation of the custody order from Nuevo Leon, Mexico. *See* R. 69, Aug. 13, 2015 Minute Entry. The Court will decide that issue in its final opinion on the merits of the petition after the bench trial.[3]

I. Background

In deciding summary judgment, the Court views the evidence in the light most favorable to the non-movant, Galvan. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). Salazar and Galvan are the parents of D.S., who was born in Monterrey, Nuevo Leon, Mexico, in October 2002. R. 55, Pet.'s SOF ¶ 3.[4] Salazar and Galvan were never married. R. 49, Salazar Dep. at 19:3–4. In 2006, a court in Monterrey, Nuevo Leon entered a custody order concerning D.S. Pet.'s SOF ¶ 7; R.

30–1, Pet.'s Exh. B, Nuevo Leon Order (Spanish-language version). That order gave Galvan physical custody of D.S. and provided Salazar with weekly visitation. Salazar Dep. at 19:13–20:10. Aside from a few instances every year when Salazar was traveling for work, he visited D.S. in accordance with the custody order. Pet.'s SOF ¶ 8; *see also* Salazar Dep. at 24:1–7 ("Q. Was there ever a Wednesday night or a Sunday on which travel for work prevented you from seeing [D.S.]? A. Well, it actually happened only maybe once or twice a year."). For most of his childhood, ***771** D.S. lived in Monterrey with his mother. Pet.'s SOF ¶ 4.

In late 2012, Galvan asked Salazar to help her get a passport and visa for D.S. to travel to the United States. R. 50, Galvan Dep. at 13:13–18:1; Salazar Dep. 32:3–21. At the time, Galvan wanted to go to Texas to visit relatives and to take D.S. to Disney World or Disneyland. Galvan Dep. at 20:9–16. She told Salazar about her travel plans. *Id.*; Salazar Dep. at 32:3–14; Pet.'s SOF ¶¶ 10–12. At some point after the parties secured D.S.'s travel documents, Galvan decided that she wanted to move to the United States with D.S. Galvan Dep. at 20:21–21:14. On July 30, 2013, Galvan and D.S. met with Salazar in a Monterrey Starbucks to discuss the move.[5] *Id.* at 21:24–23:7; Salazar Dep. at 35:3–9; Pet.'s SOF ¶ 14. At this meeting, Salazar and Galvan agreed that D.S. would live with his mother in Chicago for one school year. Pet.'s SOF ¶¶ 5, 15; R. 65, Resp.'s Resp. Pet.'s SOF ¶ 15. But the parties now dispute the scope of the agreement, specifically on the issue of what would happen after the school year was over. Pet.'s SOF ¶¶ 5, 15; Resp.'s Resp. Pet.'s SOF ¶ 15. Salazar believes that the parties agreed to let D.S. himself decide where D.S. wanted to live after the school year was up. Salazar Dep. at 35:14–36:7, 37:5–9. D.S. testified that his parents agreed to let him decide where to live at the end of the school year. R. 52, First In–Camera Hrg. Tr. at 5:9–7:21. In contrast to Salazar's and D.S.'s version, Galvan argues that they did not agree to simply leave it up to D.S. to decide: specifically, Galvan believes that they agreed that D.S. would live in Chicago for the school year and then, at the end of the year, they would discuss whether D.S. would stay in Chicago. Galvan Dep. at 26:23–27:9 ("Q. And if [D.S.] wanted to go back, what was going to happen? A. We were going to talk about it. Q. And if [D.S.] wanted to stay here, what was going to happen? A. We would talk about it."); Resp.'s Resp. Pet.'s SOF ¶ 15.

On August 15, 2013, Galvan and D.S. moved to Chicago, and D.S. enrolled in school here. Resp.'s Resp. Pet.'s SOF ¶ 5. To keep in touch with his father, D.S. set up a Skype account. Galvan Dep. at 36:6–14. Salazar and D.S. would often communicate through Skype and Facebook. *Id.* at 36:12–19, 45:2–10; Salazar Dep. at 39:18–23, 42:17–43:1, 47:4–13, 52:10–17. And for Christmas 2013, D.S. returned to Mexico for more than one week to spend the holiday with his father. Galvan Dep. at 35:16–36:5. During D.S.'s conversations with his father over the course of the year, D.S. expressed that he wanted to return to Mexico. Salazar Dep. at 39:8–23, 41:15–43:1; First In–Camera Hrg. Tr. at 10:24–13:11. At the same time, D.S. was telling his mother that he wanted to stay in Chicago. First In–Camera Hrg. Tr. at 13:12–14:1; Salazar Dep. at 41:15–23.

At the end of the school year (in around July 2014), Salazar came to Chicago to see D.S. Pet.'s SOF ¶ 16. In light of the content of the conversations with his son throughout the school year, Salazar was prepared to take D.S. back to Mexico with him and had a plane ticket for D.S. *Id.* Neither Salazar nor D.S. had told Galvan of their plan to return to Mexico; she believed that Salazar was just in Chicago to visit D.S. Galvan Dep. at 36:20–37:9; Salazar Dep. at 41:15–23; First In–Camera Hrg. Tr. at 13:12–14:1. Salazar and D.S. spent several days together sightseeing in Chicago. Salazar Dep. at 38:11–39:2. On July 21, 2014, Salazar, Galvan, ***772** and D.S. met in another coffee shop (yet again, a Starbucks) to discuss where D.S. was going to live. Pet.'s SOF ¶ 17. It was at that time that D.S. told his mother that he wanted to return to Mexico. *Id.* ¶ 18. Perhaps because D.S. had been telling her that he wanted to stay in Chicago, Galvan did not believe that D.S. truly wanted to return to Mexico. Galvan Dep. at 41:16–42:11. She thought D.S.'s father had influenced the child's decision. *Id.* The parents' accounts of what happened next differ, but they agree that it ended with D.S. leaving the coffee shop with Salazar, but then the Chicago police eventually instructed Salazar to return D.S. to Galvan's home. Galvan Dep. at 48:16–21, 51:23–52:23; Salazar Dep. at 44:1–46:12.

After this meeting, Salazar returned to Mexico without D.S. He immediately submitted his petition for return of the child to the Mexican Central Authority. Am. Petition ¶ 23. The petition was transmitted to the United States Department of State, and this petition was filed on December 2, 2014. R. 1, Petition. A guardian *ad litem* was appointed to represent the interests of D.S.[6] R. 25, Feb. 18, 2015 Minute Entry. Initially, D.S. did not want to express a preference as to where he would live. *See* R. 65–7, Guardian Report at 1–2. In late April 2015,[7] however, D.S. changed his mind: he told his guardian that he wanted to stay in the United States. *Id.* at 2–3.

After D.S. decided that he wanted to express a preference, the Court conducted an in-camera hearing with D.S.[8] *See generally* R. 52, First In–Camera Hrg. Tr. At that hearing, D.S. told the Court that he wanted to stay in Chicago because it had better schools and more opportunities than Monterrey, it was safer than Mexico, and he did not want his mom to have to pay his dad's court costs and fees. *Id.* at 23:3–25:10. D.S. wanted to finish eighth grade in the United States and then, if he did not get into a good high school, possibly return to Mexico. *Id.* at 27:9–20. Although he said that he would miss his mother, baby sister (Galvan's child with her husband, so D.S.'s half-sister), and friends if he had to return to Mexico, D.S. said that he did not object to going back. *Id.* at 30:18–32:17.

During the course of summary-judgment briefing, Galvan's counsel asked the Court to hold a second in-camera hearing with the child. R. 58, Resp.'s Emergency Mot. The second hearing was prompted by immigration-law advice: Galvan's attorney had secured an immigration lawyer for Galvan and D.S., and the immigration lawyer had given Galvan information about her immigration status that counsel believed would change D.S.'s mind (and his testimony). *Id.* at 2–3. The Court ordered that the immigration lawyer should meet with D.S. and his guardian *ad litem* to communicate the new information to D.S. R. 60, Aug. 5, 2015 Minute Entry. ***773** Over Salazar's objection, the Court decided to hold a second in-camera hearing with the child. *Id.* In that hearing, D.S. told the Court that he now objected to returning to Mexico. R. 62, Second In–Camera Hrg. Tr. at 12:16–25. D.S. gave several reasons for his objection, R. 65–11, D.S. Pros and Cons List, but he told the Court that, if his mother could freely travel between the United States and Mexico, he would no longer object, Second In Camera Hrg. Tr. at 16:7–17:5 ("Q. And let's assume ... [that Galvan] could have a green card in six months and she could travel back and forth so that she could visit Mexico.... [W]ould that change your mind about objecting to being ordered to return to Mexico to live there? ... A. Yeah, it would probably change my mind about going back.").

II. Legal Standard

Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(a). A genuine dispute exists if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). In evaluating summary judgment motions, courts must view the facts and draw reasonable inferences in the light most favorable to the non-moving party. *Scott v. Harris,* 550 U.S. 372, 378, 127 S.Ct. 1769, 167 L.Ed.2d 686 (2007). The Court may not weigh conflicting evidence or make credibility determinations, *Omnicare, Inc. v. UnitedHealth Grp., Inc.,* 629 F.3d 697, 704 (7th Cir.2011), and must consider only evidence that can "be presented in a form that would be admissible in evidence" at trial, Fed.R.Civ.P. 56(c)(2). The party seeking summary judgment has the initial burden of showing that there is no genuine dispute and that they are entitled to judgment as a matter of law. *Carmichael v. Village of Palatine,* 605 F.3d 451, 460 (7th Cir.2010); *see also Celotex Corp. v. Catrett,* 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986); *Wheeler v. Lawson,* 539 F.3d 629, 634 (7th Cir.2008). If this burden is met, the adverse party must then "set forth specific facts showing that there is a genuine issue for trial." *Anderson,* 477 U.S. at 256, 106 S.Ct. 2505.

III. Analysis

[1] **[2]** **[3]** "Although the federal courts normally have nothing to do with child custody issues, there is an exception for cases that arise under [ICARA], which implements the Hague Convention." *Norinder v. Fuentes,* 657 F.3d 526, 529 (7th Cir.2011). "The Hague Convention is an anti-abduction treaty." *Redmond v. Redmond,* 724 F.3d 729, 739 (7th Cir.2013). Its purpose is "to secure the prompt return of children wrongfully removed or retained in another signatory State."[9] *Id.* (quoting Hague Convention art. 1) (internal quotation marks omitted). "To this end, the Convention employs a remedy of return, which entitles a person whose child has wrongfully been removed to the United States in violation of the Convention to petition for return of the child to the child's country of habitual residence." *Ortiz v. Martinez,* 789 F.3d 722, 728 (7th Cir.2015) (internal quotation marks and citations omitted). "A court's role in enforcing the Convention is not to settle a custody dispute between the parties, but rather to restore the status quo prior to any wrongful removal or retention." *Id.* (internal quotation marks omitted). "The court's task is to simply determine which ***774** country is the proper forum for that custody determination." *Koch v. Koch,* 450 F.3d 703, 711 (7th Cir.2006).

[4] "The central question in any petition seeking the return of a child under the Hague Convention and ICARA is whether the child who is the subject of the petition has been 'wrongfully' removed or retained within the meaning of the Convention." *Redmond,* 724 F.3d at 737. Under the Convention, a removal or retention is wrongful where (a) "it is in breach of rights of custody attributed to a person, an institution[,] or any other body, either jointly or alone, under the law of the State in which the child was habitually resident immediately before the removal or retention"; and (b) "at the time of removal or retention[,] those rights were actually exercised, either jointly or alone, or would have been so exercised but for the removal or retention." Hague Convention art. 3.

[5] Interpreting this language, courts have established a series of four questions to determine if a removal or retention was wrongful: "(1) When did the removal or retention of the child occur? (2) In what State was the child habitually resident immediately prior to the removal or retention? (3) Was the removal or retention in breach of the custody rights of the petitioning parent under the law of the State of the child's habitual residence? and (4) Was the petitioning parent exercising those rights at the time of the unlawful removal or retention?" *Redmond,* 724 F.3d at 737–38 (citing *Karkkainen v. Kovalchuk,* 445 F.3d 280, 287 (3d Cir.2006); *Mozes v. Mozes,* 239 F.3d 1067, 1070 (9th Cir.2001)). The first two questions are questions of fact, and the last two questions involve "both legal and factual inquiries regarding the left-behind parent's custody rights under the law of the State of the child's habitual residence and whether the parent was actually exercising those rights." *Id.* at 738. The burden is on the petitioner to establish by a preponderance of the evidence that the removal or retention was wrongful. 22 U.S.C. § 9003(e)(1). If the wrongful removal or retention is established (as determined by the answers to the four questions), then the burden shifts to the respondent to establish that a defense applies. *Bader v. Kramer*, 484 F.3d 666, 668 (4th Cir.2007) ("Upon a showing of wrongful removal, return of the child is required unless the respondent establishes one of four defenses."); *see also* 22 U.S.C. § 9003(e)(2) ("[A] respondent who opposes the return of the child has the burden of establishing ... by a preponderance of the evidence that any other exception set forth in article 12 or 13 of the Convention applies.").

A. Wrongful Retention

To give the parties maximum guidance for the fast-approaching evidentiary hearing, and to narrow the scope of the hearing so that the parties can focus only what remains in the case, this Opinion will explain which specific elements of the claim and the defenses remain open for the evidentiary hearing. Based on the undisputed facts in the record, Petitioner has established, as a matter of law, two elements of his *prima facie* case for wrongful retention. [10] The first question is when the retention occurred. *Redmond,* 724 F.3d at 737–38. Although Galvan disputes that her retention was wrongful at all, the parties agree that, *if* there indeed was a wrongful retention, it occurred on July 21, 2014. Pet.'s SOF ¶¶ 5–6; Resp.'s Resp. Pet.'s SOF ¶¶ 5–6. The Court will therefore ***775** use this date in evaluating the remaining elements of the prima facie case and defenses. *Redmond,* 724 F.3d at 737–38 (instructing courts to evaluate the child's habitual residence and custody rights at the time of removal or retention).

[6] **[7]** **[8]** **[9]** The undisputed evidence also shows that Salazar was exercising his custody rights at the time of the retention (again, the scope of the custody rights is an open legal issue, as explained later in this Opinion). Although the Hague Convention does not define "exercise," American courts have largely agreed on the standard to be used: "[t]he standard for finding that a parent was exercising his custody rights is a liberal one, and courts will generally find exercise whenever 'a parent with *de jure* custody rights keeps, or seeks to keep, any sort of regular contact with his or her child.' " *Walker v. Walker,* 701 F.3d 1110, 1121 (7th Cir.2012) (quoting *Bader,* 484 F.3d at 671). Put another way, "a person cannot fail to 'exercise' his custody rights under the Hague Convention short of acts that constitute clear and unequivocal abandonment of the child." *Id.* (quoting *Friedrich v. Friedrich,* 78 F.3d 1060, 1066 (6th Cir.1996)) (internal alterations omitted). The court must evaluate whether the petitioner was exercising his custody rights *at the time of retention. Id.* at 1122 (noting that "failure to provide support *after* the retention is irrelevant to whether [the petitioner] was exercising his custody rights when the wrongful retention began"). Once a court has concluded that "the parent exercised custody rights in any manner, the court should stop—completely avoiding the question whether the parent exercised the custody rights well or badly." *Bader,* 484 F.3d at 671 (quoting *Friedrich,* 78 F.3d at 1066).

Here, Salazar testified that he spoke regularly to D.S. over Skype and Facebook while the child was living with his mother in the United States. Salazar Dep. at 39:18–23, 42:17–43:1, 47:4–13, 52:10–17. Galvan did not contradict this testimony and agreed that D.S. communicated with his father throughout the school year. Galvan Dep. at 36:12–19, 45:2–10. D.S. also visited his father for more than a week in the year before the allegedly wrongful retention occurred. *Id.* at 35:16–36:5. This evidence is more than sufficient to show that, at the time of retention, Salazar was exercising his custody rights.[11] *Walker,* 701 F.3d at 1121 ("[C]ourts will generally find exercise whenever 'a parent with *de jure* custody rights keeps, or seeks to keep, any sort of regular contact with his or her child.' "). The Court does not need to decide whether Salazar was exercising these rights well or badly, and there is certainly no evidence in the record that demonstrates "clear and unequivocal abandonment of the child." *Id.*; *Bader,* 484 F.3d at 671. Based on the undisputed evidence in the record, Salazar was exercising his custody rights before the retention in July 2014.

Moving on, to show that Galvan's retention of D.S. in the United States was "wrongful," Salazar must demonstrate that keeping D.S. in Chicago was "in breach of rights of custody attributed to" Salazar "under the law of the State in which the child was habitually resident immediately before the removal or retention." Hague Convention art. 3. To do so, Salazar must establish (1) where D.S.'s habitual residence was at the time of the retention and (2) that he had rights of custody under the laws of that State. *Redmond,* 724 F.3d at 737–38. Salazar argues that D.S.'s habitual ***776** residence was Mexico, and that Salazar had custody rights under the Mexican legal concept of *patria potestad.* Pet.'s Br. at 3–6. For the reasons discussed below, Salazar is not entitled to summary judgment on the habitual-residence element, because there is a genuine issue of material fact, and the Court will put-off, for now, deciding the custody-rights issue because a translation of the custody order is needed.

1. Habitual Residence

[10] To determine if a removal or retention was wrongful, the Court must determine the "habitual residence" of the child immediately before the removal or retention. *Redmond,* 724 F.3d at 737–38. "The determination of 'habitual residence' is to be based on the everyday meaning of these words rather than on the legal meaning that a particular jurisdiction attaches to them." *Altamiranda Vale v. Avila,* 538 F.3d 581, 583 (7th Cir.2008); *accord Kijowska v. Haines,* 463 F.3d 583, 585 (7th Cir.2006) (noting that "otherwise forum shopping would come in by the back door"); *Koch,* 450 F.3d at 712. Habitual residence is a "question of fact to be decided by reference to all the circumstances of any particular case." *Koch,* 450 F.3d at 712 (internal alterations and quotation marks omitted). "[C]ourts must consider the unique circumstances of each case when inquiring into a child's habitual residence." *Id.* at 716.

In evaluating "habitual residence" under the Hague Convention, the Seventh Circuit has adopted the approach developed by the Ninth Circuit in *Mozes v. Mozes,* 239 F.3d 1067 (9th Cir.2001). *See Redmond,* 724 F.3d at 745 ("We too have 'adopted a version of the analysis set out by the Ninth Circuit in *Mozes*.' "); *Koch,* 450 F.3d at 715. Under the *Mozes* approach, "the first step toward acquiring a new habitual residence is forming a settled intention to abandon the one left behind. Otherwise, one is not habitually residing; one is away for a temporary absence of long or short duration." *Mozes,* 239 F.3d at 1075 (noting that settled intention can "coalesce during the course of a stay abroad originally intended to be temporary"). The question, then, is whether the parents "shared an intent to abandon the prior habitual residence." *Koch,* 450 F.3d at 715; *Walker,* 701 F.3d at 1119 ("In a case alleging wrongful retention, we determine a child's habitual residence by asking whether a prior place of residence was effectively abandoned and a new residence established by the shared actions and intent of the parents coupled with the passage of time.") (internal alterations and quotation marks omitted). Recognizing that once a Hague Convention petition is filed, "the parents no longer share an intent on the child's habitual residence," the Seventh Circuit instructs that "the representations of the parties likely cannot be accepted at face value." *Koch,* 450 F.3d at 713. The Court must evaluate "the parents' actions as well as what they say." *Norinder,* 657 F.3d at 534. Ultimately, "the habitual-residence inquiry remains a flexible one, sensitive to the unique circumstances of the case and informed by common sense." *Redmond,* 724 F.3d at 744.

Even a temporary move can effectuate a change of a child's habitual residence. *Koch,* 450 F.3d at 715–16. To illustrate this principle, the Seventh Circuit describes three types of cases as separate points across a spectrum. On one end are "families which jointly take all the steps associated with abandoning habitual residence in one country to take it up in another." *Id.* at 713. In these cases, "courts would generally be unwilling to let one parent's reservations about the move stand in the way of finding a shared and settled purpose." *Id.* At the other end of the spectrum are the cases "where the child's initial move from an established residence was clearly intended to be of a ***777** specific, delimited period." *Id.* In cases like these, "courts have generally refused to allow the changed intentions of one parent to alter the habitual residence." *Id.*

And somewhere in the middle lies the cases "where the petitioning parent earlier consented to let the child stay abroad for some period of ambiguous duration." *Id.* "In these cases, the circumstances surrounding the child's stay may sometimes suggest that, despite the lack of perfect consensus, the parents intended the stay to be indefinite, leading to an abandonment of the prior habitual residence." *Id.* And "[i]n other cases, the circumstances might suggest that there was no settled mutual intent to abandon the prior habitual residence." *Id.*

For example, the shared wish of a child's parents to return to the United States "someday" after moving to Germany was not sufficient to make the United States their child's habitual residence. *Koch,* 450 F.3d at 715–16 ("[H]abitual residence is not determined 'by wishful thinking alone.' "). The parents shared a settled intention to "move [to Germany] for an indeterminate period of time," therefore making Germany their (and thus their child's) habitual residence notwithstanding their hope to return to the United States when they met certain financial conditions. *Id.* Similarly, in *Whiting v. Krassner,* 391 F.3d 540 (3d Cir.2004), the parents agreed that the child (an infant) would live with her mother in Canada after September 11, 2001. *Id.* at 542; *see also Koch,* 450 F.3d at 715–16 (discussing *Whiting*). They also agreed that she would return to the United States two years later so long as there was no imminent threat of terrorist attacks and the child's mother was allowed to work in the United States. *Whiting,* 391 F.3d at 542. After the father removed the infant to the United States, the mother filed a Hague petition. *Id.* at 543. In evaluating the petition, the court concluded that the child's habitual residence was in Canada. *Id.* at 549–50. Despite intentions to eventually return to the United States, the parents shared "an intent to abandon New York for a definite and extended period in the life of [the] infant." *Id.* at 550. "[T]he intent to abandon[ ] need not be forever." *Id.*

[11] In evaluating habitual residence, then, the intent of the child's parents is critical. Salazar and Galvan disagree as to what their intent was when D.S. moved with Galvan to Chicago. Salazar and D.S. believe that D.S. alone would decide whether he would return to Mexico when the school year was over. *See* Salazar Dep. at 35:14–36:7, 37:5–9; First In–Camera Hrg. Tr. at 5:9–7:21. Galvan, however, thought that the agreement was much more open-ended. She believed that, at the end of the year, Salazar, Galvan, and D.S. would all discuss what D.S.'s preference was and whether D.S. would stay in Chicago or not. *See* Galvan Dep. at 26:23–27:9. Because the determination of habitual residence is fact-intensive, and on summary-judgment review the evidence must be viewed in the non-movant's favor, the issue cannot be resolved as a matter of law on this record. The Court must evaluate the testimony of the parties to determine the nature of their agreement, their shared intent (if there was one) when D.S. moved to Chicago, and the circumstances surrounding the decision to move. *Koch,* 450 F.3d at 713–14 ("[T]he circumstances surrounding the child's stay may sometimes suggest that, despite the lack of perfect consensus, the parents intended the stay to be indefinite, leading to an abandonment of the prior habitual residence.").

[12] **[13]** **[14]** The intent of the parents is not the only question. "[H]abitual residence is intended to be a description of a factual state of affairs, and a child *can* lose its habitual attachment to a place even without a parent's consent." *Koch,* 450 F.3d at 717 (quotation and citation omitted) (emphasis ***778** in original). Ultimately, the question is "whether we can say with confidence that the child's relative attachments to the two countries have changed to the point where requiring return to the original forum would now be tantamount to taking the child out of the family and social environment which its life has developed." *Id.* (internal quotation marks omitted). Of course, "[a] parent cannot create a new habitual residence by the wrongful removal and sequestering of [the] child." *Kijowska,* 463 F.3d at 587 (internal alterations and quotation marks omitted). But where the parent's initial removal of the child was not wrongful, the Court can give weight to the duration of the child's residence in the United States. *Redmond,* 724 F.3d at 743; *Koch,* 450 F.3d at 717 ("[A]fter some period of time in the new environment, the habitual residence of the children will change regardless of the parents' hopes to someday return to the prior residence."). The parties agree that Galvan's initial removal of D.S. was not wrongful, as Salazar initially consented to D.S. staying in Chicago for one school year. Pet.'s SOF ¶ 5. So D.S.'s attachment to the United States developed in that first period of time (that is, the school year from 2013 to 2014) can be considered in determining his habitual residence at the time of the retention. *Redmond,* 724 F.3d at 743. D.S.'s level of attachment to the United States at that point is also a question of fact, and the parties should be prepared to present evidence on this issue at the evidentiary hearing.

To streamline the evidentiary hearing, it is important to clarify the narrow factual issues on which the parties should present evidence. The first issue is the intent of the parties at the moment in time when they agreed that D.S. would move to the United States with Galvan. This might include testimony from the parties [12] on what the agreement between the parties actually was and evidence of any actions that the parties took that might shed light on their intent. The second issue is whether D.S.'s stay in the United States before the allegedly wrongful retention effectively changed his habitual residence.

What is *not* at issue is D.S.'s actual preference in July 2014. The parties spend some time in their briefs discussing whether D.S. *actually* wanted to return to Mexico at the end of the school year or whether he was subject to Salazar's influence. Even if D.S.'s preference were relevant to the habitual-residence analysis, there is no genuine dispute of material fact on this issue. D.S. testified that, before the July 2014 meeting in Chicago, he told his father that he wanted to return to Mexico and told his mother that he wanted to stay in Chicago. First In Camera Hrg. Tr. at 10:24–14:1. This is consistent with his parents' testimony—Salazar believed that D.S. wanted to return to Mexico, and Galvan believed that he wanted to stay. Salazar Dep. at 39:8–23, 41:15–43:1, 46:21–47:23; Galvan Dep. at 49:6–50:1. D.S. also testified that he *actually* wanted to return to Mexico at that time, and that he was only telling his mother that he wanted to stay in the United States so that she would not stop Salazar from arranging to bring D.S. back to Mexico. First In Camera Hrg. Tr. at 10:24–16:8. Whether that decision was the product of Salazar's influence or not, [13] there is no dispute as to what D.S. ***779** actually wanted at the time. Because there is no genuine dispute on this fact, the parties should not present any evidence or testimony at the evidentiary hearing about D.S.'s actual preference at the July 2014 meeting.

2. Rights of Custody

[15] **[16]** A removal or retention is only "wrongful" under the Hague Convention if it is in violation of the "rights of custody" of the petitioning parent. *Abbott v. Abbott,* 560 U.S. 1, 9, 130 S.Ct. 1983, 176 L.Ed.2d 789 (2010). The Convention defines "rights of custody" to "include rights relating to the care of the person of the child and, in particular, the right to determine the child's place of residence." *Id.* (quoting Hague Convention art. 5(a)). These rights can "arise ... by operation of law or by reason of a judicial or administrative decision, or by reason of an agreement having legal effect under the law of" the country of the child's habitual residence. Hague Convention art. 3; *see also Abbott,* 560 U.S. at 10, 130 S.Ct. 1983; *Altamiranda,* 538 F.3d at 586. Rights of custody are separate from "rights of access," which "include the right to take a child for a limited period of time to a place other than the child's habitual residence." Hague Convention art. 5(b). If a removal or retention is in violation of the petitioner's rights of custody, "the country to which the child has been brought must 'order the return of the child forthwith,' unless certain exceptions apply." *Abbott,* 560 U.S. at 9, 130 S.Ct. 1983 (quoting Hague Convention art. 4, 12). But—and this is important for this case—there is no return remedy under the Convention for a violation of a petitioner's rights of *access. Id.*; *see also Redmond,* 724 F.3d at 741.

[17] Assuming that Salazar is correct that Mexico was D.S.'s habitual residence at the time of the retention, Mexican law would govern the content of Salazar's parental rights. *Altamiranda,* 538 F.3d at 583. Salazar argues that, as D.S.'s biological father, he has *patria potestad* (also called *patria potestas*) rights of custody under Mexican law. R. 56, Pet.'s Br. at 4–5. *Patria potestas* is a concept from ancient Roman law that "denoted the father's absolute right (including the right of life and death) over his wife, children, and other subordinate family members." *Altamiranda,* 538 F.3d at 584. "Much modified, it survives as a legal doctrine in civil law countries." *Id.* Under Mexican civil law, *patria potestas* is "the joint exercise of parental authority" that encompasses "the comprehensive physical, mental, moral[,] and social protection of the minor child." *Whallon v. Lynn,* 230 F.3d 450, 456–57 (1st Cir.2000); *Fernandez–Trejo v. Alvarez–Hernandez,* 2012 WL 6106418, at *2 (M.D.Fla. Dec. 10, 2012). Under the Civil Code of Nuevo Leon, *patria potestas* "is exerted jointly by both parents." Código Civil de Nuevo León (Civil Code of Nuevo Leon) art. 414 (attached as R. 30–2, Exh. F to Salazar's Amended Petition). "When the parents of a child born out of wedlock ... separate, they will both retain parental authority/responsibility (*patria potestas*) but they will agree on which one is to have custody of the child." *Id.* art. 417. Even though *patria potestas* is distinct from physical custody, *see id.* art. 415 bis, 417; *Whallon,* 230 F.3d at 457, courts agree that a parent with *patria potestas* has "rights of custody" as defined by the Hague Convention, *see, e.g., Altamiranda,* 538 F.3d at 586–87 (Venezuelan law); *Whallon,* 230 F.3d at 458 (Mexican law); *see also Gatica v. Martinez,* 2010 WL 6744790, at *5–6 (S.D.Fla. Oct. 13, 2010) (citing cases).

But "*patria potestas* is a default doctrine and hence does not override rights conferred by a valid custody agreement between the parents." *Altamiranda,* 538 F.3d at 587 (citing *Gonzalez v. Gutierrez,* 311 F.3d 942, 954 (9th Cir.2002), *abrogated* ***780** *on other grounds by Abbott,* 560 U.S. at 22, 130 S.Ct. 1983); *Gonzalez v. Preston,* 107 F.Supp.3d 1226, 1234, 2015 WL 2402659, at *6 (M.D.Ala. May

20, 2015) ("In the case of parental separation, the civil code provides that *patria potestas* rights and obligations continue, though parents mutually may alter these terms by agreement."); *see also* Civil Code of Nuevo Leon art. 443–448. Salazar acknowledges that *patria potestas* rights can be terminated by a court order, *see* Pet.'s Br. at 5, and Galvan argues that the custody order between the parties did just that, *see* R. 66, Resp.'s Br. at 4–5. Indeed, some courts have found that a custody order or divorce decree extinguishes a parent's *patria potestas* rights (and also his custody rights). *See* *Gonzalez,* 311 F.3d at 954 (holding that "the parties ha[d] executed a formal, legal custody agreement, thus eliminating any basis for relying on *patria potestas*"); *Ibarra v. Quintanilla,* 476 F.Supp.2d 630, (S.D.Tex.2007) (holding that, even though the divorce decree said that both parents would "continue executing their parental authority" over the child, the petitioning parent's *patria potestas* rights were extinguished by the divorce decree and he did not have rights of custody over the child). Other courts, however, have held that a custody order or divorce decree that expressly incorporates or preserves *patria potestas* rights affords parents the relevant rights of custody under the Convention. *See* *Altamiranda,* 538 F.3d at 587 (holding that a divorce decree that expressly preserved the right of *patria potestas* for both parents did not extinguish the father's rights of custody); *Gatica,* 2010 WL 6744790 at *5–6 (holding that a custody order that expressly incorporated and bestowed *patria potestas* rights on the petitioner could be invoked to create a right of custody); *Lieberman v. Tabachnik,* 625 F.Supp.2d 1109, 1123–24 (D.Colo.2008) (holding that a divorce decree said that "both parties shall have the *paternal authority* of their minor children" preserved the petitioner's *patria potestas* rights and therefore his rights of custody).

At the very least, an English translation of the custody order is necessary to determine whether the custody order between Salazar and Galvan extinguished Salazar's rights of *patria potestas.* Moreover, even if the custody order does extinguish Salazar's *patria potestas* rights, it might nevertheless have retained for him *other* rights of custody that would be recognizable under the Hague Convention. *See* *Whallon,* 230 F.3d at 455 ("[T]he law of the child's habitual residence is invoked in the widest possible sense, and ... the sources from which custody rights derive are all those upon which a claim can be based within the context of the legal system concerned.") (internal quotation marks omitted). So, pursuant to the Court's order of August 13, 2015, the parties must furnish the Court with a translation of the document by a court-certified interpreter.[14] Aug. 13, 2015 Minute Entry. Although this is likely a pure legal issue on which no fact-finding is required, the Court cannot resolve the question at this time. The ***781** decision on summary judgment for this specific issue is therefore reserved, and the Court will address Salazar's rights of custody after the evidentiary hearing along with the factual issue of D.S.'s habitual residence.

B. Defenses

[18] A court's determination that a child was wrongfully removed or retained does not automatically result in the return of the child to his or her habitual residence.[15] The Hague Convention "contains several defenses that may be asserted against a prima facie case for a return order." *Redmond,* 724 F.3d at 738 n. 2; *see also* Hague Convention art. 13, 20. These exceptions must "be drawn very narrowly lest their application undermine the express purposes of the Convention." *Walker,* 701 F.3d at 1123 (citing 51 Fed.Reg. 10494, 10509 (March 29, 1986)). The parent objecting to the child's return bears the burden of proving the application of an exception by a preponderance of the evidence.[16] 22 U.S.C. § 9003(e)(2)(B). Even if an exception is proven, however, "the Article 13 exceptions are permissive: a court may order return even if it finds that the parent opposing the petition has established that one of the exceptions applies." *Walker,* 701 F.3d at 1123 (citing Hague Convention art. 13; 51 Fed.Reg. at 10509); *see also* *de Silva v. Pitts,* 481 F.3d 1279, 1286 (10th Cir.2007) ("[E]ven if a defense is established, a court still has discretion to order the return of the child if it would further the aim of the Convention which is to provide for the return of a wrongfully removed child."); *Karkkainen,* 445 F.3d at 288 ("[E]ven where a defense applies, the court has the discretion to order the child's return."); *Friedrich,* 78 F.3d at 1067 ("[A] federal court retains, and should use when appropriate, the discretion to return a child, despite the existence of a defense, if return would further the aims of the Convention.").

In her response, Galvan raises two defenses against return under the Hague Convention: (1) Salazar consented or acquiesced to D.S.'s retention in the United States; and (2) D.S. objects to return to the United States and is of sufficient age and maturity for the Court to take account of his views.[17] Resp.'s Br. at 11–14. Galvan also raises several "equitable" defenses against Salazar. *Id.* at 14–15, 130 S.Ct. 1983. The Court will address each of these defenses in turn.

1. Consent or Acquiescence

[19] **[20]** **[21]** Even if a child has been wrongfully removed or retained from his habitual residence, a court need not order return of the child if the petitioning parent "consented to or subsequently acquiesced in the removal or retention." Hague Convention art. 13(a). Consent and acquiescence are separate defenses. *Walker,* 701 F.3d at 1122. "The consent exception applies when a petitioning parent, either expressly or through his conduct, agrees to a ***782** removal or retention before it takes place." *Id.* "A parent's consent need not be formal, but it is important to consider what the petitioner actually contemplated and agreed to in allowing the child to travel outside its home country." *Id.* (internal quotation marks omitted). Acquiescence, on the other hand, occurs when "a petitioning parent agrees to or accepts a removal or retention after the fact." *Id.* Acquiescence is more formal and might require evidence such as "testimony in a judicial proceeding; a convincing written renunciation of rights; or a consistent attitude of acquiescence over a significant period of time." *Id.* at 1122–23 (quoting *Friedrich,* 78 F.3d at 1070). Like all exceptions under the Hague Convention, both consent and acquiescence must "be drawn very narrowly lest their application undermine the express purposes of the Convention." *Id.* at 1123.

[22] There is no record evidence that Salazar acquiesced to D.S. remaining the United States after the retention in July 2014, and Respondent does not argue that there was any acquiescence. *See* Resp.'s Br. at 11–13 (discussing only consent). When viewing the evidence in Galvan's favor, consent is a closer question. As discussed above, there is a genuine (if narrow) dispute of fact as to what the agreement between Salazar and Galvan actually was. As explained above, the factual details of the agreement and evidence of Salazar's subjective intent are necessary to determine whether he gave consent to D.S.'s continued stay in Chicago. *See Baxter v. Baxter,* 423 F.3d 363, 371–72 (3d Cir.2005) ("The nature and scope of the petitioner's consent, and any conditions or limitations, should be taken into account. The fact that a petitioner initially allows children to travel, and knows their location and how to contact them, does not necessarily constitute consent to removal or retention under the Convention."). Summary judgment is therefore denied as to this defense, and the parties must be prepared to present evidence on the nature of their agreement and Salazar's intent, as of July 2013.

2. Mature Child

[23] Under the Hague Convention, the Court can "refuse to order the return of the child if it finds that the child objects to being returned and has attained an age and degree of maturity at which it is appropriate to take account of its views." Hague Convention art. 13; *see also Abbott,* 560 U.S. at 22, 130 S.Ct. 1983 (recognizing the mature-child exception). The respondent bears the burden to establish that this defense applies by a preponderance of the evidence. *Bader,* 484 F.3d at 668. And, as with all exceptions to return under the Hague Convention, the mature-child defense must "be drawn very narrowly." *Walker,* 701 F.3d at 1123. Although the objection of a mature child can form the basis of a court's decision not to return a child, "[a] court must apply a stricter standard in considering a child's wishes when those wishes are the sole reason underlying a repatriation decision and not part of some broader analysis." *de Silva,* 481 F.3d at 1286. Even if the Court determines that the exception applies, it can nonetheless order return of the child if return would further the aims of the Convention. *Id.*; *see also* 51 Fed.Reg. at 10509 ("As with the other Article 13 exceptions to the return obligation, the application of [the mature-child] exception is not mandatory.").

There is no set age at which a child has reached "an age and degree of maturity at which it is appropriate to take account of [his] views." *See Simcox v. Simcox,* 511 F.3d 594, 603–04 (6th Cir.2007). "Given the fact-intensive and idiosyncratic nature of the inquiry, decisions applying the age and maturity exception are understandably ***783** disparate." *de Silva,* 481 F.3d at 1287. Here, there is no question that D.S. is sufficiently mature to invoke the exception. D.S. is a bright, compassionate, and confident twelve-year old, who has demonstrated a keen understanding of the dispute between his parents. In both of the Court's conversations with D.S., he answered questions thoughtfully and showed levels of empathy and diplomacy beyond those of an ordinary twelve-year-old. *See Vasconcelos v. Batista,* 512 Fed.Appx. 403, 405 (5th Cir.2013) (holding that the determination that a thirteen-year-old is mature is consonant with other cases). Neither side (including Salazar) offers evidence that calls into question D.S.'s maturity, so no further evidentiary hearing is needed to conclude that D.S. is mature enough to trigger the possible application of this defense.

There is also no doubt that D.S. objected to returning to Mexico in the second in-camera hearing.[18] Although at the first in-camera hearing, D.S. said he preferred to stay in the United States, by the second hearing, his preference had hardened into a true objection. When the Court asked if D.S. "object[ed] to going back to Mexico," D.S. answered that he was "[s]tarting to, yes. Yes I would object to going back." Second In Camera Hrg. Tr. at 12:21–25. He acknowledged that there were "some days" where he would not object to returning, and that "[e]ven [his] mom says that sometimes she wishes she could go back," but despite his occasional feelings of nostalgia or homesickness, D.S. clearly stated that he now objects to being returned. *Id.* at 13:1–14:17.

[24] But even if a child objects to returning, and even if the child is of an age and degree of maturity at which it is appropriate to consider his views, the "child's objection to being returned may be accorded little if any weight if the court believes that the child's preference is the product of the abductor parent's undue influence over the child." 51 Fed.Reg. at 10509; *see also Walker,* 701 F.3d at 1123 ("In conducting this inquiry, we caution that the district court must be attentive to the possibility that the children's views may be the product of 'undue influence' of the parent who currently has custody."). In D.S.'s conversations with his guardian *ad litem* and with the Court, D.S. did say that his mother spoke with him about the benefits of remaining in Chicago and the problems with returning to Mexico. *See* Guardian Report at 3 (reporting that D.S. said "his mom made a good point about it could benefit him when he grows up if he were to stay here," that "his mom said that ***784** he made progress with his English since he left Mexico," and that his mom sometimes tells him about the violence in Mexico); First In–Camera Hrg. Tr. at 21:22–22:24, 23:12–21 (saying that "my mom had talked with me and she showed me all the progress I had, and the benefits of being here, and also she showed me that ... she didn't know people living in [Monterrey] that were as successful as people living here"). There is also evidence that Galvan told D.S. that, if she loses this case, she will have to pay Salazar's fees and costs, and that she cannot afford to pay. *See* Guardian Report at 3; First In Camera Hrg. Tr. at 23:3–11 ("Q. And what did she say about having to pay for your dad's lawyer? A. She told me that she—since we didn't have that much money to even maintain ourself, or do—go out every day, that she wouldn't have money to pay the lawyer."). For her part, Galvan argues that it was *Salazar* who influenced D.S. *See* Resp.'s Suppl. Br. at 14–15 (citing to evidence that Salazar told D.S. that, even though he had now expressed a preference, the case was out of Salazar's control and Salazar's pressure on the child to return).

[25] The Court need not conduct an evidentiary hearing on the issue of undue influence, however, because even if there were not undue influence, the Court would decline to apply the exception. "As with the other Article 13 exceptions to the return obligation, the application of [the mature child] exception is not mandatory." 51 Fed.Reg. at 10509. A court can, in its discretion, decline to apply the exception where it would not further the aims of the Convention. *See de Silva,* 481 F.3d at 1286. Here, D.S.'s objection to return is premised almost entirely on his concern about his or his mother's ability to travel to and from Mexico. Second In Camera Hrg. Tr. at 16:7–17:5. Although D.S. described other reasons for wanting to stay in Chicago—better schools, safer neighborhoods, seeing his baby sister—his objection dissolved if the impediment to travel was lifted. *Id.* ("Q. [A]ssuming [Galvan] could travel back and forth as of February of next year, would that change your mind about objecting to being ordered to return to Mexico to live there? ... A. Yeah, it would probably change my mind about going back."). If D.S.'s mother could "visit freely," D.S. would no longer *object* to returning to Mexico. *Id.* at 16:22–17:5. The crucial point on this issue is this: if Galvan wrongfully retained D.S. in the United States, then the travel restriction that is the basis for D.S.'s objection was created by that wrongful retention and Galvan's own conduct in violating the immigration law of the United States.[19] To allow Galvan's wrongful retention and her unstable immigration status to create the circumstances that led to D.S.'s objection would essentially "reward [Galvan] for violating [Salazar's] custody rights, and defeat the purposes of the Convention." *Yang,* 499 F.3d at 280 (agreeing with the district court's decision to decline to apply the exception where a parent's wrongful retention of the child created the attachment to the child's new environment that was the basis of her objection to return). And Galvan might be able to take steps to solve the travel restriction, because she is married to a United States citizen; as discussed during the August 5, 2015 status hearing, R. 60, if she were to apply for permanent resident status based on the marriage, then she likely would receive that status in around six months, and would be able to travel between the two countries. It is true that Galvan faces a financial obstacle to file the application, but that does not tip the scale in her favor (if she is found to have wrongfully retained ***785** D.S.). On top of all this, D.S.'s objection is also premised in part on, as time has passed, the fact that he is getting "used" to missing his father and the extended family in Mexico, and returning to Mexico would mean that D.S. would have to then get used to missing his mother and sister here. Second In Camera Hrg. Tr. at 8:7–12, 20:7–18.

Assuming that the retention was wrongful, this premise for the objection too should not be given weight, lest the wrongful conduct be rewarded. The Court holds, therefore, that even if Galvan could demonstrate that the elements of the mature-child defense had been proven, discretion is best exercised by *not* applying the exception in this case.

It is not at all easy for the Court to reject D.S.'s wishes: he is a mature and compassionate child, and his voice does and should matter. He did not choose to be put in this situation. For him (and really for both parties), there is no "winning" this case. But this Court must follow the law and must take into account the *systemic* interests at stake, not just the individual interests, no matter how intensely felt. Those systemic interests do end-up serving the interests of individuals in the long run, though that is little comfort to D.S. in this case. Summary judgment is granted for Salazar against the mature-child defense: it shall not apply.

3. Equitable Defenses

[26] In her answer to Salazar's petition, Galvan asserted several "equitable defenses," such as waiver, estoppel, laches, ratification, and unclean hands. Answer at 16. Salazar argues that these equitable defenses are not available under the Hague Convention. Pet.'s Br. at 14–15. The Court agrees.

To be sure, in interpreting federal *statutes* enacted by Congress, courts generally assume that "all the inherent equitable powers of the District Court are available for the proper and complete exercise of its equitable jurisdiction." *Town of Munster v. Sherwin–Williams Co.,* 27 F.3d 1268, 1271 (7th Cir.1994) (internal alterations, quotation marks, and citations omitted). But "[t]he Hague Convention, of course, is a treaty, not a federal statute." *Lozano v. Montoya Alvarez,* ––– U.S. ––––, 134 S.Ct. 1224, 1232–34, 188 L.Ed.2d 200 (2014). As such, the Convention was not drafted in light of the "established backdrop of American law." *Id.* It is therefore inappropriate to presume that the Hague Convention incorporates the equitable defenses of American law. *Id.*

[27] The text of the Convention also suggests that such defenses are not available. For one, the language of the Convention is focused on returning a wrongfully removed or retained child to the habitual residence so that that State can decide the custody dispute. *See Karpenko v. Leendertz,* 619 F.3d 259, 265 (3d Cir.2010). It is not a determination of the *merits* of the custody dispute, and "[t]he conduct of the parents, other than the claim of abduction or retention, is not mentioned in the Hague Convention except to the extent that [the] conduct may be relevant to one of the affirmative defenses." *Id.* To allow the conduct of the parents to affect the resolution of a petition for return would come dangerously close to deciding the underlying merits of the custody dispute and stray from the Hague Convention's purpose of promptly restoring the status quo. *Id.* Moreover, the Convention sets forth several specific and narrow defenses to the remedy of return. *See* Hague Convention art. 13, 20. The equitable defenses offered by Galvan are "simply not [included in] the narrow defenses set forth in the Hague Convention." *McCurdy v. Shreve–McCurdy,* 806 F.Supp.2d 1010, 1021 (E.D.Mich.2011); *see also* ***786** *In re Application of Stead v. Menduno,* 77 F.Supp.3d 1029, 1037, 2014 WL 7403282, at *4 (D.Colo. Dec. 29, 2014) ("The equitable doctrines invoked by respondent are not mentioned in the Convention and are therefore not properly brought as defenses to a petition for return of the child."); *Uzoh v. Uzoh,* 2012 WL 1565345, at *6 (N.D.Ill. May 2, 2012) ("The Hague Convention does not recognize unclean hands as a defense."). There is therefore no basis on which to conclude that the drafters of the Convention intended to include these background equitable defenses in the Hague Convention. Because these equitable defenses are not available under the Hague Convention, Salazar is entitled to summary judgment on Galvan's defenses of waiver, estoppel, laches, ratification, and unclean hands.

IV. Conclusion

For the reasons discussed above, Salazar's motion for summary judgment is granted in part, denied in part, and reserved in part. Salazar is entitled to summary judgment on two elements of his *prima facie* case: (1) to the extent that there was a wrongful retention, it occurred on July 21, 2014 and (2) to the extent that he had rights of custody, he was exercising those rights at the time of removal. Salazar is also entitled to summary judgment against the mature-child defense and the equitable defenses asserted by Respondent.

Summary judgment is denied as to D.S.'s habitual residence. When viewing the facts in Galvan's favor, there is a genuine dispute of material fact on the intent of the parties and D.S.'s acclimatization to the United States (as relevant only to the element of habitual residence). Summary judgment is also denied as to the consent defense because there is a factual dispute as to the scope of the agreement between the parties and Salazar's subjective intent. The parties will present evidence on these issues at the evidentiary hearing on August 21, 2015. Finally, the Court reserves decision on the "rights of custody" element. This question of law will be resolved, along with the remaining factual issues, in an opinion issued after the evidentiary hearing.

All Citations

122 F.Supp.3d 765

Footnotes

1 The Court has subject-matter jurisdiction over this ICARA case under 22 U.S.C. § 9003(a) and 28 U.S.C. § 1331. Citations to the docket are "R." followed by the entry number and, when necessary, the page or paragraph number.

2 The statute was previously codified at 42 U.S.C. § 11601 *et seq.*

3 Respondent also raises the issues of fees and costs in her response. R. 66, Resp.'s Br. at 15. The Court reserves this issue until after the resolution of the petition for return.

4 Facts drawn from the Petitioner's Statement of Facts are undisputed unless otherwise noted.

5 On July 5, 2013, Galvan had married an American citizen who lived in Illinois. Pet.'s SOF ¶ 13.

6 The Court expresses its sincere gratitude to Ms. Colleen Littmann and the Cook County Public Guardian for their dedicated representation of D.S., particularly outside the Cook County Circuit Court system. The Court also thanks counsel for both Petitioner and Respondent for their *pro bono* service to their clients. Both sides' lawyers and Ms. Littmann have lived up to the highest ideals of the legal profession.

7 Petitions for return under the Hague Convention are to be addressed as expeditiously as possible. *See* Hague Convention art 11. The Court acknowledges that appointment of counsel for Respondent, settlement negotiations, and summary-judgment briefing have consumed more time than is ideal, but given the importance of this dispute in the life of D.S. and his parents and family, the Court has authorized these delays to ensure that it reaches the most accurate outcome in this case.

8 The parties agreed that D.S.'s in-camera testimony would stand-in for trial testimony of the child. The hearing was conducted in English at the child's request.

9 Both the United States and Mexico are signatories of the Hague Convention. *See* http://travel.state.gov/content/childabduction/english/country/hague-party-countries.html (visited August 16, 2015).

10 Based on the briefs of the parties and the facts of this case, it is clear that this is a petition for wrongful *retention* of D.S. in the United States, not wrongful *removal.* Salazar concedes that he consented to D.S.'s move to the Chicago for the 2013-2014 school year. Pet.'s SOF ¶ 5.

11 There is still a dispute over whether Salazar had "rights of custody" as defined by the Hague Convention. But, assuming he did have such rights, it is clear that he was exercising them.

12 As previously agreed, D.S.'s in-camera testimony will be the stand-in for his trial testimony.

13 Galvan has cited no authority for her argument that “undue influence” before the initiation of proceedings under the Hague Convention will affect whether or not a retention was wrongful under the Convention. *See* Resp.'s Br. at 8–11.

14 As noted in the minute entry, neither party has yet submitted any evidence on the interpretation of Mexican law. *See* Fed.R.Civ.P. 44.1 (“In determining foreign law, the court may consider any relevant material or source, including testimony, whether or not submitted by a party or admissible under the Federal Rules of Evidence.”); Hague Convention art. 14 (“In ascertaining whether there has been a wrongful removal or retention within the meaning of Article 3, the judicial or administrative authorities of the requested State may take notice directly of the law of, and of judicial or administrative decisions, formally recognised or not in the State of the habitual residence of the child, without recourse to the specific procedures for the proof of that law or for the recognition of foreign decisions which would otherwise be applicable.”)

15 For the purposes of evaluating the defenses to the Convention, the Court assumes that Salazar has proved that the retention was wrongful. To repeat, the point of addressing these issues now is to give the parties guidance on what the parameters of the bench trial will be.

16 Two exceptions not relevant here—the grave-risk exception and fundamental-freedoms exception—must be proved by clear and convincing evidence. 22 U.S.C. § 9003(e)(2)(A).

17 In her Answer to Salazar's petition, Galvan also raises the well-settled child exception. R. 36, Answer at 17. The well-settled exception applies only when the petition under the Hague Convention is initiated more than a year after the allegedly wrongful removal or retention. Hague Convention art. 12. In this case, the allegedly wrongful retention occurred in July 2014. Pet.'s SOF ¶ 6. Salazar filed his petition on December 2, 2014. *See* Petition. The well-settled exception therefore does not apply.

18 In her supplemental brief on the mature-child issue, R. 70, Resp.'s Suppl. Br., Galvan argues that the mature-child exception only requires that the child *prefers* not to return to his habitual residence; it does not require an objection. *Id.* at 3–4, 130 S.Ct. 1983. Although some cases have used language like “preference” or “views” in evaluating a mature-child exception, the text of the Convention makes clear that the exception applies when “the child *objects* to being returned.” Hague Convention art. 13 (emphasis added). And though the Seventh Circuit has not directly addressed whether a preference is sufficient to invoke an exception, at least one other appellate court has held that a true objection is necessary. *See* *Yang v. Tsui,* 499 F.3d 259, 279 (3d Cir.2007); *see also* *Vilen–Burch v. Burch,* 2013 WL 1909472, at *9 (S.D.Ind. May 8, 2013) (denying to apply the mature-child exception in part because the child only expressed “a generalized desire to remain in the United States”); *Haimdas v. Haimdas,* 720 F.Supp.2d 183, 206–07 (E.D.N.Y.2010) (noting that “courts distinguish between a child's ‘objection’ to return, as reference in the Hague Convention, ‘and a child's wishes, as expressed in a custody case’ ”). But even if no objection is necessary, the in-camera testimony of D.S. demonstrates that the child did express an objection to return rather than a mere preference to remain.

19 Galvan and D.S. overstayed tourist visas.

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327 F.Supp.2d 489
United States District Court, D. New Jersey.

In re Application of Ezra SASSON, Petitioner,
v.
Miriam SASSON, Respondent.

No. CIV.03–4385 WGB.
|
July 30, 2004.

Synopsis

Background: Father, an Israeli citizen, petitioned for return of child pursuant to the Hague Convention On the Civil Aspects of International Child Abduction, as implemented in the International Child Abduction Remedies Act (ICARA).

[Holding:] The District Court, Bassler, J., held that child's habitual residence was not Israel, but United States, and thus her retention in this country by mother was not wrongful under Convention.

Petition denied.

West Headnotes (6)

[1] **Child Custody** Wrongful retention or removal

Removal or retention of child under the Hague Convention On the Civil Aspects of International Child Abduction is only wrongful if the child is removed from his or her habitual residence. International Child Abduction Remedies Act, § 4(e)(1)(A), 42 U.S.C.A. § 11603(e)(1)(A).

2 Cases that cite this headnote

[2] **Child Custody** Habitual residence

"Habitual residence," for purpose of Hague Convention On the Civil Aspects of International Child Abduction, is the place where the child has been physically present for an amount of time sufficient for acclimatization and which has a degree of settled purpose from the child's perspective. International Child Abduction Remedies Act, §§ 2-12, 42 U.S.C.A. §§ 11601-11610.

1 Cases that cite this headnote

[3] **Child Custody** Habitual residence

Determination of whether any particular place satisfies habitual residence standard under Hague Convention On the Civil Aspects of International Child Abduction must focus on the child and consists of an analysis of the child's circumstances in that place and the parents' present, shared intentions regarding their child's presence there. International Child Abduction Remedies Act, §§ 2-12, 42 U.S.C.A. §§ 11601-11610.

[4] **Child Custody** Hearing

Determination of a child's habitual residence, for purpose of Hague Convention On the Civil Aspects of International Child Abduction, is a mixed question of fact and law. International Child Abduction Remedies Act, §§ 2-12, 42 U.S.C.A. §§ 11601-11610.

1 Cases that cite this headnote

[5] **Child Custody** Habitual residence

Israel was not habitual residence of eight-year-old daughter who came to United States on tourist visa with her parents when she was six, and had resided in country almost one year before father sought her return under Hague Convention On the Civil Aspects of International Child Abduction, and thus her retention by mother in United States was not wrongful under Convention; parents had shared intention of remaining in United States permanently at time of their entry as evidenced by sale of their home, furnishings, cars, and some business equipment in Israel, enrollment of children in New Jersey schools, execution of lease, purchase of vehicles, incorporation of business, and opening of checking and savings accounts in New Jersey, and child had acclimatized to country, as evidenced by her English language skills, her school attendance, participation in activities outside school, and close relationship with extended family residing in New Jersey. International Child Abduction Remedies Act, §§ 2-12, 42 U.S.C.A. §§ 11601-11610.

2 Cases that cite this headnote

[6] **Child Custody** Habitual residence

Unlawful or precarious immigration status does not preclude one from becoming a habitual resident under the Hague Convention On the Civil Aspects of International Child Abduction. International Child Abduction Remedies Act, §§ 2-12, 42 U.S.C.A. §§ 11601-11610.

2 Cases that cite this headnote

Attorneys and Law Firms

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Karin Duchin Haber, Esq., Haber & Silver, Florham Park, NJ, for Respondent.

OPINION

BASSLER, District Judge.

On September 17, 2003, Petitioner Ezra Sasson ("Petitioner") filed in this Court a Verified Complaint and Petition for the Return of Child (his daughter Maya Sasson) pursuant to the Hague Convention On the Civil Aspects of International Child Abduction ("the Hague Convention") and the International Child Abduction Remedies Act, 42 U.S.C. § 11601, *et seq.* ("ICARA").[1]

After the parties conducted expedited discovery, the Court held an evidentiary hearing on July 20, 21, and 22, 2004. Having heard testimony and reviewed the relevant submissions, the Court now makes the following findings of fact[2] and conclusions of law pursuant to Rule 52 of the Federal Rules of Civil Procedure.[3] For the following reasons, the Court finds that Maya Sasson's habitual residence is the United States and accordingly, **denies** Petitioner's Petition for the Return of Child.

*491 I. *FINDINGS OF FACT*

A. *Facts*

Petitioner is an Israeli citizen domiciled in Ramat Gan, Israel. Respondent Miriam Sasson ("Respondent") is an Israeli citizen currently living in New Jersey.

Petitioner and Respondent were married in Israel on April 13, 1995. Their daughter, Maya (a/k/a Maia) Sasson ("Maya") was born on May 11, 1996 in Israel. Petitioner has two sons from a former marriage, Ohad and Adi.

The first time that Petitioner visited the United States was with Respondent and his three children in or around December 1999. Petitioner thought the United States was a beautiful place to visit as a tourist. Respondent, however, testified that her husband loved the United States from the minute he arrived here and that he told her he would figure out a way for them to move to the United States.

In August of 2000, Petitioner returned to the United States alone for business. Petitioner's business involves building models and prototypes for the paramedical industry and defense systems, including improving engines for drones.[4] During that visit, Petitioner met with people in the United States Navy at a naval base in Baltimore, Maryland.

The parties agree that their marriage was an unhappy one, for which they underwent marital counseling. Then, sometime in the summer of 2002, Petitioner contends that Respondent conditioned any efforts to salvage the marriage on going to the United States. Thus, Petitioner claims that because he had no other choice, he agreed to come to the United States for a "prolonged period of time" to try to rehabilitate his marriage. Petitioner thought the length of time they would stay in the United States would depend on how well the marriage went—between a few months to a half a year, or maybe even longer.

In contrast, Respondent denies placing any conditions on coming to the United States, and maintains that in fact, Petitioner told her that he wanted to move to the United States because he believed that here, they would have a better life with less stress.

In any event, for whatever reason, whether prompted by Petitioner or by Respondent, on October 8, 2002, Petitioner, Respondent, Maya, Ohad, Adi ("the Sassons") traveled from Israel to Florham Park, New Jersey on B–1 non-immigrant tourist visas that were to expire in April of 2003. Petitioner purchased round-trip plane tickets for that trip. According to the plane tickets, the Sassons were to return to Israel on October 21, 2004. At the airport, Petitioner told the United States immigration officer that the purpose of his family's trip to the United States was to see relatives and to visit Disney World as a Bar Mitzvah gift for his son, Adi.

Prior to coming to the United States on October 8, 2002, Petitioner sold his house in Moshav Eshtaol, two cars, a majority of his home furnishings and furniture, as well as a portion of his business equipment. While there was conflicting testimony at the evidentiary hearing as to when the house was placed on the market, and when the closing on the house actually occurred, what is clear is that the Sassons moved out of the house in Moshav Eshtaol sometime in August of 2002.

The Sassons then moved into an apartment in Beit Shemesh, Israel, where the Sassons lived in August and September, 2002 until they left for the United States in ***492** October 2002. Although Petitioner signed a one year lease for the apartment, he subsequently sublet the apartment.

Additionally, prior to leaving for the United States, in October of 2002, Petitioner had most of his wife's paintings (Respondent is an artist) shipped to the United States. Also, sometime in July of 2002, Petitioner retained an attorney in Florida, Diana Boruchin, Esq. (*See* Trial Ex. D–4.) Petitioner hired Boruchin to file an L–1 business visa[5] on his behalf, to apply for the "Immigration Lottery"[6] on his behalf and on behalf of his wife, to prepare a work visa for his wife, to incorporate for him a company in the United States called S.E. Technologies and Prototypes, Inc., ("S.E.Technologies"), and to help prepare a business plan. (*See* Trial Exs. D–3 through D–7.)

The Sassons arrived in the United States in October 2002 with books, clothes, documents, money, and small business equipment that Petitioner needed to work. Once they arrived, Petitioner obtained an Employer Identification Number ("EIN") for his company, S.E. Technologies. (*See* Trial Ex. D–8.) Petitioner also signed a one year lease for an apartment at Sun Valley Plaza in Florham Park, New Jersey ("Sun Valley"), beginning on October 1, 2002 (*see* Trial Ex. D–2), opened a savings and checking bank account at Commerce Bank, (*see* Trial Ex. D–9), purchased two vehicles—a Jeep Grand Cherokee (in which Petitioner had GPS (Global Positioning System) installed) and a Chrysler, obtained car insurance through October 2003, purchased two cellular telephones, bought an American television, and arranged for cable television. Petitioner paid his bills and the rent by check. In January 2003, Petitioner also paid for a one-year membership in the Jewish Community Center ("JCC") in West Orange for his family.

Because Petitioner wanted his children to obtain a Hebrew education, he and Respondent met a number of times with the Director of Admissions at Solomon Schechter Day School, a Jewish school affiliated with a conservative movement. At that time, tuition at Solomon Schechter was $14,000 per year at the high school level and $8,000 or $9,000 for the lower level, kindergarten through fifth grade. However, based on placement tests that Ohad and Adi took, the school determined that the two boys did not know enough English and would be better served in public school where they had a better ESL (English as a Second Language) program. Consequently, Petitioner and Respondent enrolled Ohad in Hanover Park High School, Adi in Ridgedale Middle School, and Maya in Brooklake Elementary School. In January 2003, Petitioner completed a form listing courses for Adi's expected enrollment in Hanover Park High ***493** School in the fall of 2003. (*See* Trial Ex. D–11.)

About three months after arriving in the United States, Petitioner and Respondent's marriage began to deteriorate. On April 3, 2003, Petitioner went back to Israel with his two sons, Ohad and Adi. According to his own testimony, Petitioner told his wife that he would return to the United States in three weeks. He also informed her that when he came back from his business trip to Israel, due to the deterioration of their marriage, he would live elsewhere while she remained living at Sun Valley. Petitioner further acknowledged that he had intended to take all three of his children back to Israel and therefore had taken Maya's passport with him. Nevertheless, Petitioner admitted that he lied to Respondent and told her that he only planned to take his two sons. Petitioner ultimately decided not to take Maya with him to Israel because he concluded that his wife would scream and yell, making a scene, and that that would upset or traumatize Maya, which he wanted to avoid. Petitioner testified that he thought he would obtain custody of Maya through the legal process.

During the nearly seven month stay in the United States, Petitioner did not take his son, Adi, to Disney World as he had told the immigration officer that he intended to do.

Maya is still enrolled in the Brooklake Elementary School and has started religious classes in Hebrew school at Temple Beth Shalom in Livingston, New Jersey. Since January or February 2003, Maya began swimming regularly at the JCC and continues to swim there. She also is currently enrolled in karate classes at the JCC. She now reads and speaks English well. Maya can speak Hebrew, but cannot read or write it. Maya also has friends in her neighborhood with whom she speaks English. She is close to her maternal aunts and uncles, as well as her cousins.

B. *Procedural History*

On May 21, 2003, Respondent brought an action in Superior Court for custody of Maya. By Order entered on June 19, 2003, the state court granted Respondent sole legal and residential custody pendente lite. Respondent has not yet taken any action to obtain permanent custody of Maya because Petitioner failed to respond in the child custody suit.

Meanwhile, on or about June 6, 2003, Petitioner filed with the U.S. Central Authority a Request Pursuant to the Hague Convention, seeking the return of Maya. On September 17, 2003, Petitioner filed this Petition seeking the return of his daughter to Israel pursuant to the Convention and ICARA. Shortly thereafter, on September 24, 2003, Petitioner filed an Order to Show Cause For a Preliminary Injunction (1) Preventing The Removal of the Child to Another Jurisdiction, (2) Staying the State Action for Custody, and (3) Providing Expedited Discovery. After hearing oral argument on November 25, 2003, the Court denied Petitioner's request for a preliminary injunction due to the existence of factual disputes, granted the request for expedited discovery, and denied as moot Petitioner's request for a stay of the state custody action.

II. *CONCLUSIONS OF LAW*

A. *Framework for The Hague Convention*

The purpose of the Hague Convention is “to protect children internationally from the harmful effects of their wrongful removal or retention and to establish procedures to ensure their prompt return to the State of their habitual residence, as well as to secure protection for rights of access.” Hague Convention, Preamble. Both the ***494** United States and Israel are signatory nations. The Hague Convention, which is implemented by ICARA, 42 U.S.C. § 11601, *et seq.,* “empower[s] courts in the United States to determine only rights under the Convention and not the merits of any underlying child custody claims.” 42 U.S.C. § 11601(b)(4); *see also* *Friedrich v. Friedrich,* 983 F.2d 1396, 1400 (6th Cir.1993).

[1] In an action brought pursuant to the ICARA and the Hague Convention, the petitioner bears the burden to show by a preponderance of the evidence that “the child has been wrongfully removed or retained within the meaning of the Convention.” 42 U.S.C. § 11603(e)(1)(A). The Hague Convention considers the removal of a child to be wrongful when:

> *a* it is in breach of rights of custody attributed to a person, an institution or any other body, either jointly or alone, under the law of the State in which the child was habitually resident immediately before the removal or retention; and
>
> *b* at the time of removal or retention those rights were actually exercised, either jointly or alone, or would have been so exercised but for the removal or retention.
>
> The rights of custody mentioned in sub-paragraph *a* above may arise in particular by operation of law or by reason of a judicial or administrative decision, or by reason of an agreement having legal effect under the law of that State.

Hague Convention, Article 3. For purposes of the Hague Convention, “ ‘rights of custody’ shall include rights relating to the care of the person of the child and, in particular, the right to determine the child's place of residence.”[7] Hague Convention, Article 5. “Removal or retention under the [Hague] [C]onvention is only wrongful if the child is removed from his or her ‘habitual residence.’ ” *Delvoye v. Lee,* 224 F.Supp.2d 843, 847 (D.N.J.2002) (citing *Friedrich,* 983 F.2d at 1400)), *aff'd,* 329 F.3d 330 (3d Cir.2003)).

If the petitioner meets his burden, then the respondent opposing the return of the child must establish one of four affirmative defenses:

> 1) by clear and convincing evidence that there is a grave risk that the return of the child would expose the child to physical or psychological harm; Hague Convention, Article 13b, 42 U.S.C. § 11603(e)(2)(A);
>
> 2) by clear and convincing evidence that the return of the child “would not be permitted by the fundamental principles of the requested State relating to the protection

> of human rights and fundamental freedoms"; Hague Convention, Article 20, 42 U.S.C. § 11603(e)(2)(A);
>
> 3) by a preponderance of the evidence that the proceeding was commenced more than one year after the abduction and the child has become settled in its new environment; Hague Convention, Article 12, 42 U.S.C. § 11603(e)(2)(B); or
>
> 4) by a preponderance of the evidence that [the petitioner] was not actually exercising the custody right at the time of removal or retention, or had consented to or subsequently acquiesced in the removal or retention; Hague Convention, Article 13a, 42 U.S.C. § 11603(e)(2)(B).

Friedrich, 983 F.2d at 1400.

In this case, Respondent concedes that none of these four affirmative defenses are at issue here.

***495** B. *Analysis of "Habitual Residence" Under The Hague Convention*

The question of Maya's "habitual residence" immediately prior to her retention in New Jersey is the threshold issue that this Court must determine. *See Feder v. Evans–Feder,* 63 F.3d 217, 222 (3d Cir.1995).

[2] **[3]** **[4]** Although the Hague Convention does not provide a definition for "habitual residence", the Third Circuit has defined it as

> the place where [the child] has been physically present for an amount of time sufficient for acclimatization and which has a "degree of settled purpose" from the child's perspective.... [A] determination of whether any particular place satisfies this standard must focus on the child and consists of an analysis of the child's circumstances in that place and the parents' present, shared intentions regarding their child's presence there.

Id. at 224. "The determination of a person's habitual residence is a mixed question of fact and law." *Delvoye v. Lee,* 329 F.3d 330, 332 (3d Cir.2003). [8]

In *Feder,* the parents, Mr. and Mrs. Feder, who were American citizens, moved with their only child, Evan, from Pennsylvania to Australia due to a job opportunity for Mr. Feder. While Mr. Feder viewed the move to Australia with enthusiasm, Mrs. Feder was reluctant. Nonetheless, once in Australia, the Feders purchased a house, Evan attended nursery school and was enrolled to begin kindergarten the following year. Mrs. Feder applied to have Evan admitted to a private school when he reached the fifth grade, some seven years later. Mrs. Feder, who was an opera singer, also accepted a role in one of the Australian Opera Company's performances set for the following year.

Although Mrs. Feder had had doubts about the deteriorating marriage while living in the United States, it was only after moving to and living in Australia for about five or six months that she decided to leave her husband and return to the United States with Evan. However, believing that Mr. Feder would not agree to her plans, Mrs. Feder told her husband that she was going to take Evan to visit her parents in Pennsylvania. Mr. Feder made travel arrangements, buying two round-trip tickets to the United States.

Subsequently, Mrs. Feder filed a complaint in the Court of Common Pleas of Montgomery County, Pennsylvania, seeking a divorce, property distribution, custody of Evan, and financial support. Mr. Feder commenced a proceeding in the Family Court of Australia in Sydney under the Hague Convention. He also filed a petition pursuant to the Convention in the District Court for the Eastern District of Pennsylvania, alleging that his parental custody rights had been violated by Mrs. Feder's "wrongful removal and/or retention" of Evan and requesting the child's return.

The Third Circuit held that Australia was Evan's habitual residence immediately prior to his retention in the United States by Mrs. Feder. *Feder,* 63 F.3d at 224. In reaching that conclusion, the Circuit noted that while Evan had lived a majority of his ***496** life in the United States, living in Australia for close to six months immediately preceding his return to the United States was a significant period of time for a four-year old child. *Id.* at 224. It further observed that in Australia,

> Evan attended preschool and was enrolled in kindergarten for the upcoming year, participating in one of the most central activities in

> a child's life. Although Mr. and Mrs. Feder viewed Australia very differently, both agreed to move to that country and live there with one another and their son, and did what parents intent on making a new home for themselves and their child do—they purchased and renovated a house, pursued interests and employment, and arranged for Evan's immediate and long-term schooling. That Mrs. Feder did not intend to remain in Australia permanently and believed that she would leave if her marriage did not improve does not void the couple's settled purpose to live as a family in the place where Mr. Feder had found work.

Id.

1. *Parents' Shared Intentions*

[5] In this case, Petitioner contends that he and Respondent traveled from Israel to the United States in October 2002 merely for a temporary stay while they attempted to salvage their deteriorating marriage and that they never intended to live in the United States permanently. Petitioner further asserts that it was only upon Respondent's insistence that the family remained in this country for several months, and that Respondent has now refused to return to Israel and wrongfully detained Maya in New Jersey. In contrast, Respondent maintains that she and Petitioner moved to the United States from Israel with an intent to settle here permanently.

In examining the parties' contradictory positions, the Court notes that Respondent was a more credible witness than Petitioner. *See supra* n. 2. Even giving credence to Petitioner's story that he came to this country in an effort to salvage his marriage and that that was a condition imposed by Respondent,[9] which he may have felt reluctant or unenthusiastic about satisfying, Petitioner's actions and his own testimony clearly portray an intent to settle in the United States. *See Mozes v. Mozes,* 239 F.3d 1067, 1075 ("one's actions may belie any declaration that no abandonment was intended.") For instance, when Petitioner left for Israel in April of 2003, he did not take Maya with him and admittedly lied to his wife by telling her that he would be returning to the United States in a few weeks. It defies common sense to believe that Petitioner would have lied to his wife about his intent to return to the United States if in fact, they had not intended to live in this country.[10]

Additionally, the parties came to the United States with all of their clothing and personal belongings. Moreover, prior to ***497** arriving in the United States, Petitioner had the majority of his wife's paintings sent to the United States, and also sold his house in Moshav Eshtaol, as well as the family's furniture, furnishings and cars. *See* Dr. E.M. Clive, "The Concept of Habitual Residence," 1997 Jurid. Rev. 137, 142 ("A person who has sold house and furniture and set off for a new life in another country would not be using words normally if he or she claimed to be still habitually resident in the old country.") Although initially, Petitioner, in his Order to Show Cause application,[11] claimed that the sale of the house in Israel occurred in February 2002, and not the summer of 2002 as alleged by his wife, Petitioner presented no evidence at trial to support that position. In any event, Petitioner's contention is belied by his unequivocal testimony at the hearing that his family did not move out of the house in Moshav Eshtaol until August of 2002.

Petitioner also provided no evidence to buttress the assertions he initially made in his sworn affidavit that he sold his home simply to pay off mounting debt, rather than in preparation for any move to the United States, and that upon selling his house, he paid his debt from the sales proceeds, and with the remaining funds, eventually bought a house in Tel Aviv, which he owns to date.[12]

Respondent's testimony that she and Petitioner decided to move to the United States to settle here is further supported by the fact that Petitioner incorporated his company, S.E. Technologies, in the United States and established an EIN. While Petitioner admits that he considered the possibility of doing some business in the United States and also consulted with an attorney regarding an L–1 business visa, he emphasizes that he never actually signed the L–1 visa application.[13] However, as testified by Petitioner, he did not tell the Florida attorney to stop the L–1 visa process until April of 2003. *See* Trial Ex. D–20. Therefore, although Petitioner may have changed his mind sometime between October 2002 and April 2003 and formed a unilateral intent to return to Israel due to the unsuccessful efforts to salvage his marriage, that does not bear on the parents' initial shared intent when they left Israel in October 2002. *See In re the Application of Sonja E. Morris,* 55 F.Supp.2d 1156, 1162–63 (D.Colo.1999) (noting that shared intent cannot be altered by the unilateral change in position of one of the parents after arriving at the new state).

While Petitioner admits that immediately prior to coming to the United States in October 2002, he sold a portion of his business machines and equipment, he denies having done so in preparation for any move to the United States. Petitioner insists, rather, that he has always bought, traded, and sold various machinery and tooling required by certain projects or rendered obsolete by the completion of certain projects. However, Petitioner did not testify ***498** or otherwise establish at trial that aside from selling, he actually *bought or traded* any new business equipment immediately prior to his travel to the United States in October 2002. Nor did Petitioner present sufficient evidence to substantiate his conclusory assertion that he did not sever his business ties in Israel. Additionally, while Petitioner may have supplied his Commerce bank account with funds from Israel, there was no evidence to show that, as Petitioner alleges, he continued earning salary from his employment in Israel.

Next, Petitioner claims that he was essentially tricked into signing the one year apartment lease by his wife and her family. Specifically, according to Petitioner, the Sun Valley apartment, owned by a business owned by Respondent's sister's family, was supposed to have been free of charge, but his wife and her sister asked him to sign the lease because having a written lease would be beneficial for Respondent's sister's family's business. Petitioner alleges that he was told that he would not actually have to stay in the apartment for a year.

This argument, however, is undermined by the fact that Petitioner opened a bank account in early October 2002 for the purpose of, among other things, paying rent. Moreover, Respondent, whom the Court found to be more credible than Petitioner, testified that no one ever gave her the impression that she and her husband would not have to pay rent; she also stated that Petitioner never told her that they would be living at Sun Valley for free. Consistent with that testimony, Murray Halpern, Petitioner's brother-in-law, who was the Managing Partner at Sun Valley, stated that he never told Petitioner that he did not have to pay rent. Thus, Petitioner has failed to demonstrate that he was in any way "tricked" into signing the one year apartment lease by his wife and her family.[14]

While Petitioner does not dispute that he opened a savings and checking bank account, he maintains that he always has, and continues to have, his principal bank accounts in Israel. Petitioner also claims that he had bought a cellular telephone on a prior visit to the United States and that both times, he simply cancelled the service upon his return to Israel. To date, Petitioner purportedly continues to have six operational cell phone lines in Israel, all of which remained operational while he was in the United States. Petitioner further represents that his family's only health insurance plan and doctors all were, and remain in, Israel. Petitioner, however, proffered no evidence to support any of these assertions.

Petitioner explained during his trial testimony that he purchased vehicles instead of renting because he did not have a credit card and because it was cheaper to buy and sell a used car than to rent it. The Court finds that explanation unconvincing. In any event, such conduct certainly does not assist Petitioner in satisfying his burden to show that he had no intent to live in the United States. The Court notes that a tourist intending to visit a foreign country temporarily typically does not buy two cars and home appliances such as a television, and order cable service.

Having paid for a one-year membership at the JCC for his family in January 2003, Petitioner explains that exercise is an integral part of his medically prescribed therapy for his diabetes, and that the annual membership, which was the only type offered by the JCC, was very affordable. The Court, however, questions why, if exercise ***499** is so integral to Petitioner's therapy, he would not have signed up for a membership during the first three months of his stay in the United States.

As for the children, Petitioner alleges in his sworn affidavit that they were enrolled in school because he and Respondent decided that the children's education should not suffer because of their trip, which was taken during the school year. Moreover, he states that he was assured by his wife that it would be possible to enroll the children in school even though they were only visitors, and further, that she forged documents to have the children enrolled. Petitioner also asserts that for the duration of their stay in this country, Maya and her brothers continued to be registered in Israeli schools. Petitioner, however, presented absolutely no evidence at trial to substantiate any of these contentions.

Further, contrary to Petitioner's efforts to highlight his own lack of knowledge and involvement in the children's school enrollment and portray his wife as having controlled that aspect of the children's lives, there was unrefuted trial testimony that Petitioner and Respondent *both* met with the Director of Admissions at Solomon Schechter on multiple occasions to discuss enrolling the children at that school. Petitioner and Respondent then both toured Brooklake Elementary School together before enrolling Maya there. Additionally, in January 2003, it was Petitioner who completed a form listing courses for Adi's expected enrollment in Hanover Park High School in the fall. *See* Trial Ex. D–11.

In an effort to refute the weight of evidence supporting Respondent's position, Petitioner, as proof of a shared intent to return to Israel, points to the fact that he and his family arrived in the United States on round-trip plane tickets that had return dates set for October 21, 2002. The Court, however, does not find that fact to be an accurate indicia of intent. Indeed, Petitioner even acknowledged that they had no intent to go back to Israel on that date and that the return dates are flexible. As an example, Petitioner explained that although his return ticket to Israel after the evidentiary hearing is for July 25, 2004, he could stay in the United States for one year. Moreover, the Court takes judicial notice of the fact that it is cheaper to purchase a round trip ticket than a one way ticket from Israel to the United States on El Al Israeli Airlines.

To show that their trip to the United States was merely intended as a visit, Petitioner, relying on *Mozes,* also points to the fact that they left Israel with B type, non-immigrant tourist visas, which were to expire in April of 2003.[15] In *Mozes,* a factor that the Ninth Circuit considered in examining shared intent was that the parties had left Israel with a temporary visa. However, in so noting, the court stated that unlawful immigration status was highly relevant in circumstances where, as in that case, "the shared intent of the parents is in dispute" such that the district court had properly refrained from finding that the parents had agreed to an indefinite stay in the new forum. *Id.* Here, in contrast, the Court finds that the parents did share the intent to abandon Israel as the habitual residence. Moreover, the fact that Petitioner and Respondent arrived on a B–1 tourist visa is counterbalanced by the fact that Petitioner, even before leaving Israel, hired an attorney to file an L–1 visa on his behalf, and also subsequently ***500** signed an application for the Immigration Lottery. Thus, the Court concludes that under the circumstances of this case, the type of visa the Sassons traveled with to the United States is not necessarily dispositive of the parents' shared intent regarding Maya's habitual residence.

[6] While Petitioner also argues that a change in Maya's habitual residence "could only have occurred if the Sassons received immigration status permitting them to reside in the United States permanently," Petitioner's Summation at 4, that argument is patently wrong. The Ninth Circuit has clearly stated that, "an unlawful or precarious immigration status does not preclude one from becoming a habitual resident under the [Hague] Convention ..." *Mozes,* 239 F.3d at 1082, n. 45 (citing Dr. Clive, "The Concept of Habitual Residence," 1997 Jurid. Rev. at 147).

Additionally, Petitioner declares that it is evident from "look[ing] to the future" how unsettled the question of Maya's habitual residence, *see* Petitioner's Summation at 8; more specifically, Petitioner contends that because it is uncertain where Respondent will live in 2006 after her O–1 artist visa expires, there could not have been a shared intent to change Maya's habitual residence. However, it is clear that "[t]o determine the habitual residence, the court must ... examine past experience, not future intentions." *Friedrich,* 983 F.2d at 1401 (finding that mother's intent to return to the United States with her child in the future when she was discharged from the military was irrelevant to court's inquiry into habitual residence of child).

Thus, based on Petitioner's own testimony and conduct prior to and upon arrival in the United States, the Court finds that at the time the parties left Israel for the United States in October of 2002, they had a shared intent to settle in the United States.

Finally, even if, as Petitioner maintains, he and Respondent only intended to live in the United States for a "prolonged" but limited period of time while trying to resolve their marital problems, rather than permanently, that intent is still sufficient to establish a new habitual residence. *See Feder,* 63 F.3d at 224 ("That Mrs. Feder did not intend to remain in Australia *permanently* and believed that she would leave if her marriage did not improve does not void the couple's settled purpose to live as a family in the place where Mr. Feder had found work." (emphasis added)); *Mozes,* 239 F.3d at 1074 (noting that habitual residence does not mean a place "where you plan to leave your bones"). As explained in *In re Bates,* No. CA 122–89, High Court of Justice, Family Div'l Ct. Royal Courts of Justice, United Kingdom (1989):

> All the law requires is that there is a settled purpose. That is not to say that the propositus intends to stay where he is indefinitely; *indeed his purpose, while settled, may be for a limited period.* Education, business or profession, employment, health, family or merely love of the place spring to mind as common reasons for a choice of regular abode. And there may well be many others. All that is necessary is that the purpose of living where one does has a sufficient degree of continuity to be properly described as settled.

Feder, 63 F.3d at 223 (emphasis added); *Toren v. Toren,* 26 F.Supp.2d 240, 243 (D.Mass.1998) (holding that habitual residence was United States regardless of fact that parents had agreed that children would return to Israel on a date certain and that United States was not intended to be the children's permanent residence), *vacated on other grounds,* 191 F.3d 23 (1st Cir.1999).

***501** 2. *Maya's Circumstances in the United States*

When Petitioner, in June of 2003, filed with the U.S. Central Authority a Request Pursuant to the Hague Convention seeking the return of his daughter, Maya had already been residing in the United States for eight months and had nearly completed the entire first grade in the United States. By the time Petitioner filed the present petition before this Court, Maya had been living in this country for almost a year. By now, Maya has finished second grade and been residing in the United States for approximately twenty-two months, an amount of time that the Court finds is sufficient for acclimatization and a "degree of settled purpose" from the child's perspective. *See Feder,* 63 F.3d at 224 (finding that while child had lived a majority of his life in the United States, living in Australia for close to six months was a sufficient period of time to find Australia to be new habitual residence); *In re Philip Edward Robinson,* 983 F.Supp. 1339 (D.Colo. 1997) (finding that after living in Colorado for 22 months, children were "settled" in that environment); Carol S. Bruch, "Temporary or Contingent Changes in Location Under the Hague Child Abduction Convention," (2000) (noting that stays of a year or longer almost invariably produce findings of a new habitual residence); Dr. Clive, "The Concept of Habitual Residence," 1997 Jurid. Rev. at 141 (noting no discovery of any cases "where a person has been found not to be habitually resident in a country where he or she has lived for a year or more.")

Indeed, various witnesses testified that Maya is essentially well adjusted to life here in this country. Such testimony on this issue was not refuted by Petitioner with any evidence to the contrary. Maya attends school here, participates in various activities outside of school (i.e.swimming, karate), speaks English, has English speaking friends, and maintains a close relationship with her extended family residing in New Jersey. Lastly, while Maya has many relatives currently residing in Israel, *see* Trial Ex. P–24, she also has many friends and relatives in the United States. *See* Trial Ex. D–25.

Petitioner, however, argues that should this Court find that in October 2002, he intended to permanently reside in the United States, he abandoned that intent by November 2002. Therefore, he erroneously concludes that this Court should only look at Maya's acclimatization between October 2002 and November 2002. To do otherwise, he contends, would be ignoring shared parental intent and rewarding Respondent for kidnaping. However, as discussed above, the parents in this case formed a shared intent to settle in the United States, if even for a limited duration. That shared intent cannot then be unilaterally altered by a change in position of one of the parents after arriving at the new habitual residence. *See Mozes,* 239 F.3d at 1078 n. 29 (" 'If ... there is a genuine difference [of parental intention] then the conclusion must be that there is no settled purpose or intention.' " (citation omitted)); *In re the Application of Sonja E. Morris,* 55 F.Supp.2d at 1162–63. Because Respondent never agreed to return to Israel once they arrived in the United States with the intent to settle here, there was no subsequent "shared" intent by the parents to return to Israel that Petitioner can accuse this Court of ignoring, nor has there been any wrongful retention or kidnaping.

Based on the testimony at the evidentiary hearing and the applicable law, the Court concludes that Petitioner has failed to meet his burden of establishing, by a preponderance of the evidence, that Israel is Maya's habitual residence. Rather, Maya was habitually resident in the United ***502** States immediately prior to her retention by Respondent in the United States. Maya's habitual residence shifted from Israel to the United States in October 2002 when the parents arrived in this country with the shared intent to settle here, if even for a limited time. Thus, Respondent's retention of Maya in the United States was not wrongful under the Hague Convention.

III. *CONCLUSION*

For the foregoing reasons, Petitioner Ezra Sasson's Petition for the Return of the Child is denied.[16]

An appropriate Order follows.

ORDER

This matter having come before the Court on the Verified Complaint of Petitioner; and

The Court having considered the submissions of the parties; and

The Court having held an evidentiary hearing on July 20, 21, 22, 2004; and

For the reasons set forth in the Court's Opinion issued this day; and

For good cause shown;

IT IS on this 30th day of July, 2004, hereby ORDERED that Maya Sasson's "habitual residence" pursuant to the terms of the Hague Convention is the United States of America; and

IT IS FURTHER ORDERED that Petitioner Verified Complaint is **dismissed**; and

IT IS FURTHER ORDERED that the Clerk of the Court shall close this case.

All Citations

327 F.Supp.2d 489

Footnotes

[1] The Court has jurisdiction pursuant to 42 U.S.C. § 11603.

[2] In evaluating the evidence of record, the Court undertook an individualized assessment of the credibility of each witness, and assigned the appropriate weight to the testimony based on the Court's conclusions with respect to credibility. These findings of fact were made despite the fact that the testimony of the witnesses at times conflicted. In assessing the credibility of each witness in this case, the Court has taken into consideration how well each witness was able to recall and describe the things testified to, the manner of the witness while testifying, whether the witness had an interest in the outcome of the case or any bias or prejudice concerning any party or matter involved in the case, how reasonable the witness' testimony was considered in light of all the evidence in the case, 9A Wright & Miller, *Federal Practice and Procedure:* Civil 2d § 2585 (1995); *see also Miller v. Mercy Hospital, Inc.,* 720 F.2d 356, 365 (4th Cir.), *cert. denied,* 470 U.S. 1083, 105 S.Ct. 1841, 85 L.Ed.2d 141 (1985) ("Credibility involves more than a witness' demeanor and comprehends an overall evaluation of testimony in light of its rationality or internal consistency and the manner in which it hangs together with other evidence"), and whether the witness' testimony was contradicted by what that witness had said or done at another time, by the testimony of other witnesses, or by other evidence.

In general, unless otherwise noted, the Court found Respondent Miriam Sasson to be the more credible witness and credited her testimony over that of Petitioner Ezra Sasson given numerous inconsistencies or contradictions between statements in his sworn affidavit and his trial testimony. For example, contrary to Petitioner's contention that he could not speak English, it was evident from the testimony of numerous witnesses that Petitioner spoke English well enough to communicate to people who spoke little or no Hebrew, purchase a television, obtain cell phones, and open a bank account.

3 To the extent that any of the findings of fact might constitute conclusions of law, they are adopted as such. Conversely, to the extent that any conclusions of law constitute findings of fact, they are adopted as such.

4 “Drones” are defined in Merriam–Webster Online Dictionary as “an unmanned airplane, helicopter, or ship guided by remote control.”

5 An L–1 visa is a non-immigrant, temporary visa, which enables a person to work in the United States for up to seven years. To qualify for an L–1 visa, the applicant must have worked for one continuous year within the preceding three years, in a managerial, executive, or specialized knowledge capacity for a foreign corporation that has a United States affiliate. L–1 visa holders are exempted from the requirement of having to establish their continued non-immigrant intent, which eases the transition to an immigrant employment visa and eventually to a “green card.” *See* 8 U.S.C. § 1101(a)(15)(L); *see also* http:// www.immihelp.com/visas/llvisa.html

6 The “Immigration Lottery” is otherwise referred to as the Diversity Visa Lottery Program (“DV”). The State Department's DV program makes 55,000 immigrant visas available through a lottery to people who come from countries with low rates of immigration to the United States. Those receiving visas through the DV program are authorized to live and work permanently in the United States and may bring their spouses and any unmarried children under the age of 21. *See* 8 U.S.C. § 1153; *see also* http://uscis.gov/graphics/services/residency/divvisa.htm

7 In the present action, the parties stipulate that both parents are Maya's guardians and as such, have the right to determine her place of residence.

8 Petitioner filed a custody proceeding in the Israeli Rabbinical Court in Jerusalem. That court determined that it had no jurisdiction, noting that the parties' last place of residence was in the United States where they lived for about seven months, where Maya had attended school, and where Petitioner had started a business. (*See* Trial Ex. D–19.) That decision was affirmed by the Israeli Supreme Court. While that decision may be interesting, because the determination of the parents' “residence” does not necessarily equate to “habitual residence” of the child, this Court declines to give any weight to the Rabbinical Court's determination.

9 In *In re Application of Guido Sten Ponath,* 829 F.Supp. 363 (D.Utah 1993), the court held that the mother had not wrongfully removed the child from Germany to Utah. In so holding, the court noted that because the husband had, by means of verbal, emotional and physical abuse, coerced his wife to stay in Germany, he had “removed any element of choice and settled purpose which earlier may have been present in the family's decision to visit Germany.” *Id.* at 368. Here, while Petitioner makes conclusory allegations that he was “coerced” by Respondent into visiting the United States and extending their stay here, there is no evidence that Respondent used any verbal, emotional, or physical abuse to remove any element of choice that Petitioner had regarding his intent in coming to the United States in October of 2002.

10 Petitioner's admitted lie also undermines his credibility. *See supra,* n. 2.

11 Petitioner's sworn affidavit in support of his Order to Show Cause application contains statements relevant to the Court's determination of the parties' shared intent and Maya's habitual residence. Therefore, notwithstanding that the Court has already ruled on Petitioner's Order to Show Cause application, the Court addresses throughout this Opinion the statements contained in Petitioner's affidavit.

12 Respondent testified that Petitioner's mother owned a house in Tel Aviv. According to Respondent, Petitioner convinced his mother to transfer ownership of that house to his name. Respondent did not know whether Petitioner actually purchased that house from his mother.

13 Petitioner's contention that his wife and sister-in-law pressured him into filing the L–1 application is, like so many of his other conclusory claims, unsupported by any evidence in the record.

14 It is difficult to believe that a sophisticated businessman who has had dealings with the United States Navy could be so easily "tricked" into unwittingly signing a lease.

15 Respondent has since applied for and received an O–1 artist visa, which will expire in 2006. An O–1 visa is given to those who seek to enter the United States and have an "extraordinary ability in the sciences, arts, education, business, or athletics ..." 8 U.S.C. § 1101(a)(O)(I). Respondent intends to apply for permanent residency in the United States.

16 As the Court stated at the hearing, this Court's ruling that Respondent's retention of the child is not wrongful under the Hague Convention merely determines that a court in the United States, instead of Israel, will make the ultimate decision with regard to custody. This Court's decision has no bearing on the ultimate issue of custody. *See Friedrich,* 983 F.2d at 1400.

End of Document

2016 WL 7188019
Only the Westlaw citation is currently available.
United States District Court, N.D. California.

Jahi MCMATH, et al., Plaintiffs,
v.
State of CALIFORNIA, et al., Defendants.

Case No. 15-cv-06042-HSG
|
Signed 12/12/2016

Attorneys and Law Firms

Quinton Blair Cutlip, Aimee Elizabeth Kirby, The Dolan Law Firm, San Francisco, CA, for Plaintiffs.

Susan M. Carson, Deputy Attorney General, Charles J. Antonen, California Department of Justice, Nimrod Pitsker Elias, California State Attorney General's Office, San Francisco, CA, John Lauchlan Kortum, Kenneth C. Ward, Archer Norris, Walnut Creek, CA, for Defendants.

ORDER GRANTING IN PART AND DENYING IN PART MOTIONS TO DISMISS AND STAYING CASE

HAYWOOD S. GILLIAM, JR., United States District Judge

***1** Pending before the Court are three motions: (1) a motion to dismiss, or in the alternative to stay, brought by Defendants State of California, California Department of Public Health, Tony Agurto, and Dr. Karen Smith (together, the "State Defendants"), Dkt. No. 35; (2) a motion to dismiss or to abstain brought by Defendants County of Alameda, Alameda County Department of Public Health, Dr. Muntu Davis, Alameda County Coroner & Medical Examiner, Alameda County Counsel, David Nefouse, Scott Dickey, Alameda County Clerk's Office, Patrick O'Connell, Alameda County Sheriff's Office, and Jessica D. Horn (together, the "County Defendants"), Dkt. No. 48; and (3) a motion to dismiss, or in the alternative stay, brought by Intervenor Defendants UCSF Benioff Children's Hospital and Dr. Frederick S. Rosen, Dkt. No. 69. For the reasons articulated below, the Court GRANTS IN PART and DENIES IN PART the motions to dismiss, and STAYS this action.[1]

I. BACKGROUND

A. Factual History

This action arises out of a tragic sequence of events. On December 9, 2013, Plaintiff Jahi McMath received a tonsillectomy and adenoidectomy at Children's Hospital Oakland[2] ("CHO"). Dkt. No. 1 ("Compl.") ¶ 1. Following the routine surgery, Ms. McMath experienced excessive blood loss that eventually led to cardiac arrest. *See id.* ¶¶ 1-5. After extensive CPR and fluid administration, the CHO staff was able to restart Ms. McMath's heart, and Ms. McMath was placed on a ventilator. *Id.* ¶ 6. On December 12, 2013, CHO doctors officially pronounced Ms. McMath "brain dead." *Id.* ¶ 8.

Despite Ms. McMath's official diagnosis of brain death, Ms. McMath's mother, Nailah Winkfield, continues to believe that her daughter is alive. *See id.* ¶ 18. As such, after filing several lawsuits, Winkfield secured a death certificate for Ms. McMath so that Winkfield could transport her to a medical facility in New Jersey where there is a religious exemption for brain death. *See id.* ¶¶ 11-13. Ms. McMath and Winkfield have remained in New Jersey since. *See id.* ¶¶ 13-14, 19.

B. Procedural History

On December 23, 2015, Plaintiffs Ms. McMath and Winkfield filed this action against the State Defendants and County Defendants, requesting (1) a declaration that Ms. McMath is not now and was never "brain dead" under California Health and Safety Code §§ 7180 and 7181; (2) an injunction requiring Defendants to invalidate Ms. McMath's Certificate of Death and expunge all related records; (3) a declaration that Ms. McMath has the right to receive healthcare as a living human being; and (4) a declaration that Ms. Winkfield has the right to exercise control over Ms. McMath's healthcare. *See generally* Compl. Plaintiffs assert claims under (i) 42 U.S.C. § 1983 for violations of their First, Fourth, Fifth, and Fourteenth Amendment rights; (ii) § 504 of the Federal Rehabilitation Act of 1973; (iii) the

Americans with Disabilities Act; and (iv) the Religious Land Use and Institutionalized Persons Act. *Id.* At the May 12, 2016, hearing on Defendants' motions to dismiss, the Court granted the Intervenor Defendants' motion to intervene. Dkt. No. 68.

***2** In addition to this lawsuit, there are five other proceedings arising from the same nucleus of facts that warrant discussion: (1) a 2013 state court probate action filed in Alameda Superior Court ("Probate Action"); (2) a first federal action filed in 2013 ("2013 Federal Action"); (3) a state court writ petition appealing the probate court's findings ("2013 Writ Petition"); (4) a 2014 petition for writ of error coram nobis requesting that the Alameda Superior Court overturn its finding of brain death ("Petition for Writ of Error Coram Nobis"); and (5) a pending state court action seeking either personal injury or wrongful death damages ("Damages Action").

i. Probate Action

On December 20, 2013, Winkfield filed an action in Alameda County Superior Court seeking an emergency ex parte temporary restraining order ("TRO") to prevent CHO from removing Ms. McMath from life support and to require CHO to provide her with further medical care. Dkt. No. 69-2, Exh. A ("Ex Parte Petition") ¶¶ 4-5. CHO opposed the Ex Parte Petition, arguing that it had no duty to provide continuing medical support to Ms. McMath because she was deceased as a result of brain death. Dkt. No. 69-2, Exh. B. After hearing testimony and evidence from several physicians, including from court-appointed independent physician Dr. Paul Fisher, Judge Grillo found by "clear and convincing evidence ... on December 24, 2013, that [Ms. McMath] had suffered brain death and was deceased as defined under Health and Safety Code sections 7180 and 7181." Dkt. No. 36-2, Ex. D at 16:20-22. Accordingly, Judge Grillo denied Winkfield's Ex Parte Petition and ordered CHO to continue providing Ms. McMath with treatment and support only until December 30, 2013, at 5:00 pm. *Id.* at 1, 19.

On January 17, 2014, Judge Grillo denied Winkfield's renewed motion for a court order requiring CHO to insert feeding and tracheal tubes into Ms. McMath. Dkt. No. 36-2, Ex. E at 1-2. Judge Grillo held that Ms. McMath had "been found to be brain dead pursuant to Health and Safety Code sections 7180-7181," and thus the feeding and tracheal tubes "would arguably be medically ineffective or contrary to generally accepted health care standards, or could violate medical or ethical norms." *Id.* at 2. Thereafter, Judge Grillo entered final judgment denying Winkfield's petition. Dkt. No. 36-2, Ex. F.

ii. 2013 Federal Action

On December 30, 2013, Winkfield filed an action in the United States District Court for the Northern District of California. Compl. ¶ 64; Dkt. No. 69-3, Ex. F. Among other relief, Winkfield requested an injunction "precluding removal of ventilator support and mandating introduction of nutritional support, insertion of a tracheostomy tube [and] gastric tube, and to provide other medical treatments and protocols designed to promote [Ms. McMath's] maximum level of medical improvement and provision of sufficient time for Plaintiff to locate an alternate facility to care for [Ms. McMath] in accordance with her religious beliefs." *Id.* at 15.

After attending a settlement conference with a Magistrate Judge, the parties were able to reach a settlement that allowed Winkfield to remove her daughter from CHO. Compl. ¶¶ 64-65.

iii. 2013 Writ Petition

Also on December 30, 2013, Ms. McMath, by and through Winkfield, petitioned the California Court of Appeal for a writ of mandate directing the Alameda Superior Court to "reverse and vacate its Order of December 26, 2013, denying Plaintiff Winkfield's Petition to continue life support measures, and transfer the minor, McMath." Dkt. No. 69-3, Ex. F at 1. The Court of Appeal temporarily stayed Judge Grillo's order for 24 hours in order to consider the writ petition on its merits. Dkt. No. 69-3, Ex. G at 1. On January 6, 2014, the Court of Appeal denied as moot Plaintiffs' petition for writ of mandate because Ms. McMath had been removed from CHO as a result of the negotiated settlement in the 2013 Federal Action. *Id.* at 3.

iv. Petition for Writ of Error Coram Nobis

***3** On October 3, 2014, Ms. McMath, by and through Winkfield, filed a Writ of Error Coram Nobis in Alameda Superior Court. Dkt. No. 69-4, Ex. K. Plaintiffs requested that the Alameda Superior Court reverse its determination that Ms. McMath had suffered brain death in light of new evidence. *Id.*

In response to the petition, Judge Grillo again appointed Dr. Fisher as the court-appointed expert witness. Dkt. No. 69-6, Ex. Q. Plaintiffs' objected to Dr. Fisher's appointment, and thereafter, on October 9, 2014, withdrew their Petition for Writ of Error Coram Nobis. Dkt. No. 69-6, Ex. R at 4.

In his order acknowledging Plaintiffs' withdrawal of their petition, Judge Grillo informed Plaintiffs that they could seek future relief in his court by requesting a case management conference at a later date. *Id.*

v. Damages Action

Finally, Plaintiffs and other family members have brought a medical malpractice action against Dr. Rosen and CHO that is currently proceeding in Alameda County Superior Court. *See* Dkt. No. 69-7, Ex. S. The Damages Action plaintiffs seek personal injury damages or, in the alternative, wrongful death damages. *Id.*

Dr. Rosen and CHO demurred to the first amended complaint in the Damages Action on the basis that Judge Grillo had already determined the fact of Ms. McMath's brain death in the Probate Action. Dkt. No. 69-7, Exs. T, U. According to Dr. Rosen and CHO, any personal injury claims were barred by, among other theories, collateral estoppel and res judicata. *Id.*

Judge Robert Freedman of Alameda County Superior Court overruled the demurrers brought by Dr. Rosen and CHO. Dkt. No. 69-7, Exs. W, X. Judge Freedman also certified two questions to the California Court of Appeal: (1) whether Judge Grillo's determination of brain death in the Probate Action is entitled to collateral estoppel in a subsequent civil case seeking personal injury damages and whether collateral estoppel on this basis should be determined at the pleading stage; and (2) whether Judge Grillo's determination of brain death in the Probate Action should be accorded finality for all purposes pertaining to Ms. McMath's brain death status unless Judge Grillo's order is set aside on appeal or otherwise. Dkt. No. 69-7, Ex. Y.

On July 12, 2016, the California Court of Appeal held that Dr. Rosen and CHO's argument that Judge Grillo's brain death determination is entitled to collateral estoppel "should not be resolved at the pleading stage." Dkt. No. 77-3, Ex. A at 3; *see also* Dkt. No. 83-1, Ex. B.

II. DISCUSSION

On March 3, 2016, the State Defendants filed a motion to dismiss, or in the alternative to stay, this action under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). Dkt. No. 35 ("State MTD"). The State Defendants move to dismiss or stay this action on four grounds: (i) the Court lacks subject matter jurisdiction under the *Rooker-Feldman* doctrine; (ii) the complaint is barred by the Eleventh Amendment because there is an insufficient nexus between the State Defendants and the challenged acts; (iii) Plaintiffs' first through sixth claims fail to state a claim; and (iv) if the Court declines to dismiss the complaint, the action should be stayed under *Colorado River. Id.*

On March 16, 2016, the County Defendants moved to dismiss the complaint or, in the alternative, requested that the Court abstain from hearing the matter. Dkt. No. 48 ("County MTD"). The County Defendants articulate three main arguments in support of their motion: (i) Plaintiffs have failed to exhaust available state court procedures; (ii) the Court lacks subject matter jurisdiction under the *Rooker-Feldman* doctrine; and (iii) the Court should abstain under the *Younger* doctrine or other similar doctrines such as *Pullman*, *Colorado River*, and *Burford. Id.*

***4** Finally, on May 20, 2016, the Intervenor Defendants moved to dismiss or stay this action. Dkt. No. 69 ("Intervenors' MTD"). The Intervenor Defendants move to dismiss on three bases: (i) reconsideration of Ms. McMath's brain death diagnosis is barred by the doctrines of res judicata and collateral estoppel; (ii) the Court should decline to consider Plaintiffs' request for a declaration that Ms. McMath is not brain dead under the Declaratory Judgment Act; and (iii) the Court should dismiss the complaint based on "a host of legal doctrines" included in the State and County Defendants' motions. *Id.*

The State Defendants, County Defendants, and Intervenor Defendants each join in each other's arguments. *Id.* at 24; Dkt. No. 73 at 22:18-23:13.

A. Rule 12(b)(1) Legal Standard

Rule 12(b)(1) allows a defendant to move for dismissal on the ground that a court lacks jurisdiction over the subject matter of an action. Fed. R. Civ. P. 12(b)(1). The plaintiff bears the burden of establishing a court's subject matter jurisdiction. *See Assoc. of Am. Medical Colleges v. United States*, 217 F.3d 770, 778-79 (9th Cir. 2000); *Kokkonen v. Guardian Life Ins. Co. of America*, 511 U.S. 375, 376-78 (1994).

"A complaint will be dismissed if, looking at the complaint as a whole, it appears to lack federal jurisdiction either 'facially' or 'factually.' " *Thornhill Publishing Co., Inc. v. General Tel. & Elecs. Corp.*, 594 F.2d 730, 733 (9th Cir. 1979). In resolving a "facial" attack, a court limits its inquiry to a plaintiff's allegations, which are taken as true, and construes the allegations in the light most favorable to the plaintiff. *Safe Air for Everyone v. Meyer*, 373 F.3d 1035, 1039 (9th Cir. 2004); *NL Indus. v. Kaplan*, 792 F.2d 896, 898 (9th Cir. 1986).

B. Rule 12(b)(6) Legal Standard

Federal Rule of Civil Procedure 8(a) requires that a complaint contain "a short and plain statement of the claim showing that the pleader is entitled to relief[.]" A defendant may move to dismiss a complaint for failing to state a claim upon which relief can be granted under Federal Rule of Civil Procedure 12(b)(6). "Dismissal under Rule 12(b)(6) is appropriate only where the complaint lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory." *Mendiondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008). To survive a Rule 12(b)(6) motion, a plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 540, 570 (2007). A claim is facially plausible when a plaintiff pleads "factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

In reviewing the plausibility of a complaint, courts "accept factual allegations in the complaint as true and construe the pleadings in the light most favorable to the nonmoving party." *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008). Nonetheless, courts do not "accept as true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences." *In re Gilead Scis. Secs. Litig.*, 536 F.3d 1049, 1055 (9th Cir. 2008).

C. Analysis

The Court begins by addressing Defendants' argument that the Court lacks subject matter jurisdiction, then considers Defendants' alternate position that the Court should stay this action pending the outcome of California state court proceedings.

i. *Rooker-Feldman* Doctrine

Defendants argue that the Court lacks subject matter jurisdiction over Plaintiffs' complaint under the *Rooker-Feldman* doctrine.

***5** The *Rooker-Feldman* doctrine "bars federal courts from exercising subject-matter jurisdiction over a proceeding in 'which a party losing in state court' seeks 'what in substance would be appellate review of the state judgment in a United States district court, based on the losing party's claim that the state judgment itself violates the loser's federal rights.' " *Doe v. Mann*, 415 F.3d 1038, 1041 (9th Cir. 2005) (quoting *Johnson v. De Grandy*, 512 U.S. 997, 1005–06 (1994)). The *Rooker-Feldman* doctrine applies unless Congress has granted federal district courts statutory authority to review certain state court judgments. *See id.* The Ninth Circuit has interpreted *Rooker-Feldman* to bar jurisdiction "[i]f a federal plaintiff asserts as a legal wrong an allegedly erroneous decision by a state court, and seeks relief from a state court judgment based on that decision." *Noel v. Hall*, 341 F.3d 1148, 1164 (9th Cir. 2003). *Rooker-Feldman* does not bar an action in which "a federal plaintiff asserts as a legal wrong an allegedly illegal act or omission by an adverse party." *Id.* If a district court finds that it lacks jurisdiction to hear an issue under *Rooker-Feldman*, the court must also "refuse to decide any issue raised in the suit that is 'inextricably intertwined' with an issue resolved by the state court in its judicial decision." *Noel*, 341 F.3d at 1158.

Here, *Rooker-Feldman* bars some, but not all, of Plaintiffs' claims. In the Probate Action, Judge Grillo found by "clear and convincing evidence ... on December 24, 2013, that [Ms. McMath] had suffered brain death and was deceased as defined under Health and Safety Code sections 7180 and 7181." Dkt. No. 36-2, Ex. D at 16:20-22. Thus, under *Rooker-Feldman*, Plaintiffs cannot appeal Judge Grillo's determination that as of December 24, 2013, Ms. McMath was "brain dead." In other words, *Rooker-Feldman* prohibits Plaintiffs' request for a declaration that Ms. McMath "did not suffer, on December 13, 2013, irreversible cessation of all functions of the entire brain, including the brain stem" and that Ms. McMath "was not ever 'brain dead' by pertinent California statute." *See, e.g.*, Compl. ¶¶ 249, 250. However, Plaintiffs bring several other claims, including a request "to present to a court for the first time evidence of [Ms.] McMath's neurological function subsequent to the issuance of her facially invalid death certificate." Dkt. No. 60 ("Opp'n to State MTD") at 13. Relatedly, Plaintiffs assert that Defendants' failure to invalidate, correct, or amend Ms. McMath's death certificate in light of this subsequent evidence violates her constitutional rights. These claims founded on evidence not before Judge Grillo do not seek to appeal his judgment, nor are they so inextricably intertwined with his judgment so as to deprive this Court of jurisdiction.

The Court finds that *Rooker-Feldman* deprives it of jurisdiction over Plaintiffs' claims that Ms. McMath never experienced brain death and was not brain dead on December 24, 2013. Accordingly, the Court GRANTS Defendants' requests to dismiss any such claims. However, the Court holds that Plaintiffs' remaining claims are not barred by *Rooker-Feldman* and DENIES Defendants' request as to all other claims.

ii. Abstention

Next, Defendants assert that the Court must stay or dismiss this action under a variety of abstention doctrines, including *Colorado River*, *Younger*, *Pullman*, and *Burford.* Because the Court finds that *Pullman* abstention is appropriate, the Court declines to address the other potential bases for abstaining from or staying this action.

Pullman abstention allows "federal courts to refrain from deciding sensitive federal constitutional questions when state law issues may moot or narrow the constitutional questions." *Porter v. Jones*, 319 F.3d 483, 492 (9th Cir. 2003). "Three factors must be present before a district court may abstain under the *Pullman* doctrine: (1) the complaint must involve a sensitive area of social policy that is best left to the states to address; (2) a definitive ruling on the state issues by a state court could obviate the need for federal constitutional adjudication by the federal court; and (3) the proper resolution of the potentially determinative state law issue is uncertain." *Fireman's Fund Ins. Co. v. City of Lodi, California*, 302 F.3d 928, 939-40 (9th Cir. 2002), *as amended on denial of reh'g and reh'g en banc* (Oct. 8, 2002) (internal quotations omitted). *Pullman* abstention requires all three of these factors and should be rarely applied "[i]n order to give due respect to a suitor's choice of a federal forum for the hearing and decision of his federal constitutional claims." *Porter*, 319 F.3d at 492. If a court abstains under *Pullman*, the "federal plaintiff must then seek[ ] a definitive ruling in the state courts on the state law questions before returning to the federal forum." *1049 Mkt. St. LLC v. City & Cty. of San Francisco*, No. C 15-02075 JSW, 2015 WL 5676019, at *2 (N.D. Cal. Sept. 28, 2015) (*quoting San Remo Hotel v. City & Cty. of San Francisco*, 145 F.3d 1095, 1104 (9th Cir. 1998)).

***6** The Court finds that all three of the *Pullman* factors are present here. First, this action undeniably concerns sensitive areas of social policy best left to California to address: California's definition of brain death under Health and Safety Code §§ 7180 and 7181, and whether a diagnosis of brain death under California law subsequently can—or must—be overturned as a result of new evidence.

Second, a definitive ruling from the California courts regarding the state's policies for making and revisiting a determination of brain death under §§ 7180 and 7181 could obviate the need for this Court to adjudicate the alleged violations of Plaintiffs' federal constitutional rights. If the California courts conclude that §§ 7180 and 7181 permit or require a brain death diagnosis to be overturned as a result of new evidence, Defendants will be legally obligated to follow the California courts' guidance with respect to Ms. McMath's determination of brain death. Such a finding in that forum could moot this entire action, which asserts violations of Plaintiffs' federal constitutional rights as a result of Defendants' refusal to "reconsider[ ] and correct[ ] ... [Ms. McMath's] diagnosis of death." *See* Compl. ¶ 15. Additionally, there remains a chance that the parties to the Damages Action will litigate whether Ms. McMath is currently brain dead, and that litigation also has the potential to moot or substantially narrow the federal constitutional questions presented here.

Third, the proper resolution of the potentially determinative state law issue is uncertain. "Uncertainty for purposes of *Pullman* abstention means that a federal court cannot predict with any confidence how the state's highest court would decide an issue of state law." *Pearl Inv. Co. v. City & Cty. of San Francisco*, 774 F.2d 1460, 1465 (9th Cir. 1985). "Resolution of an issue of state law might be uncertain because the particular statute is ambiguous, or because the precedents conflict, or because the question is novel and of sufficient importance that it ought to be addressed first by a state court." *Id.* The Court cannot envision an issue more novel and important than a state's policies surrounding a determination of death. In a case of first impression, Plaintiffs argue that, notwithstanding the superior court's December 2013 determination of brain death in the Probate Action, Ms. McMath "has regained brain function." Compl. ¶ 50. Essentially, Plaintiffs argue that even if the Court were to accept the December 2013 determination as accurate when made, Ms. McMath now has come back to life. In this unique and novel situation, this Court cannot predict with any confidence how the California Supreme Court would interpret the finality of a brain death diagnosis under Health and Safety Code §§ 7180 and 7181. The uncertainty of this issue is further underscored by the fact that in the Damages Action, the superior court has held, and the California Court of Appeal has affirmed, that defendants' collateral estoppel argument cannot be resolved at the pleading stage. Dkt. No. 83-1, Ex. B; Dkt. No. 77-3 at 3; Dkt. No. 69-7, Exs. W, X. Accordingly, there remains an open question as to whether, under California Health and Safety Code §§ 7180 and 7181, Ms. McMath's brain death diagnosis can or must be overturned.

The Court finds that all three of the *Pullman* factors are present here, and this case thus presents the rare situation in which *Pullman* abstention is warranted. Accordingly, the Court STAYS this action pending the outcome of Plaintiffs' efforts to seek a determinative ruling from the California courts as to whether a brain death diagnosis under California Health and Safety Code §§ 7180 and 7181 can or must be overturned based on subsequent evidence of brain function.[3]

III. CONCLUSION

***7** For the reasons above, the Court GRANTS IN PART and DENIES IN PART Defendants' motion to dismiss for lack of subject matter jurisdiction under *Rooker-Feldman.* The Court GRANTS the motion as to Plaintiffs' claims that Ms. McMath never experienced brain death and was incorrectly found to be brain dead on December 24, 2013. The Court DENIES the motion as to the remainder of Plaintiffs' claims.

In addition, the Court STAYS this action under the *Pullman* abstention doctrine pending the outcome of Plaintiffs' efforts to seek a determinative ruling from the California courts as to whether under California Health and Safety Code §§ 7180 and 7181 a brain death diagnosis can or must be overturned based on subsequent evidence of brain function. The parties shall file joint status reports every 120 days updating the Court on the status of the Damages Action or any other California state court action addressing the issues identified in this order. The parties shall also file a joint status update within 10 days of the issuance of a final judgment in the Damages Action or any other California state court action addressing the issues identified in this order.

IT IS SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2016 WL 7188019

Footnotes

[1] The parties have submitted several requests for judicial notice. *See* Dkt. Nos. 36, 47, 52, 61, 63, 69-1, 75-4, 77-1, 83. The Court GRANTS the requests to take judicial notice of court documents and filings in other actions because they are public documents that "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." *See* Fed. R. Evid. 201(b). Because the Court does not rely on the remainder of the documents that the parties have submitted for judicial notice, the Court DENIES AS MOOT the remainder of the parties' requests.

[2] Children's Hospital Oakland is now UCSF Benioff Children's Hospital Oakland.

[3] Because the Court finds *Pullman* abstention appropriate here, the Court declines at this time to address the Defendants' remaining arguments in support of dismissing or staying the action.

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403 F.3d 1223
United States Court of Appeals, Eleventh Circuit.

Theresa Marie Schindler SCHIAVO, incapacitated ex rel., Robert SCHINDLER and Mary Schindler, her parents and next friends, Plaintiffs–Appellants,
v.
Michael SCHIAVO, as guardian of the person of Theresa Marie Schindler Schiavo, incapacitated, Judge George W. Greer, The Hospice of the Florida Suncoast, Inc., Defendants–Appellees.

No. 05–11556
|
March 23, 2005.
|
As Corrected March 25, 2005.

Synopsis

Background: Parents of daughter whose artificial life support had been removed pursuant to Florida court order brought action pursuant to Congressional Act stating that United States District Court for the Middle District of Florida would have jurisdiction to hear suit on behalf of daughter for alleged violation of daughter's rights with respect to withholding of food, fluids, or medical treatment. Parents moved for temporary restraining order directing daughter's husband, who was her legal guardian, and hospice to transport daughter to hospital for medical treatment. The United States District Court for the Middle District of Florida, No. 05-00530-CV-T-27-TBM, James D. Whittemore, J., 2005 WL 641710, denied relief, and parents appealed.

Holdings: The Court of Appeals held that:

finding that parents had failed to demonstrate substantial case on merits of their claim was not abuse of discretion;

statute authorizing parents to bring action did not mandate grant of temporary or preliminary relief; and

All Writs Act could not be used to evade requirements for preliminary injunction.

Affirmed.

Wilson, Circuit Judge, dissented and filed opinion.

Procedural Posture(s): On Appeal.

Attorneys and Law Firms

***1225** David C. Gibbs, III, Gibbs Law Firm, P.A., Seminole, FL, for Plaintiffs–Appellants.

George James Felos, Felos & Felos, P.A., Dunedin, FL, for Defendants–Appellees.

Appeal from the United States District Court for the Middle District of Florida.
Before CARNES, HULL and WILSON, Circuit Judges.

Opinion

PER CURIAM:

Plaintiffs have appealed the district court's denial of their motion for a temporary restraining order to require the defendants to transport Theresa Marie Schindler Schiavo to a hospital to reestablish nutrition and hydration and for any medical treatment necessary to sustain her life, and to require the state court judge defendant to rescind his February 25, 2005 order directing removal of nutrition and hydration from Schiavo and to restrain him from issuing any further orders that would discontinue nutrition and hydration.[1] After notice and a hearing, the district court entered a careful order which is attached as an Appendix to this opinion. Plaintiffs have also petitioned this Court to grant the same injunctive relief under the All Writs Act, 28 U.S.C. § 1651(a).

Although we ordinarily do not have jurisdiction over appeals from orders granting or denying temporary restraining orders, in circumstances such as these, "when a grant or denial of a TRO might have a serious, perhaps irreparable, consequence, and can be effectually challenged only by immediate appeal, we may exercise appellate jurisdiction." *Ingram v. Ault,* 50 F.3d 898, 900 (11th Cir.1995) (internal citations, marks, and ellipsis omitted); *see also United States v. Wood,* 295 F.2d 772, 778 (5th

Cir.1961). In these circumstances we treat temporary restraining orders as equivalent to preliminary injunctions or final judgments, either of which are appealable. *See* 28 U.S.C. §§ 1291 & 1292(a)(1).

The district court correctly stated the four factors to be considered in determining whether temporary restraining or preliminary injunctive relief is to be granted, which are whether the movant has established: (1) a substantial likelihood of success on the merits; (2) that irreparable injury will be suffered if the relief is not granted; (3) that the threatened injury outweighs the harm the relief would inflict ***1226** on the non-movant; and (4) that entry of the relief would serve the public interest. *See Ingram,* 50 F.3d at 900; *Siegel v. LePore,* 234 F.3d 1163, 1176 (11th Cir.2000) (en banc). Requests for emergency injunctive relief are not uncommon in federal court and sometimes involve decisions affecting life and death. Controlling precedent is clear that injunctive relief may not be granted unless the plaintiff establishes the substantial likelihood of success criterion. *See Siegel,* 234 F.3d at 1176; *see also Grupo Mexicano de Desarrollo v. Alliance Bond Fund, Inc.,* 527 U.S. 308, 339, 119 S.Ct. 1961, 1978, 144 L.Ed.2d 319 (1999) ("Plaintiffs with questionable claims would not meet the likelihood of success criterion.").

Applying those factors, the district court determined that the last three weighed in favor of granting the temporary restraining order. The court reasoned that because those three factors were met, plaintiffs only had to show a substantial case on the merits. After analyzing each of plaintiffs' claims, the district court concluded they had failed to show a substantial case on the merits as to any of the claims.[2]

While the district court conducted *de novo* review of plaintiffs' claims, we review the district court's denial of temporary injunctive relief only for an abuse of discretion. This scope of review will lead to reversal only if the district court applies an incorrect legal standard, or applies improper procedures, or relies on clearly erroneous factfinding, or if it reaches a conclusion that is clearly unreasonable or incorrect. *Klay v. United Healthgroup, Inc.,* 376 F.3d 1092, 1096 (11th Cir.2004); *Chicago Tribune Co. v. Bridgestone/Firestone, Inc.,* 263 F.3d 1304, 1309 (11th Cir.2001). Short of that, an abuse of discretion standard recognizes there is a range of choice within which we will not reverse the district court even if we might have reached a different decision. *See McMahan v. Toto,* 256 F.3d 1120, 1128 (11th Cir.2001); *Rasbury v. Internal Revenue Serv. (In re Rasbury),* 24 F.3d 159, 168–69 (11th Cir.1994).[3]

For the reasons explained in the district court's opinion, we agree that the plaintiffs have failed to demonstrate a substantial case on the merits of any of their claims. We also conclude that the district court's carefully thought-out decision to deny temporary relief in these circumstances is not an abuse of discretion.[4]

The principal theme of plaintiffs' argument against the district court's denial of a temporary restraining order is that Pub. L. No. 109–3, which Congress enacted to enable them to bring this lawsuit, mandates that injunctive relief be granted to enable them to have a full trial on the merits of their claims. Pub. L. No. 109–3 is an extraordinary piece of legislation, and it does many things. Defendants contend ***1227** that the legislation is so extraordinary that it is unconstitutional in several respects. We need not decide that question. For purposes of determining whether temporary or preliminary injunctive relief is appropriate, we indulge the usual presumption that congressional enactments are constitutional. *United States v. Morrison,* 529 U.S. 598, 607, 120 S.Ct. 1740, 1748, 146 L.Ed.2d 658 (2000); *Benning v. Georgia,* 391 F.3d 1299, 1303 (11th Cir.2004). It is enough for present purposes that in enacting Pub.L. No. 109–3 Congress did not alter for purposes of this case the long-standing general law governing whether temporary restraining orders or preliminary injunctions should be issued by federal courts.

There is no provision in Pub. L. No. 109–3 addressing whether or under what conditions the district court should grant temporary or preliminary relief in this case. There is no more reason in the text of the Act to read in any special rule about temporary or preliminary relief than there would be to read in a special rule about deciding the case before trial on Fed.R.Civ.P. 12(b)(6) or summary judgment grounds. Not only that, but Congress considered and specifically rejected provisions that would have mandated, or permitted with favorable implications, the grant of the pretrial stay. There is this enlightening exchange in the legislative history concerning the Senate bill that was enacted:

> Mr. LEVIN. Mr. President, I rise to seek clarification from the majority leader about one aspect of this bill, the issue of whether Congress has mandated that a Federal court issue a stay pending determination of the case.
>
> Mr. FRIST. I would be pleased to help clarify this issue.
>
> Mr. LEVIN. Section 5 of the original version of the Martinez bill conferred jurisdiction on a Federal court to hear a case like this, and then stated that the Federal court "shall" issue a stay of State court proceedings pending determination of the Federal case. I was opposed to that provision because I believe Congress should not mandate that a Federal judge issue a stay. Under longstanding law and practice, the decision to issue a stay is a matter of discretion for the Federal judge based on the facts of the case. The majority leader and the other bill sponsors accepted my suggestion that the word "shall" in section 5 be changed to "may."
>
> The version of the bill we are now considering strikes section 5 altogether. Although nothing in the text of the new bill mandates a stay, the omission of this section, which in the earlier Senate-passed bill made a stay permissive, might be read to mean that Congress intends to mandate a stay. I believe that reading is incorrect. The absence of any state [sic] provision in the new bill simply means that Congress relies on current law. Under current law, a judge may decide whether or not a stay is appropriate.
>
> Does the majority leader share my understanding of the bill?
>
> Mr. FRIST. I share the understanding of the Senator from Michigan, as does the junior Senator from Florida who is the chief sponsor of this bill. Nothing in the current bill or its legislative history mandates a stay. I would assume, however, the Federal court would grant a stay based on the facts of this case because Mrs. Schiavo would need to be alive in order for the court to make its determination. Nevertheless, this bill ***1228** does not change current law under which a stay is discretionary.
>
> Mr. LEVIN. In light of that assurance, I do not object to the unanimous consent agreement under which the bill will be considered by the Senate. I do not make the same assumption as the majority leader makes about what a Federal court will do. Because the discretion of the Federal court is left unrestricted in this bill, I will not exercise my right to block its consideration.

151 Cong. Rec. S3099–100 (daily ed. Mar. 20, 2005) (colloquy between Sens. Levin & Frist).

This enlightening exchange does not contradict the plain meaning of Pub. L. No. 109–3, but instead reinforces it. Plainly, Congress knew how to change the law to favor these plaintiffs to the extent that it collectively wished to do so. That is what the changes it did make, including those to standing law, the *Rooker–Feldman* doctrine, and abstention, demonstrate. When Congress explicitly modifies some pre-existing rules of law applicable to a subject but says nothing about other rules of law, the only reasonable reading is that Congress meant no change in the rules it did not mention. The dissent characterizes the language of the Act as clear. It is on this point: the language of the Act clearly does not purport to change the law concerning issuance of temporary or preliminary relief.[5]

To interpret Pub. L. No. 109–3 as requiring that temporary or preliminary relief be entered regardless of whether it is warranted under pre-existing law would go beyond reading into the Act a provision that is not there. It would require us to read into the Act a provision that Congress deliberately removed in order to clarify that pre-existing law did govern this issue.

Nor do we find convincing plaintiffs' argument that in reaching its decision to deny the motion for a temporary restraining order the district court violated Pub. L. No. 109–3 by considering the procedural history of extensive state court litigation. The plaintiffs' complaint and other filings in the district court asserted that they had not been afforded procedural due process by the state courts. Their pleadings and brief in the district court and this Court are replete with citations to and discussion about the state court proceedings and decisions. In deciding whether the plaintiffs had shown a substantial case on the merits of their federal procedural due process claims, the district court had to consider the prior proceedings in state court. There is no way to consider a claim that the state court proceedings violated the Due Process Clause without examining what those proceedings were. In obedience to Pub. L. No. 109–3 the district court considered the federal constitutional claims *de novo* and made its own independent evaluation of them.

Plaintiffs have also moved this Court under the All Writs Act, 28 U.S.C. § 1651(a), for emergency injunctive relief pending appeal, asking us to order the same temporary or preliminary relief that we have concluded the district court did not abuse its discretion in denying. They are supported in that motion by a Statement ***1229** of Interest filed by the United States' Department of Justice.

The All Writs Act provides: "The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." *Id.* The purpose of the power codified in that statute is to allow courts "to protect the jurisdiction they already have, derived from some other source." *Klay,* 376 F.3d at 1099. It gives a "residual source of authority to issue writs that are not otherwise covered by statute" and is an "extraordinary remedy that ... is essentially equitable and, as such, not generally available to provide alternatives to other, adequate remedies at law." *Id.* at 1100 (internal quotes and citations omitted).

Our decisions make clear that where the relief sought is in essence a preliminary injunction, the All Writs Act is not available because other, adequate remedies at law exist, namely Fed.R.Civ.P. 65, which provides for temporary restraining orders and preliminary injunctions. *See Fla. Med. Ass'n v. U.S. Dep't of Health, Educ. & Welfare,* 601 F.2d 199, 202–03 (5th Cir.1979) (reversing the district court's grant of injunction under the All Writs Act because "Rule 65 provides sufficient protection for the jurisdiction of the district court"); *Klay,* 376 F.3d at 1101 n. 13.

In *Klay,* we explained that the injunction sought in *Florida Medical Association* was a "textbook" example of a preliminary injunction because "[i]t was issued to preserve the status quo and prevent allegedly irreparable injury until the court had the opportunity to decide whether to issue a permanent injunction." *Klay,* 376 F.3d at 1101 n. 13. The injunction being sought by the plaintiffs is another textbook example of an effort to use the All Writs Act in order to circumvent the requirements for preliminary injunctive relief. Granting the injunctive relief would "confer [ ] the same legal rights upon plaintiffs and impose[ ] the same legal duties upon defendants as would a preliminary injunction." *Fla. Med. Ass'n,* 601 F.2d at 202; *id.* (the All Writs Act "does not authorize a district court to promulgate an ad hoc procedural code"). Under our circuit law, the All Writs Act cannot be used to evade the requirements for preliminary injunctions. *Klay,* 376 F.3d at 1101 n. 13.

There is no denying the absolute tragedy that has befallen Mrs. Schiavo. As the Florida Second District Court of Appeals has observed, we all have our own family, our own loved ones, and our own children. However, we are called upon to make a collective, objective decision concerning a question of law. *In re Guardianship of Schiavo*, 916 So.2d 814, 2005 WL 600377, at *4 (Fla. 2d DCA Mar. 16, 2005). In the end, and no matter how much we wish Mrs. Schiavo had never suffered such a horrible accident, we are a nation of laws, and if we are to continue to be so, the pre-existing and well-established federal law governing injunctions as well as Pub.L. No. 109–3 must be applied to her case. While the position of our dissenting colleague has emotional appeal, we as judges must decide this case on the law.

AFFIRMED; PETITION FOR INJUNCTIVE RELIEF DENIED.[6]

***1230** APPENDIX

THERESA MARIE SCHINDLER SCHIAVO, Incapacitated ex rel., ROBERT SCHINDLER and MARY SCHINDLER, her Parents and Next Friends, Plaintiffs, vs. MICHAEL SCHIAVO, JUDGE GEORGE W. GREER and THE HOSPICE OF THE FLORIDA SUNCOAST, INC., Defendants.

Case No. 8:05–CV–530–T–27TBM

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

2005 U.S. Dist. LEXIS 4265

March 22, 2005, Decided

COUNSEL: **[*1]** For Theresa Marie Schindler Schiavo, incapacitated ex rel., Robert Schindler and Mary Schindler, her parents and next friends, Plaintiff: David C. Gibbs, III, Gibbs Law Firm, Seminole, FL; George E. Tragos, Law Office of George E. Tragos, Clearwater, FL; Robert A. Destro, Columbus School Of Law, Washington, DC.

For Michael Schiavo, as guardian of the person of Theresa Marie Schindler Schiavo, incapacitated, Defendant: George J. Felos, Felos & Felos, P.A., Dunedin, FL; Iris Bennett, Jenner & Block LLC, Washington, DC; Randall C. Marshall, American Civil Liberties Union Foundation of Florida, Inc., Miami, FL; Rebecca H. Steele, ACLU Foundation of Florida, Inc., West Central Florida Office, Tampa, FL; Robert M. Portman, Jenner & Block, Washington, DC; Thomas J. Perrelli, Jenner & Block, Washington, DC.

For The Hospice of the Florida Suncoast, Inc., Defendant: Gail Golman Holtzman, Constangy, Brooks & Smith, LLC, Tampa, FL; John W. Campbell, Constangy, Brooks & Smith, LLC, Tampa, FL; Robin G. Midulla, Robin Greiwe Midulla, P.A., Tampa, FL.

For Liberty Counsel, Inc., Amicus: Erik W. Stanley, Liberty Counsel, Longwood, FL.

For United States, Interested Party: Paul I. Perez, **[*2]** U.S. Attorney's Office, Middle District of Florida, Orlando, FL; Warren A. Zimmerman, U.S. Attorney's Office, Middle District of Florida, Tampa, FL.

For Morton Plant Hospital Association, Inc., Victor E. Gambone, M.D., Morton Plant Mease Primary Care, Inc., Stanton P. Tripodis, M.D., Interested Parties: James Addison Martin, Jr., MacFarlane Ferguson & McMullen, Clearwater, FL; Jeffrey W. Gibson, MacFarlane Ferguson & McMullen, Clearwater, FL.

Gordon Wayne Watts, Interested Party, Pro se, Lakeland, FL.

JUDGES: JAMES D. WHITTEMORE, United States District Judge.

OPINION BY: JAMES D. WHITTEMORE

OPINION:
ORDER

BEFORE THE COURT is Plaintiffs' Motion for Temporary Restraining Order (Dkt.2). In their motion, Plaintiffs seek an order directing Defendants to Schiavo and Hospice to transport Theresa Schiavo to Morton Plant Hospital for any necessary medical treatment to sustain her life and to reestablish her nutrition and hydration. This action and Plaintiffs' motion were filed in response to an order of Pinellas County Probate Judge George W. Greer directing Defendant Schiavo, Theresa Schiavo's husband and plenary guardian, to discontinue her nutrition and hydration.

The court **[*3]** conducted a hearing on Plaintiffs' motion after notice to Defendants. Upon consideration, Plaintiffs' Motion for Temporary Restraining Order is denied.

***1231** Plaintiffs, the parents of Theresa Marie Schindler Schiavo, brought this action pursuant to a Congressional Act signed into law by the President during the early morning hours of March 21, 2005. n1. The Act, entitled “An Act for the relief of the parents of Theresa Marie Schiavo,” provides that the:

> United States District Court for the Middle District of Florida shall have jurisdiction to hear, determine, and render judgment on a suit or claim by or on behalf of Theresa Marie Schiavo for the alleged violation of any right of Theresa Marie Schiavo under the Constitution or laws of the United States relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain life.

n1. Pub. L. No. 109–3 (March 21, 2005).

Jurisdiction and Standing
The federal district courts are courts of limited jurisdiction, “empowered **[*4]** to hear only those cases ... which have been entrusted to them by a jurisdictional grant authorized by Congress.” *University of S. Ala. v. American Tobacco Co.,* 168 F.3d 405, 409 (11th Cir.1999) (*quoting Taylor v. Appleton,* 30 F.3d 1365, 1367 (11th Cir.1994)). The plain language of the Act establishes jurisdiction in this court to

determine *de novo* "any claim of a violation of any right of Theresa Schiavo within the scope of this Act." The Act expressly confers standing to Plaintiffs as her parents to bring any such claims. There can be no substantial question, therefore, that Plaintiffs may bring an action against a party to the state court proceedings in this court for claimed constitutional deprivations or violations of federal law occasioned on their daughter relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life. Whether the Plaintiffs may bring claims in federal court is not the issue confronting the court today, however. The issue confronting the court is whether temporary injunctive relief is warranted.

Applicable Standards

While there may be substantial issues concerning **[*5]** the constitutionality of the Act, for purposes of considering temporary injunctive relief, the Act is presumed to be constitutional. *Benning v. Georgia,* 391 F.3d 1299, 1303 (11th Cir.2004).

The purpose of a temporary restraining order, like a preliminary injunction, is to protect against irreparable injury and preserve the status quo until the district court renders a meaningful decision on the merits. *Canal Auth. of State of Florida v. Callaway,* 489 F.2d 567, 572 (5th Cir.1974). A district court may grant a preliminary injunction only if the moving party shows that:

(1) it has a substantial likelihood of success on the merits;

(2) irreparable injury will be suffered unless the injunction issues;

(3) the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and

(4) if issued, the injunction would not be adverse to the public interest.

Klay v. United Healthgroup, Inc., 376 F.3d 1092, 1097 (11th Cir.2004); *Suntrust Bank v. Houghton Mifflin Co.,* 268 F.3d 1257, 1265 (11th Cir.2001). A preliminary injunction is "an extraordinary **[*6]** and drastic remedy" and is "not to be granted unless the movant 'clearly established the burden of persuasion' as to the four prerequisites." *United States v. Jefferson County,* 720 F.2d 1511, 1519 (11th Cir.1983) (*quoting Canal Auth. of State of Florida,* 489 F.2d at 573). n2.

> ***1232** n2. The Act does not address the traditional requirements for temporary injunctive relief. Accordingly, these standards control whether temporary injunctive relief is warranted, notwithstanding Congress' intent that the federal courts determine *de novo* the merits of Theresa Schiavo's claimed constitutional deprivations.

It is apparent that Theresa Schiavo will die unless temporary injunctive relief is granted. This circumstance satisfies the requirement of irreparable injury. Moreover, that threatened injury outweighs any harm the proposed injunction would cause. To the extent Defendants urge that Theresa Schiavo would be harmed by the invasive procedure reinserting the feeding tube, this court finds **[*7]** that death outweighs any such harm. Finally, the court is satisfied that an injunction would not be adverse to the public interest. Notwithstanding these findings, it is essential that Plaintiffs establish a substantial likelihood of success on the merits, which the court finds they have not done.

The first of the four prerequisites to temporary injunctive relief is generally the most important. *Gonzalez v. Reno,* No. 00–11424–D, 2000 WL 381901 at *1 (11th Cir. April 19, 2000). The necessary level or degree of possibility of success on the merits will vary according to the court's assessment of the other factors. *Ruiz v. Estelle,* 650 F.2d 555, 565 (5th Cir.1981) (*citing with auth. Washington Metro. Area Transit Comm'n v. Holiday Tours, Inc.,* 182 U.S.App. D.C. 220, 559 F.2d 841, 843 (D.C.Cir.1977)).

A substantial likelihood of success on the merits requires a showing of only *likely* or probable, rather than *certain,* success. *Home Oil Company, Inc. v. Sam's East, Inc.,* 199 F.Supp.2d 1236, 1249 (M.D.Ala.2002) (emphasis in original); *see also Ruiz,* 650 F.2d at 565. "Where the 'balance **[*8]** of the equities weighs heavily in favor of granting the [injunction],' the movant need only show a 'substantial case on the merits.' " *Garcia–Mir v. Meese,* 781 F.2d 1450, 1453 (11th Cir.1986) (*citing Ruiz,* 650 F.2d at 565).

This court has carefully considered the Act and is mindful of Congress' intent that Plaintiffs have an opportunity to litigate any deprivation of Theresa Schiavo's federal rights. The Court is likewise mindful of Congress' directive that a *de novo* determination be made "notwithstanding any prior State court determination." In resolving Plaintiffs' Motion for Temporary Restraining Order, however, the court is limited to a consideration of the constitutional and statutory deprivations alleged by Plaintiffs in their Complaint and motion. Because Plaintiffs urge due process violations are premised primarily on the procedures followed and orders entered by Judge Greer in his official capacity as the presiding judge in the dispute between Michael Schiavo and Plaintiffs, their Complaint necessarily requires a consideration of the procedural history of the state court case to determine whether there is a showing of any due process **[*9]** violations. On the face of these pleadings, Plaintiffs have asserted five constitutional and statutory claims. To obtain temporary injunctive relief, they must show a substantial likelihood of success on at least one claim. n3.

> n3. Plaintiffs have submitted affidavits of health care professionals regarding Theresa's medical status, treatment techniques and therapies which are available and their opinions regarding how and whether these treatments might improve Theresa's condition. Plaintiffs have not, however, discussed these affidavits in their papers and how they relate to the claimed constitutional deprivations.

***1233** *A. Count I—Violation of Fourteenth Amendment Due Process Right to a Fair and Impartial Trial*

Plaintiffs allege in Count I that Theresa Schiavo's Fourteenth Amendment right to a fair and impartial trial was violated, contending that the presiding judge "became Terri's health care surrogate" and "also purported to act as an impartial trial judge in the same proceeding." (Dkt. 1, PP 47–48). They **[*10]** allege that once he "became an advocate for Terri's death, it became impossible for Judge Greer to maintain his role as an impartial judge in order to review his own decision that Terri would want to die." (Dkt. 1, P 49). Finally, they allege that "Judge Greer's dual and simultaneous role as judge and health-care surrogate denied Terri a fair and impartial trial." (Dkt. 1, P 50). These contentions are without merit.

Florida's statutory scheme, set forth in Chapter 765, contemplates a process for designation of a proxy in the absence of an executed advance directive and provides for judicial resolution of disputes arising concerning decisions made by the proxy. *See Fla. Stat.* § 765.401(1). Where a decision by the proxy is challenged by the patient's other family members, it is appropriate for the parties to seek "expedited judicial intervention." *Fla. Slat.* § 765.105. Applying this statutory scheme, the state court appointed Michael Schiavo, Theresa Schiavo's husband, as plenary guardian and proxy for Theresa. Thereafter, a dispute arose between Michael Schiavo and Plaintiffs concerning whether to continue Theresa on artificial life support, and Judge Greer, the presiding **[*11]** judge, was called upon to resolve that dispute.

Florida's statutory scheme contemplates a judicial resolution of these competing contentions. *See In re Guardianship of Browning*, 568 So.2d 4, 16 (Fla.1990). As the Florida Second District Court of Appeal explained, where two "suitable surrogate decision-maker[s] ... could not agree on the proper decision, ..." the guardian may invoke "the trial court's jurisdiction to allow the trial court to serve as the surrogate decision-maker." *In re Guardianship of Schiavo,* 780 So.2d 176, 178 (Fla.Dist.Ct.App.2001) ("*Schiavo I*"). Pursuant to Florida law, therefore, Judge Greer, as the presiding judge, had a statutory obligation to resolve the competing contentions between Michael Schiavo and Plaintiffs. *Fla. Stat.* § 765.105.

Plaintiffs offer no authority for their contention that Judge Greer compromised the fairness of the proceeding or the impartiality of the court by following Florida law and fulfilling his statutory responsibilities under Chapter 765 as presiding judge and decision-maker. n4. Plaintiffs' argument is that Judge Greer could not fulfill his judicial duties impartially while at **[*12]** the same time fulfilling his statutory duty to resolve the competing contentions of the parties as surrogate or proxy "to make decisions about life-prolonging procedures." *In re Guardianship of Schiavo,* No. 2D05–968, —F.3d ——, ——, 2005 WL 600377 at *4 (Fl.Ct.App. March 16, 2005) ("*Schiavo VI*").

n4. During argument, Plaintiffs' counsel explained their criticism of Judge Greer's official actions as Judge Greer having exceeded his lawful authority by acting as a guardian contrary to *Fla. Stat.* § 744.309(1)(b). Contrary to Plaintiffs' argument, § 744.309 merely prohibits a judge from acting as a guardian except under certain specified familial circumstances.

Plaintiffs' argument effectively ignores the role of the presiding judge as judicial fact-finder and decision-maker under the Florida statutory scheme. By fulfilling his statutory judicial responsibilities, the ***1234** judge was not transformed into an advocate merely because his rulings are unfavorable to a litigant. Plaintiffs' contention that the statutory **[*13]** scheme followed by Judge Greer deprived Theresa Schiavo of an impartial trial is accordingly without merit. Defendant is correct that no federal constitutional right is implicated when a judge merely grants relief to a litigant in accordance with the law he is sworn to uphold and follow. This Court concludes that Plaintiffs cannot establish a substantial likelihood of success on the merits of Count I.

B. Count II—Violation of Fourteenth Amendment Procedural Due Process Rights

In Count II, Plaintiffs contend that Theresa Schiavo's Fourteenth Amendment procedural due process rights were violated by Judge Greer's (1) failure to appoint a guardian *ad litem* (Dkt. 1, P 53), (2) failure to appoint an independent attorney to represent Theresa Schiavo's legal rights (Dkt. 1, P 54) and (3) denial of what Plaintiffs describe as "access to court" by his "failure to ever meet Terri personally" and failure to "personally assess Terri's level of cognition and her responsiveness" (Dkt. 1, P 55).

Initially, the Court finds no authority recognizing as a matter of federal constitutional or statutory right that a state trial judge is required to "personally assess" a ward's "level of cognition **[*14]** and ... responsiveness." *Fla. Stat.* § 744.3725, on which Plaintiffs rely, is applicable to an action seeking to commit the ward to a facility and other circumstances not relevant to this case. Plaintiffs' conclusory allegation that Judge Greer denied Theresa Schiavo access to court by not requiring her presence is without merit.

With respect to Plaintiffs' contention that Judge Greer violated Theresa Schiavo's procedural due process rights by failing to appoint a guardian *ad litem,* the record belies this contention. In June, 1998, Judge Rives *sua sponte* appointed Richard L. Pearse, Jr., Esq. as guardian *ad litem* "for the purpose of reviewing the request for termination of life support on behalf of the wards [sic]." *In re Guardianship of Schiavo,* No. 90–2908–GD–003 (Pinellas Cty. Circ. Ct., June 11, 1998). The record reflects that attorney Pearse "fully complied with his June 11, 1998 Court Order of appointment" and was accordingly discharged on June 16, 1999 by Judge Boyer of the Pinellas County Circuit Court. Pearse served as guardian *ad litem* for one year and ultimately testified as a witness in the trial before Judge Greer. *In re Guardianship of Schiavo,* **[*15]** No. 90–2908–GD–003 (Pinellas Cty. Circ. Ct., Feb. 28, 2000). n5. Accordingly, assuming Fourteenth Amendment procedural due process requires the appointment of a guardian *ad litem,* there would be no constitutional deprivation here because three guardians *ad litem* were appointed to represent Theresa Schiavo's interests over the course of the litigation.

n5. The record also reveals that attorney John H. Pecarek was appointed as guardian *ad litem* early in the proceedings. *In re Guardianship of Schiavo,* No. 90–2908–GD–003 (Pinellas Cty. Circ. Ct., Feb. 17, 1994). Late in the litigation, at the request of Florida Governor Jeb Bush, Pinellas County Chief Judge David Demers also appointed attorney Jay Wolfson, M.D. as guardian *ad litem*. *Schiavo VI,* 2005 WL 600377 at *1, n. 2.

Plaintiffs' last contention is that Theresa Schiavo's procedural due process rights were violated by Judge Greer's refusal to appoint an independent attorney to represent her interests. The due process clause is **[*16]** implicated when there is a "deprivation ***1235** of life, liberty or property at the hands of the government." *Grayden v. Rhodes,* 345 F.3d 1225, 1232 (11th Cir.2003). If one or more of these constitutionally protected interests is at stake, as they undoubtedly are in this case, the due process clause requires notice and the opportunity to be heard. *Id.* "It is ... fundamental that the right to notice and an opportunity to be heard must be granted at a meaningful time and in a meaningful manner." *Fuentes v. Cortese,* 407 U.S. 67, 80, 92 S.Ct. 1983, 32 L.Ed.2d 556 (1972). Unquestionably, in some circumstances, a meaningful opportunity to be heard includes the right to be represented by counsel. However, "due process is a flexible concept that varies with the particular circumstances of each case, and to determine the requirements of due process in a particular situation we must apply the balancing test articulated in *Mathews v. Eldridge,* 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976)." *Grayden,* 345 F.3d at 1232–33.

The *Mathews* balancing test requires consideration of three distinct factors: "First, the private interest that will be affected by the official **[*17]** action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Mathews,* 424 U.S. at 335, 96 S.Ct. 893.

The first factor weighs the interest at stake. Plaintiffs urge that Theresa Schiavo's life is at stake, while Defendant argues that her liberty to exercise her right to refuse medical treatment is the interest being adjudicated. In either case, a fundamental and important interest is implicated in the court proceedings determining the removal of artificial life support.

The second *Mathews* factor requires consideration of the risk of erroneous deprivation under the procedures used and the probable value of the additional protections urged by the Plaintiffs. Theresa Schiavo's case has been exhaustively litigated, including an extensive trial, followed by another "extensive hearing at which many highly qualified physicians testified" to reconfirm that no meaningful treatment **[*18]** was available, and six appeals. As the Florida Second District Court of Appeal stated, "few, if any, similar cases have ever been afforded this heightened level of process." *Schiavo VI,* 2005 WL 600377 at *3.

Throughout the proceedings, the parties, represented by able counsel, advanced what they believed to be Theresa Schiavo's intentions concerning artificial life support. In Florida, counsel for Michael Schiavo as Theresa Schiavo's guardian owed a duty of care to Theresa Schiavo in his representation. *Op. Atty. Gen.* 96–94 (November 20, 1996). Finally, with respect to presenting the opposing perspective on Theresa Schiavo's wishes, the Court cannot envision more effective advocates than her parents and their able counsel. Plaintiffs have not shown how an additional lawyer appointed by the court could have reduced the risk of erroneous rulings.

With regard to the third factor, without question the state of Florida has an interest in the welfare of its citizens and in the legal process for adjudicating disputed claims such as were presented to Judge Greer in this case, as evidenced by Florida's well defined statutory scheme. The court's inherent authority to appoint **[*19]** a guardian *ad litem,* consult independent experts or appoint an attorney if warranted protects the state's interest.

***1236** Balancing the three factors, this court concludes that Theresa Schiavo's life and liberty interests were adequately protected by the extensive process provided in the state courts. Defendant Michael Schiavo and Plaintiffs, assisted by counsel, thoroughly advocated their competing perspectives on Theresa Schiavo's wishes. Another lawyer appointed by the court could not have offered more protection of Theresa Schiavo's interests. Accordingly, Plaintiffs have not established a substantial likelihood of success on the merits on Count II.

C. Count Three—Violation of Fourteenth Amendment Right to Equal Protection of the Law

For the same reasons relief under Count I was not appropriate, the relief sought in Count III via the equal protection clause is without merit. Plaintiff has not established a substantial likelihood of success on the merits of the claims set forth in Count III. *See Cruzan v. Missouri Dept. of Health,* 497 U.S. 261, 287 n. 12, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990) ("The differences between the choice made *by* a competent person to refuse **[*20]** medical treatment, and the choice made *for* an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class.") (emphasis in original).

D. Counts IV and V—Violation of Religious Land Use and Institutionalized Persons Act (RLUIPA) and Violation of First Amendment Free Exercise of Religion Clause

Plaintiffs bring Counts IV and V alleging that Theresa Schiavo's right to exercise her religion has been burdened by the state court's order to remove the feeding tube. With respect to Count IV of the Complaint, Plaintiffs allege a claim under the Religious Land Use and Institutionalized Persons Act *(42 U.S.C. § 2000cc–1),* claiming that her rights to free exercise of her religion have been burdened by the state court's order authorizing removal of her feeding tube in that removal of the feeding tube "imposes a substantial burden on Terry's religious free exercise." That statute expressly requires, however, that "no *government* shall impose a substantial burden on the religious exercise of **[*21]** a person ..." *42 U.S.C. § 2000cc*(a) (emphasis added).

In Count V, Plaintiffs make a similar contention under the *42 U.S.C. § 1983* and the free exercise clause, alleging that "Terry's religious beliefs are burdened" by execution of order "in that Terry is being forced to engage in an activity contrary to the tenets of her Roman Catholic faith...." Plaintiffs allege that Defendants have a constitutional duty to accommodate "Terry's sincerely-held religious beliefs."

Undoubtedly, Terry Schiavo enjoys, by virtue of *42 U.S.C. § 2000* cc(a), a statutorily protected right not to have substantial burdens placed on her religious exercise by the government. The plain language of the statute prohibits government from imposing a substantial burden on the religious exercise of an individual such as Theresa Schiavo. Similarly, the Free Exercise Clause contained in the First Amendment of the Constitution expressly protects the exercise of religion. In their Complaint, Plaintiffs allege that the state court's order imposes a substantial burden on Theresa Schiavo's free exercise of religion. (Complaint, P 67).

In order **[*22]** to succeed on either claim, however, Plaintiffs must establish that the Defendants were state actors. Plaintiffs' claims fail because neither Defendant Schiavo nor Defendant Hospice ***1237** are state actors. Moreover, the fact that the claims were adjudicated by a state court judge does not provide the requisite state action for purposes of the statute or the Fourteenth Amendment. *See Harvey v. Harvey,* 949 F.2d 1127, 1133–34 (11th Cir.1992) ("Use of the courts by private parties does not constitute an act under color of state law."); *Torres v. First State Bank of Sierra County,* 588 F.2d 1322, 1326–27 (10th Cir.1978) ("We do not think that the 'color of law' reference in § 1983 was intended to encompass a case such as this one, where the only infirmities are the excesses of the court order itself, ... subject to the normal processes of appeal."); *see also Dahl v. Akin, 630 F.2d 277, 281 (5th Cir.1980)*.

This court appreciates the gravity of the consequences of denying injunctive relief. Even under these difficult and time strained circumstances, however, and notwithstanding Congress' expressed interest in the welfare of Theresa Schiavo, **[*23]** this court is constrained to apply the law to the issues before it. As Plaintiffs have not established a substantial likelihood of success on the merits, Plaintiffs' Motion for Temporary Restraining Order (Dkt. 2) must be **DENIED.**

DONE AND ORDERED in chambers this 22nd day of March, 2005.

JAMES D. WHITTEMORE

United States District Judge

WILSON, Circuit Judge, dissenting:

I strongly dissent from the majority's decision to deny the request for an injunction pursuant to the All Writs Act and the request for a preliminary injunction. First, Plaintiffs have demonstrated their entitlement to a preliminary injunction. Second, the denial of Plaintiffs' request for an injunction frustrates Congress's intent, which is to maintain the status quo by keeping Theresa Schiavo alive until the federal courts have a new and adequate opportunity to consider the constitutional issues raised by Plaintiffs. The entire purpose for the statute was to give the federal courts an opportunity to consider the merits of Plaintiffs' constitutional claims with a fresh set of eyes. Denial of Plaintiffs' petition cuts sharply against that intent, which is evident to me from the language of the statute, as well as the swift and unprecedented manner of its enactment. Theresa Schiavo's death, which is imminent, effectively ends the litigation without a fair opportunity to fully consider the merits of Plaintiffs' constitutional claims.

We should, at minimum, grant Plaintiffs' All Writs Petition for emergency injunctive relief. First, I note that there is no precedent that prohibits our granting of this petition. Second, mindful of equitable principles, the extraordinary circumstances presented by this appeal require that we grant the petition to preserve federal jurisdiction and permit the opportunity to give Plaintiffs' claims the full and meaningful review they deserve.

In considering this extraordinary case, I am mindful that "[t]he essence of equity jurisdiction has been the power of the Chancellor to do equity and to mould each decree to the necessities of the particular case. Flexibility rather than rigidity has distinguished it. The qualities of mercy and practicality have made equity the instrument for nice adjustment and reconciliation between the public interest and private needs as well as between competing private claims." *Swann v. Charlotte–Mecklenburg Bd. of Educ.,* 402 U.S. 1, 15, 91 S.Ct. 1267, 28 L.Ed.2d 554 (1971) (citations omitted). Keeping those principles firmly in mind, "mercy and practicality" compel us to grant the relief requested.

***1238** *I. All Writs Act, 28 U.S.C. § 1651*

The All Writs Act provides: "The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." 28 U.S.C. § 1651. Federal courts have "both the inherent power and the *constitutional obligation* to protect their jurisdiction ... to carry out Article III functions." *Procup v. Strickland,* 792 F.2d 1069, 1074 (11th Cir.1985) (en banc) (emphasis added). Toward that end, the All Writs Act permits federal courts to protect their jurisdiction with regards to "not only ongoing proceedings, but potential future proceedings." *Klay v. United Healthgroup, Inc.,* 376 F.3d 1092, 1099 (11th Cir.2004) (internal citations omitted); *ITT Comm. Devel. Corp. v. Barton,* 569 F.2d 1351, 1359 n. 19 (5th Cir.1978)[1] ("When potential jurisdiction exists, a federal court may issue status quo orders to ensure that once its jurisdiction is shown to exist, the court will be in a position to exercise it."). Although the Act does not create any substantive federal jurisdiction, it empowers federal courts "to issue writs in aid of jurisdiction previously acquired on some other independent ground," *see Brittingham v. Comm'r,* 451 F.2d 315, 317 (5th Cir.1971), and codifies the "federal courts' traditional, inherent power to protect the jurisdiction they already have." *Klay,* 376 F.3d at 1099.

An injunction under the All Writs Act is an extraordinary remedy, one that "invests a court with a power that is essentially equitable, and as such, not generally available." *Clinton v. Goldsmith,* 526 U.S. 529, 537, 119 S.Ct. 1538, 1543, 143 L.Ed.2d 720 (1999). A federal court's power under the Act, while limited, is broad enough that "[a] court may grant a writ under this act whenever it is 'calculated [in the court's] sound judgment to achieve the ends of justice entrusted to it." *Klay,* 376 F.3d at 1100 (citing *Adams v. United States,* 317 U.S. 269, 273, 63 S.Ct. 236, 239, 87 L.Ed. 268 (1942)).

I am careful to stress that equitable relief under the All Writs Act is not to be confused with a traditional injunction, which is "predicated upon some cause of action." *Klay,* 376 F.3d at 1100. An injunction entered pursuant to the All Writs Act is not a substitute for traditional injunctive relief. The All Writs Act injunction is distinguished from a traditional injunction not by its effect, but by its purpose. To obtain relief under the All Writs Act, Plaintiffs need not satisfy the traditional four-part test associated with traditional injunctions "because a court's traditional power to protect its jurisdiction, codified by the act, is grounded in entirely separate concerns." *Id.* However, Plaintiffs must show that "some ongoing proceeding ... is being threatened by someone else's action or behavior." *Id.* Relief pursuant to the All Writs Act should only be granted in extraordinary circumstances where inaction would prevent a federal court from exercising its proper Article III jurisdiction.[2]

***1239** As an appellate court, we may grant All Writs Act relief to preserve our "potential jurisdiction ... where an appeal is not then pending but may be later perfected." *F.T.C. v. Dean Foods Co.,* 384 U.S. 597, 603, 86 S.Ct. 1738, 1742, 16 L.Ed.2d 802 (1966). In *Dean Foods,* the Supreme Court sustained the entry of a preliminary injunction that prevented the consummation of a merger of two corporations. The Supreme Court held that the use of an All Writs Act injunction was particularly appropriate in a situation where "an effective remedial order ... would otherwise be virtually impossible." *Id.* at 605, 86 S.Ct. 1738. That is precisely the case here.

Plaintiffs have demonstrated that the issuance of an injunction is essential to preserve the federal courts' ability to "bring the litigation to a natural conclusion." *Klay,* 376 F.3d at 1102. By failing to issue an injunction requiring the reinsertion of Theresa Schiavo's feeding tube, we virtually guarantee that the merits of Plaintiffs' claims will never be litigated in federal court. That outcome would not only result in manifest injustice, but it would thwart Congress's clearly expressed command that Plaintiffs' claims be given *de novo* review by a federal court.

Given the extraordinary circumstances of this case, we are fully within our power to issue an injunction "in aid of [our] jurisdiction" pursuant to the All Writs Act. Under the Act, "[a] court may enjoin almost any conduct 'which, left unchecked, would have ... the practical effect of diminishing the court's power to bring the litigation to a natural conclusion." *Klay,* 376 F.3d at 1102 (citing *Barton,* 569 F.2d at 1359). Federal courts may "compel acts necessary to promote the resolution of issues in a case properly before it" including "issu[ing] orders to aid in conducting factual inquiries." *Id.* (citations and internal quotation omitted).

The issuance of an All Writs Act injunction is, as mentioned earlier, an extraordinary remedy. However, this case is clearly extraordinary. Furthermore, entry of an All Writs Act injunction is necessary to preserve federal jurisdiction to hear Plaintiffs' claims. My research has not revealed any precedent which clearly prohibits the entry of an All Writs Act injunction in a situation where a few days' delay is "necessary or appropriate in aid of" federal court jurisdiction. 28 U.S.C. § 1651. In contrast, refusing to grant the equitable relief would, through Theresa Schiavo's death, moot the case and eliminate federal jurisdiction.

This deprivation would directly contravene Congress's recent enactment granting jurisdiction in this case. An Act for the relief of the parents of Theresa Marie Schiavo, Pub. L. No. 109–3 § 2 (Mar. 21, 2005). The first step in statutory interpretation requires that courts apply the plain meaning of the statutory language unless it is ambiguous. *Conn. Nat'l Bank v. Germain,* 503 U.S. 249, 253–54, 112 S.Ct. 1146, 1149, 117 L.Ed.2d 391 (1992); *United States v. Fisher,* 289 F.3d 1329, 1337–38 (11th Cir.2002). Only when we find ambiguity in the statute's text should we apply canons of statutory interpretation, such as the canon of constitutional avoidance. *Dep't of Hous. & Urban Dev. v. Rucker,* 535 U.S. 125, 134, 122 S.Ct. 1230, 1235, 152 L.Ed.2d 258 (2002).

Because the language of the statute is clear, the majority's reliance on legislative history is unwarranted and incorrect. As originally proposed, the Act mandated a stay of proceedings while the district court considered Plaintiffs' claims. A later version ***1240** changed the language from "shall" (mandating a stay) to "may" (authorizing a stay). *See* 151 Cong. Rec. 3099, 3100 (daily ed. Mar. 20, 2005) (statement of Sen. Levin). Although the final version of the Act did not contain any stay provision, we should not read this to mean that Congress intended to deny this Court the power to issue a stay. The reason that Congress deleted the stay provision is that "this bill does not change current law under which a stay is discretionary." *Id.* (statement of Sen. Frist). In short, the legislation did not need an explicit stay provision because, given the already-existing discretionary power of federal courts to issue injunctions in aid of jurisdiction, it would have been redundant and unnecessary. Therefore, the majority's assertion that the text of the statute limits or eliminates our power to enter an injunction is misplaced.

Here, we have Congress's clear mandate requiring the federal courts to consider the actual merits of Plaintiffs' claims. Congress intended for this case to be reviewed with a fresh set of eyes. We are not called upon to consider the wisdom of this legislation. In granting this injunction we would merely effectuate Congress's intent.

If Congress had intended that federal review of the issues raised by Plaintiffs be given customary and ordinary treatment, that review would be confined to consideration of the denial of the motion for a writ of habeas corpus in Case No. 05–11517. There, consideration of Plaintiffs' constitutional claims would be limited by the substantial deference that is afforded to previous state court determinations. Yet, Congress went to great lengths to remove many of those limitations. First, the legislation eliminates any "standing" barriers to the commencement of an action by Plaintiffs. Secondly, the legislation gives the

Middle District of Florida entirely new consideration over any claim of a violation of Theresa Schiavo's constitutional rights, without respect to "any prior state court determination and regardless of whether such a claim has previously been raised, considered, or decided in state court proceedings." The legislation goes even further to eliminate any exhaustion requirements. Congress obviously intended that this case be considered by federal courts without the customary limitations. Today, we are not called upon to second-guess the wisdom of Congress, but to apply the law it has passed.

II. Preliminary Injunction

At first glance, Plaintiffs' request for an injunction does not appear as strong as their claim pursuant to the All Writs Act. However, I believe that an injunction is appropriate and, at the very least, we should issue an injunction to permit the district court to review Plaintiffs' claims on the merits.

To prevail on their request for injunctive relief, Plaintiffs must demonstrate the following: (1) a substantial likelihood of success on the merits; (2) irreparable injury if the injunction is not issued; (3) threatened injury to the movant outweighs the potential damage that the proposed injunction may cause the defendants; and (4) the injunction will not be adverse to the public interest. *See All Care Nursing Serv., Inc. v. Bethesda Mem'l Hosp., Inc.,* 887 F.2d 1535, 1537 (11th Cir.1989) (citation omitted). The issuance of an injunction is an extraordinary remedy, and the moving party "bears the burden to clearly establish the four prerequisites." *Cafe 207, Inc. v. St. Johns County,* 989 F.2d 1136, 1137 (11th Cir.1993).

It is clear from our cases that proof of a substantial likelihood of success on the merits is an indispensable prerequisite to a preliminary injunction. *All Care Nursing Serv.,* 887 F.2d at 1537. However, the ***1241** movant must demonstrate a "substantial likelihood," not a substantial certainty. To require more undermines the purpose of even considering the other three prerequisites. Thus, instead, "the movant need only present a substantial case on the merits when a serious legal question is involved and show that the balance of the equities weighs heavily in favor of granting the [preliminary injunction]." *Ruiz v. Estelle,* 650 F.2d 555, 565 (5th Cir.1981) (per curiam); *see Gonzalez v. Reno,* No. 00–11424–D, 2000 WL 381901 at *1 (11th Cir. Apr. 19, 2000); *United States v. Hamilton,* 963 F.2d 322, 323 (11th Cir.1992); *Garcia–Mir v. Meese,* 781 F.2d 1450, 1453 (11th Cir.1986). The review "require[s] a delicate balancing of the probabilities of ultimate success at final hearing with the consequences of immediate irreparable injury which could possibly flow from the denial of preliminary relief." *Siegel v. LePore,* 234 F.3d 1163, 1178 (11th Cir.2000) (en banc).

As we stated in *Gonzalez,* "where the balance of the equities weighs heavily in favor of granting the [injunction], the movant need only show a substantial case on the merits." *Gonzalez,* 2000 WL 381901 at *1 (internal citations omitted) (alteration in original). In this case, the balance of the equities weighs heavily in favor of granting the injunction. We determine the balance of the equities by examining the three final factors required to grant a preliminary injunction. *Garcia–Mir,* 781 F.2d at 1453.

"A showing of irreparable harm is the *sine qua non* of injunctive relief." *Northeastern Fla. Chapter of the Ass'n of Gen. Contractors of Am. v. City of Jacksonville,* 896 F.2d 1283, 1285 (11th Cir.1990) (citation and internal quotation omitted). Here, the immediate irreparable injury is not only possible, it is imminent. I am aware of no injury more irreparable than death. Clearly, the threatened injury of death outweighs any harm the proposed injunction may cause, i.e. reinserting the feeding tube. In fact, I fail to see any harm in reinstating the feeding tube. On the other hand, a denial of the request for injunction will result in the death of Theresa Schiavo. Finally, an injunction in this case clearly would not be adverse to public interest, thus satisfying the fourth and final criteria necessary to grant a preliminary injunction. Upon reviewing these three factors, it is obvious that the equities weigh heavily in favor of granting the injunction.

I now consider the first prong, whether Plaintiffs presented a substantial case on the merits. In the complaint, Plaintiffs claim that Theresa Schiavo's Fourteenth Amendment due process rights were violated in that she was not provided a fair and impartial trial, she was not given adequate procedural due process, and she was not afforded equal protection of the laws. Further, Plaintiffs contend that Theresa Schiavo's First Amendment freedom to exercise her religion has been burdened by the state court's order to remove the feeding tube. Plaintiffs also allege a violation of the Religious Land Use and Institutionalized Persons Act (RLUIPA), 42 U.S.C. § 2000cc–1(a).

The establishment of a "substantial likelihood for success on the merits" is a heavy burden, but not an insurmountable one. A movant need not establish that he can hit a home run, only that he can get on base, with a possibility of scoring later. In fact, our circuit jurisprudence establishes that the movant need not establish a "probability" of success, taking all things into consideration. The merits of Plaintiffs' substantial claims warrant a more complete review. I do not mean to suggest that Plaintiffs will definitely prevail on the merits, but merely that they have presented a sufficient case on the merits. Plaintiffs raise legal issues necessitating ***1242** the grant of the preliminary injunction and should be afforded an opportunity to defend the merits of their claims. Adjudication on the merits is impossible if we do not grant the injunction.

Finally, I note that awarding an injunction is an equitable decision. We have broad powers to fashion a remedy in equity. We are required to balance the equities, and when we do, we should find that the gravity of the irreparable injury Theresa Schiavo would suffer could not weigh more heavily in Plaintiffs' favor. In contrast, there is little or no harm to be found in granting this motion for a temporary injunction and deciding the full merits of the dispute.

For the foregoing reasons, I respectfully dissent.

All Citations

403 F.3d 1223, 30 NDLR P 2, 18 Fla. L. Weekly Fed. C 343

Footnotes

[1] Our dissenting colleague says that "the denial of Plaintiffs' request for an injunction frustrates Congress's intent, which is to maintain the status quo." Dissenting Op. at 1237. The status quo is that Mrs. Schiavo is not receiving nutrition and hydration. The plaintiffs do not want the status quo maintained. They want this Court or the district court to issue an injunction affirmatively requiring the respondents to change the status quo by bringing about the surgical procedure necessary to reinsert the feeding tube into Mrs. Schiavo.

[2] The dissent bemoans the fact that the merits of the plaintiffs' claims will never be litigated in federal court. The district court's finding regarding the first-prong injunctive relief factor reflects that those claims lack merit, or at least that the possibility of any merit is too low to justify preliminary injunctive relief.

[3] Part II of the dissent argues that we should grant an injunction and discusses the four factors as though this Court were making the decision in the first instance. We are not. We are an appellate court reviewing the district court's decision. There is no occasion for us to decide whether to issue an injunction pending appeal, because the only appeal we have before us is from the district court's denial of a temporary restraining order, and we are deciding that appeal now.

[4] In arguing that an injunction should be issued, the dissent refers to "a situation where a few days' delay" is all that is necessary. That is not this situation. To afford the plaintiffs the pretrial discovery and full jury trial of all issues they demand would require a delay of many months, if not longer.

[5] Contrary to the dissent's assertion, we do not believe that the text of the Act limits or eliminates a court's power to grant temporary or preliminary relief. Exactly the contrary. Our position is that the Act, which does not mention that subject, and which was amended to remove a provision that would have changed the law, does not affect it at all. The district court applied settled law and so do we.

[6] A petition for rehearing or suggestion for rehearing en banc is not, of course, required before a petition for certiorari may be filed in the United States Supreme Court. If, however, a petition for rehearing or rehearing en banc is to be filed, it must be filed by 10:00 a.m. ET, March 23, 2005. *See* Fed.R.App.P. 35(c) & Fed.R.App.P. 40(a)(1).

[1] In *Bonner v. Prichard,* 661 F.2d 1206, 1209 (11th Cir.1981) (en banc), we adopted as binding precedent the decisions of the former Fifth Circuit handed down prior to October 1, 1981.

[2] The majority opinion holds that the All Writs Act is not appropriate in this case because "where the relief sought is in essence a preliminary injunction, the All Writs Act is not available because other, adequate remedies at law exist, namely Fed.R.Civ.P. 65, which provides for temporary restraining orders and preliminary injunctions" Maj. Opn. at 1228–29. I do not argue with that point. However, in this case, the relief Plaintiffs seek is not a preliminary injunction by another name. Rather, the purpose for which Plaintiffs ask that we reinsert Theresa Schiavo's feeding tube is to permit a federal court to have time within which to exercise its jurisdiction and fully entertain Plaintiffs' claims. Thus, the purpose of entering an injunction in this case is limited to the narrow goal of aiding the exercise of federal jurisdiction. Plaintiffs' claim is precisely the one and only type of situation in which an All Writs Act injunction is appropriate and for which there is no other adequate remedy at law.

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701 F.3d 1110
United States Court of Appeals, Seventh Circuit.

Iain WALKER, Petitioner–Appellant,
v.
Norene WALKER, Respondent–Appellee.

No. 11–3602
|
Argued Sept. 11, 2012.
|
Decided Nov. 16, 2012.
|
Rehearing and Rehearing En Banc Denied Jan. 8, 2013.

Synopsis

Background: Father, a citizen of Australia, filed suit under the International Child Abduction Remedies Act (ICARA), seeking to compel mother, a citizen of the United States and father's wife, to return the couple's three children to Australia. The United States District Court for the Northern District of Illinois, Samuel Der–Yeghiayan, J., 2011 WL 5008533, denied petition. Father appealed.

Holdings: The Court of Appeals, Wood, Circuit Judge, held that:

[1] evidence that father and mother mutually intended to abandon Australia and take up residence with children in United States was too contradictory and underdeveloped to support finding that United States was children's habitual residence;

[2] father did not clearly and unequivocally abandon his children at time of their allegedly wrongful retention in United States; and

[3] father did not unconditionally consent to mother's retention of children in United States.

Reversed and remanded.

Procedural Posture(s): On Appeal.

West Headnotes (16)

[1] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Jurisdiction

Proceeding on petition under ICARA by father, a citizen of Australia, to compel mother, a citizen of the United States and father's wife, to return the couple's three children to Australia, was not rendered moot by Illinois state-court judgment awarding sole custody of the children to mother; mother and father disputed which country was children's habitual residence, and until that question was resolved, it could not be determined which country's courts had the power to resolve the issue of custody. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 17, 1988 WL 411501.

[2] **Child Custody** 🔑 Constitutional and statutory provisions and treaties

The entire purpose of the Hague Convention on the Civil Aspects of International Child Abduction is to deter parents from absconding with their children and crossing international borders in the hopes of obtaining a favorable custody determination in a friendlier jurisdiction. International Child Abduction Convention, Art. 17, 1988 WL 411501.

13 Cases that cite this headnote

[3] **Evidence** 🔑 Particular Cases and Contexts

Letter from father to mother, which offered to compromise their state-court divorce dispute, including claims over both property and child custody, was settlement offer that was inadmissible to show father consented to mother's custody, in proceeding on petition under ICARA by father, a citizen of Australia, to compel mother, a citizen of United States, to return couple's children to Australia; if custody-related settlement offers were admissible to show offering parent abandoned custody rights or consented to child remaining abroad, parents would be less willing to make such offers at all. Fed.Rules Evid.Rule 408, 28 U.S.C.App.(2006 Ed.); International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

2 Cases that cite this headnote
More cases on this issue

[4] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Wrongful retention or removal

For purposes of ICARA petition by father, a citizen of Australia, to compel mother, a citizen of United States and father's wife, to return their children to Australia, mother's allegedly wrongful retention of children in United States began either when father sent mother a letter, in connection with divorce proceeding, that unequivocally stated children's habitual residence was Australia, or when father in following weeks took steps in Australia for children's return pursuant to procedures approved by Hague Convention on the Civil Aspects of International Child Abduction and Australian government. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

3 Cases that cite this headnote

[5] **Child Custody** 🔑 Questions of Fact and Findings of Court

In proceeding on parent's petition under ICARA to compel other parent to return children who are allegedly wrongfully retained in country that is not their habitual residence, date on which wrongful retention of children commenced is a question of fact on which Court of Appeals normally defers to the district court. Fed.Rules Evid.Rule 408, 28 U.S.C.App.(2006 Ed.); International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

2 Cases that cite this headnote

[6] **Child Custody** 🔑 Habitual residence

Under the Hague Convention on the Civil Aspects of International Child Abduction, the merits of parents' custody dispute are irrelevant to the distinct question of which country is the child's habitual residence in which the custody dispute should be resolved. International Child Abduction Convention, Arts. 1, 19, 1988 WL 411501.

12 Cases that cite this headnote

[7] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Return of child

In proceeding on parent's petition under ICARA to compel other parent to return child who is allegedly wrongfully retained in country that is not child's habitual residence, court determines child's habitual residence by asking whether a prior place of residence was effectively abandoned and a new residence established by the shared actions and intent of the parents coupled with the passage of time, and because the parents often dispute their intentions, the court should look at actions as well as declarations in determining whether the parents shared intent to abandon prior habitual residence. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

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Jennie contacted Roger for assistance and they agreed that Thad would move to London to attend a private school and visit Jennie every holiday and the entire summer.

11 Cases that cite this headnote

[8] **Child Custody** 🔑 Trial de novo

Child Custody 🔑 Questions of Fact and Findings of Court

In an appeal from a habitual residence determination in a proceeding on parent's petition under ICARA to compel other parent to return children who are allegedly wrongfully retained in country that is not their habitual residence, Court of Appeals reviews findings on the parties' intent to abandon prior place of residence and establish new residence for clear error, while the ultimate determination of habitual residence is a mixed question of law and fact subject to de novo review. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

7 Cases that cite this headnote

[9] **Child Custody** 🔑 Habitual residence

Child Custody 🔑 Return of child

Evidence that father and mother mutually intended to abandon Australia and take up residence with their children in United States was too contradictory and underdeveloped to support finding that United States was children's habitual residence, as would defeat ICARA petition by father, a citizen of Australia, to compel mother, a citizen of United States and father's wife, to return allegedly wrongfully retained children to Australia, nor were children in United States for so long prior to filing of petition that their lives became so firmly embedded in United States as to make them habitually resident regardless of parents' lack of mutual intent. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 1 et seq., 1988 WL 411501.

2 Cases that cite this headnote

More cases on this issue

[10] **Child Custody** 🔑 Habitual residence

Child Custody 🔑 Return of child

Child Custody 🔑 Wrongful retention or removal

Parent petitioning under ICARA to compel other parent to return child who is wrongfully retained in country that is not child's habitual residence must show he was actually exercising his custody rights at the time of the wrongful retention. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 3, 1988 WL 411501.

16 Cases that cite this headnote

[11] **Child Custody** 🔑 Habitual residence

Child Custody 🔑 Wrongful retention or removal

Child Custody 🔑 Abandonment

Standard for finding that a parent was exercising his custody rights at time of other parent's wrongful retention of child in country that is not child's habitual residence, as required to prevail on ICARA petition for return of child, is a liberal one, and court will generally find exercise whenever a parent with de jure custody rights keeps, or seeks to keep, any sort of regular contact with his or her child, indeed, a person cannot fail to exercise his custody rights short of acts that constitute clear and unequivocal abandonment of the child. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 3, 1988 WL 411501.

20 Cases that cite this headnote

[12] **Child Custody** 🔑 Wrongful retention or removal

Child Custody 🔑 Abandonment

Father, a citizen of Australia, did not clearly and unequivocally abandon his children at time of their allegedly wrongful retention in United States, as would preclude relief on father's ICARA petition to compel mother, a citizen of United States and father's wife, to return children to Australia, where family lived for 12 years, although father had not been to United States for several months prior to allegedly wrongful retention and ceased supporting mother financially after retention began, where father kept regular contact with the children by speaking to them weekly and sought to secure custody and visitation when first learning mother intended to file for divorce. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Arts. 1, 3, 19, 1988 WL 411501.

[13] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Acquiescence to removal
Child Custody 🔑 Return of child
Child Custody 🔑 Wrongful retention or removal

Even if child is wrongfully retained by parent in country that is not child's habitual residence, other parent may waive his right to return of child under ICARA if he consented to, or acquiesced in, the child's retention. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 13, 1988 WL 411501.

1 Cases that cite this headnote

[14] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Acquiescence to removal
Child Custody 🔑 Wrongful retention or removal

Consent and acquiescence are analytically distinct defenses to parent's ICARA petition for return of child wrongfully retained by other parent in country that is not child's habitual residence: "consent exception" applies when petitioning parent, either expressly or through conduct, agrees to removal or retention before it takes place, and while consent need not be formal, it is important to consider what petitioning parent actually contemplated and agreed to in allowing child to travel outside its home country; "acquiescence" is implicated if petitioning parent agrees to or accepts removal or retention post facto, and must be formal. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 13, 1988 WL 411501.

9 Cases that cite this headnote

[15] **Child Custody** 🔑 Habitual residence
Child Custody 🔑 Acquiescence to removal
Child Custody 🔑 Wrongful retention or removal

Parent's post-facto acquiescence to child's wrongful retention by other parent in country that is not child's habitual residence, as defense to ICARA petition for return of child, may be shown by petitioning parent's testimony in a judicial proceeding, a convincing written renunciation of rights, or a consistent attitude of acquiescence over a significant period of time. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 13, 1988 WL 411501.

4 Cases that cite this headnote

[16] **Child Custody** 🔑 Acquiescence to removal
Child Custody 🔑 Wrongful retention or removal

Father, a citizen of Australia, did not unconditionally consent to mother's retention of children in United States, as would preclude relief on father's ICARA petition to compel mother, a citizen of United States and father's wife, to return children to Australia, where family lived for 12 years; although father proposed to settle couple's divorce proceeding, which mother initiated after father returned to Australia, if mother agreed to certain terms regarding custody and visitation, father did not contemplate or agree to children's remaining in United States without mother's agreement to conditions that she consistently rejected. International Child Abduction Remedies Act, § 2 et seq., 42 U.S.C.A. § 11601 et seq.; International Child Abduction Convention, Art. 13, 1988 WL 411501.

Attorneys and Law Firms

***1114** Paul John Bargiel (argued), Attorney, Chicago, IL, for Petitioner–Appellant.

Herman J. Marino (argued), Attorney, Chicago, IL, for Respondent–Appellee.

Before BAUER, POSNER, and WOOD, Circuit Judges.

Opinion

WOOD, Circuit Judge.

Iain Walker, a citizen of Australia, filed this suit under the International Child Abduction Remedies Act (ICARA), 42 U.S.C. § 11601 *et seq.,* in an effort to compel his wife, Norene, a citizen of the United States, to return the couple's three children to Australia. ICARA implements the Hague Convention on the Civil Aspects of International Child Abduction (the Convention), T.I.A.S. No. 11,670, 1343 U.N.T.S. 89 (Oct. 25, 1980). The Convention, to which both the United States and Australia are parties, "entitles a person whose child has wrongfully been [retained in] the United States ... to petition for return of the child to the child's country of 'habitual residence,' unless certain exceptions apply." *Norinder v. Fuentes,* 657 F.3d 526, 529 (7th Cir.2011).

The district court denied Iain's petition. It found that notwithstanding the fact that the Walker family lived in Australia from 1998 until 2010, the children's habitual residence had become the United States by the time Iain filed his petition. In addition, as the court saw it, Norene's act of keeping the children in the United States could not have been "wrongful" within the meaning of the Convention for two reasons: first, Iain was not exercising his custody rights at the relevant time; and, second, Iain had consented to the children's remaining in the United States permanently. Iain challenges all of these rulings on appeal. We conclude that the record does not support the court's decision and that a remand is necessary before the case can be resolved.

I

Iain and Norene were married in Chicago in 1993. They lived in Seattle, Washington, until 1998 when they moved to Perth, in Western Australia. The couple's eldest child was born in the United States in 1997, but lived in this country only one year; the two younger children were born in Australia in 1999 and 2001.

Although Norene testified that she and Iain initially intended to stay in Australia for only five years, they ended up spending 12 years there. Over this period, they and their children appeared to be well-settled: they owned a home, furniture, and a dog named Chubba; the children attended school, had friends, and participated in activities; and Iain worked as a software test engineer while Norene cared for the children.

In June 2010, the Walkers traveled to the United States. When they left Australia, both Iain and Norene expected that Norene and the children would remain in the United States for six months to one year. There the common ground ends. According to Iain, the plan was for Norene ***1115** and the children to live with Norene's parents in Chicago while the family demolished its existing house in Perth and built a new one. According to Norene, the trip was intended as an extended prelude to a permanent move to the United States; she testified (a bit inconsistently, it seems to us) that Iain promised to look for a job in Chicago and that they looked at real estate in San Francisco and Seattle. Although both recalled that Norene and the children had concrete plans to return to Australia by June 2011 at the latest, Norene labeled this most likely a temporary visit and Iain understood it to be a permanent return. After spending several weeks with Norene and the children in the United States, Iain returned to Australia in late July 2010.

As may be apparent, all was not well with the marriage. In November, Norene filed for divorce in Cook County, Illinois. As of that time, she said, she had not made up her mind whether she (and presumably the children) would remain in the United States permanently or return to Australia.

Upon receiving Norene's petition for divorce, Iain's lawyer in Australia sent a letter to Norene's attorney offering to settle the divorce out of court. The lawyer described the letter, which was transmitted on January 21, 2011, as a "once off attempt to have all outstanding matters resolved." In it he made, "on a without prejudice basis," certain proposals that were expressly conditioned on Norene's acceptance of Iain's offer. For example, in exchange for granting primary custody to Norene and allowing the children to remain in the United States, Iain wanted to be guaranteed custody of the children for the full nine weeks of their summer vacation and for two weeks over the Christmas holidays; he further requested that he be allowed to visit the children in the United States at least twice a year. The letter also dealt with the division of property.

Notably, the letter explicitly referred to the Hague Convention. On Iain's behalf, the lawyer asserted that "[t]he parties' habitual residence is quite clearly Australia," and that Iain "would clearly be entitled to bring an Application under the Hague Convention to have the children returned to Australia." In closing, the letter stated "this offer is open for a period of 7 days ... and if not accepted [Iain] will then proceed to exercise his full rights pursuant to the Hague Convention, and do all that is required to ensure that proceedings are transferred" to the Family Court of the State of Western Australia.

The January 21 letter marked a turning point for Norene. She regarded it as giving her permission to stay in the United States and indicating that Iain "didn't want the kids." She testified that shortly after receiving the letter, she made up her mind not to return to Australia. Norene did not, however, accept Iain's offer of settlement; after an exchange of several more letters, the negotiations ended without a resolution in mid-February. Iain immediately filed a request for the return of the children with the Australian Central Authority charged with administering the Convention. In May, Iain filed a petition for return in the district court for the Northern District of Illinois.

Following a two-day evidentiary hearing, the district court denied the petition. This appeal followed.

II

A

[1] Before discussing the merits of the district court's decision, we must address two preliminary issues. First, Norene argues that this case was mooted by an Illinois state-court judgment awarding sole custody of the children to Norene. According to Norene, the Illinois judgment ***1116** conclusively resolves the parties' custody dispute in her favor and thus precludes this court from ruling that the Hague Convention requires the custody determination to occur in the courts of Australia.

Norene is mistaken: the case is not moot. Article 17 of the Hague Convention expressly states that "[t]he sole fact that a decision relating to custody has been given in or is entitled to recognition in the requested State *shall not* be a ground for refusing to return a child under this Convention." (Emphasis added.) This treaty provision qualifies the finality of any state-court custody judgment and thus ensures that there is still a live controversy before the federal court.

Norene relies on *Navani v. Shahani,* 496 F.3d 1121 (10th Cir.2007), for the proposition that an order granting custody to one or another of the parents can moot a Hague Convention case, but *Navani* did not speak to this question. Indeed, the issue of habitual residence—and thus the question of which country's courts had the power finally to determine custody under the Convention—was not before the court in *Navani;* all parties agreed that the child's habitual residence was England. Rather, the question on appeal was whether the U.S. court that adjudicated the father's petition for return erred in concluding that an English custody order granted some custody rights to the father. *Id.* at 1125–26. While the appeal was pending, an English court entered a new custody order that granted the father sole custody. *Id.* at 1126. The Tenth Circuit concluded that this superseding custody order mooted the appeal—both because any possible error in the interpretation of the previous order was no longer of any moment given the new order, and because relief that directly conflicted with that ordered by the courts of the child's habitual residence would undermine the Hague Convention's purpose of allowing those courts to resolve the parents' custody disputes. *Id.* at 1127–29.

Here, in contrast, Iain and Norene dispute habitual residence. Until that question is resolved, we cannot say which country's courts have the power to resolve the issue of custody. As Article 17 of the Convention implies, this antecedent question must be answered before we know what weight to give to the judgment of the Illinois court.

[2] This makes sense, given the purpose of the Convention. Accepting Norene's position that an abducting parent may render a petition for return moot by racing to a courthouse in her chosen country to obtain a custody judgment would turn the Convention on its head. The entire purpose of the Convention is to deter parents from absconding with their children and crossing international borders in the hopes of obtaining a favorable custody determination in a friendlier jurisdiction. See Elisa Pérez–Vera, *Explanatory Report on the 1980 Hague Child Abduction Convention, in* Acts & Documents of the Fourteenth Session, Vol. 3, 17 (1980). To consider this case moot would encourage the very sort of jurisdictional gerrymandering the Convention was designed to prevent. We note as well that courts faced with similar arguments based on abstention, the *Rooker–Feldman* doctrine, and *res judicata* have held that these doctrines do not deprive the federal courts of jurisdiction to rule on the merits of Convention petitions, either in the first instance or on appeal. See, *e.g., Yang v. Tsui,* 416 F.3d 199, 201–04 (3d Cir.2005) (*Younger* abstention not appropriate); *Silverman v. Silverman,* 338 F.3d 886, 894 (8th Cir.2003) (*Rooker–Feldman* doctrine inapplicable); *Holder v. Holder,* 305 F.3d 854, 864–66 & 867–72 (9th Cir.2002) (*res judicata* inapplicable; *Colorado River* abstention inappropriate); ***1117** *Mozes v. Mozes,* 239 F.3d 1067, 1085 n. 55 (9th Cir.2001) (*Rooker–Feldman* doctrine inapplicable). Norene raises several cursory arguments based on the latter doctrines; like our sister circuits, we find no merit in these points.

B

[3] The second preliminary issue concerns the district court's decision to admit the January 21 letter into evidence over Iain's objection that the letter is an offer of settlement and thus is inadmissible under Federal Rule of Evidence 408. Rule 408 says that evidence of “furnishing or offering or promising to furnish ... a valuable consideration in ... attempting to compromise the claim” may not be admitted to “prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount.” Iain argues that this language is broad enough to cover the letter's use here: the letter was an offer to compromise the parties' divorce dispute; the divorce proceeding included claims over both property and child custody; and the letter was being offered to prove the “invalidity” of Iain's petition for the return of the children on the theory that he had waived that right by consenting to Norene's custody.

The district court rejected Iain's argument under Rule 408 and admitted the letter, however, because in its view, the divorce and Convention proceedings were “entirely separate.” The court also believed that Iain had failed to show that the use of the letter in the Convention case “would impair the settlement process in the underlying divorce action.”

This ruling is flawed in at least two respects. First, the divorce and Convention proceedings are not “entirely separate.” A decision or action in one proceeding almost inevitably will have an impact on the other. A successful petition for return identifies the proper forum for the custody determination in a divorce case, and (as the losing parent often fears) the courts of the habitual residence may be sympathetic to the local parent's position. More importantly, although the district court was correct to consider Rule 408's purpose in deciding whether to admit the letter, see *Zurich Am. Ins. Co. v. Watts Indus., Inc.,* 417 F.3d 682, 689 (7th Cir.2005), in focusing on the letter's potential to impede settlement in *Iain and Norene's* ongoing divorce action, the district court was looking at the wrong thing. Rule 408 addresses the concern that a norm of admitting offers of settlement will reduce efforts to settle by others in the future; its focus is not on the effect of admitting an offer of settlement on *these parties'* likelihood of settling. Almost by definition, the parties in the present case have already failed to settle and are now deeply involved in litigation, and so for them, there is nothing left to chill.

When viewed in the proper perspective, there is little doubt that admitting a document like the January 21 letter has the potential to deter future efforts to settle international divorce and custody disputes. A parent in Iain's situation with an interest in reaching an out-of-court settlement with his or her spouse would have no incentive to make an offer without including some mention of child custody (often the single most significant issue in a divorce). But if that parent knows that any offer related to custody may later be relied upon to find that the parent has abandoned his custody rights or consented to the child's remaining abroad, then that parent will be less willing to make any offer at all. In our view, the court should have excluded the letter pursuant to Rule 408.

That said, we must still consider whether this error had an effect on the outcome ***1118** of the case. Since this was a trial to the court, the contents of the letter were very likely to come to the judge's attention anyway: the court had to read the letter in order to determine whether it was admissible. At that point, the horse was effectively out of the barn. In any event, the critical question is whether the judge was entitled to give weight to the letter. He should not have done so. Moreover, as we explain below, the letter in any event provides no basis for denying Iain's petition for return.

III

Iain challenges the district court's findings that he (1) failed to establish that the children were habitually resident in Australia; (2) failed to establish that he was exercising his custody rights; and (3) consented to the children remaining permanently in the United States. Because any one of these findings would suffice to defeat a petition for return, we must affirm unless we conclude that the district court reached the wrong conclusion on each of them.

A

[4] Everyone agrees that this is not a case of wrongful removal of the children; it is a case of wrongful retention. The first question is therefore when the retention began. The district court identified May 4, 2011, the day Iain filed his petition for return in the district court, as the date the retention began. It considered that to be the date when Iain first "unequivocally signaled h[is] opposition to [the children's] presence in the United States." Although Iain had expressed his intent to file a petition for return of the children in the January 21 letter (and again in a follow-up letter on February 16), the district court declined to view these statements as "unequivocal[ ] signal[s]" of opposition because, in the court's view, "it was apparent that Petitioner was referring to the Convention as a bargaining chip."

[5] The date on which the wrongful retention commenced is a question of fact on which we would normally defer to the district court. See *Karkkainen v. Kovalchuk,* 445 F.3d 280, 290 (3d Cir.2006). Here, however, nothing but speculation supports the district court's "bargaining chip" idea. Worse, whether Iain's mention of the Convention was meant as a "bargaining chip" is irrelevant to whether Iain signaled his opposition to the children remaining in the United States in the January 21 letter. What matters is that the January 21 letter unequivocally says that "[t]he parties' habitual residence is quite clearly Australia." It goes on to point out that the "clearly appropriate forum" for the parties' divorce proceedings is Australia and that it is "an abuse of process to unilaterally decide to remain in the United States." It then repeats that "Western Australia is the habitual residence of the children." Finally, the letter announces Iain's intent to file a petition under the Hague Convention, a step that he confirmed in his February 16 letter. Under the circumstances, it is hard to see how much more "unequivocal" one could be.

The district court was apparently under the impression that Iain then did nothing during the five months between the exchange of letters with Norene and the filing of the petition for return on May 4, but if so, it was mistaken. The petition reveals that in mid-February, Iain filed a request for return with the Central Authority in Australia. The Convention provides for the establishment of Central Authorities (designated agencies responsible for administering the Convention) and contemplates that parents will seek their assistance in obtaining the return of their children. Arts. 6–10. In Australia, the ***1119** Central Authority directs parents seeking return of their children to file a request for return. See *About International Child Abduction,* Attorney General's Department, Australian Government, http://www.ag. gov.au/Families/Pages/Internationalfamilylaw/FAQaboutinternationalparentalchild abduction.aspx#to (last visited Nov. 13, 2012). That was exactly what Iain did here. In acting promptly to secure the return of the children according to procedures approved by both the Convention and the government of Australia, Iain properly signaled his opposition to the children's retention in the United States. For the district court to conclude that this opposition was not apparent until May 4 was clear error. Accordingly, for purposes of our analysis, we assume that the retention began on January 21, or, at the latest, several weeks thereafter.

[6] Before moving on, we note our concern with the district court's interpretation of the January 21 letter. The district court inferred that Iain was uninterested in the children except to the extent that they could be used as a "bargaining chip" to obtain a more favorable property settlement. We find nothing in the letter that supports such a view. Under the Convention, the merits of Iain and Norene's custody dispute are irrelevant to the distinct question whether that dispute should be resolved by the courts of Australia or the United States. Arts. 1 & 19; see also *Friedrich v. Friedrich,* 78 F.3d 1060, 1065 (6th Cir.1996). Assumptions about likely motives of either parent also play no part in Convention decisions. As it happens, fathers are far more likely than mothers to file petitions for return and access under the Convention. In 2008 (the last year for which detailed statistics are available), fathers filed roughly 69% of global applications (and 59% of U.S. applications) for return and roughly 79% of global applications (and 73% of U.S. applications) for access. See Nigel Lowe, *A Statistical Analysis of Applications Made in 2008 Under the Hague Convention of October 25, 1980 on the Civil Aspects of International Child Abduction,* Pt. I, 14, 54 (2011); *id.* at Pt. III, 199, 209. (We say "roughly" because the Hague Conference on Private International Law reports statistics on the people against whom petitions for return are filed, but it does not specifically report statistics on who files the petitions. Inferring how many fathers file petitions for return or access is thus somewhat imprecise. Although in the vast majority of cases in which a petition is filed against a mother, the petitioner will be the father, the petitioner could conceivably be a grandparent, other relative, or an institution as well.)

B

[7] [8] [9] To prevail on his petition, Iain was required to show that Australia was the children's habitual residence at the time of their retention in the United States. We explained in detail how to determine a child's habitual residence in *Koch v. Koch,* 450 F.3d 703 (7th Cir.2006). In a case alleging wrongful retention, we determine a child's habitual residence by asking "whether a prior place of residence ... was effectively abandoned and a new residence established ... 'by the shared actions and intent of the parents coupled with the passage of time.' " *Norinder,* 657 F.3d at 534 (quoting *Koch,* 450 F.3d at 715). Because the parents often dispute their intentions, "the court should look at actions as well as declarations" in determining whether the parents "shared an intent to abandon a prior habitual residence." *Koch,* 450 F.3d at 715. In an appeal from a habitual residence determination, the court reviews findings on the parties' intent for clear error, while "[t]he ultimate determination of habitual residence ***1120** is a mixed question of law and fact to which we will apply *de novo* review." *Id.* at 710.

The district court found that the children's habitual residence became the United States by January 21, 2011, at the latest. This conclusion was premised on the following findings: (1) that Iain consented to the children's living in the United States in the January 21 letter; (2) that five months passed between the letter and the filing of the petition for return in district court; and (3) that Iain and Norene looked for houses in the United States.

As we already have explained, the first finding fundamentally misreads the January 21 letter. There is no need to repeat that discussion. Norene did not accept the offer contained in the letter, and it therefore dropped out of the picture.

We have already pointed out the problem with the second finding as well. Iain took prompt steps to secure the children's return by filing a request for return with the Australian Central Authority in mid-February 2011, as soon as it became apparent that a negotiated settlement was not forthcoming.

That leaves the third finding, which suggests that the court may have concluded that Iain and Norene came to the United States in June 2010 with the shared intention of establishing a new habitual residence in this country. Iain and Norene certainly could have established a new habitual residence in this fashion. See, *e.g., id.* at 715 (change in habitual residence accomplished by a shared intent to abandon a prior habitual residence plus an "actual change in geography") (citing *Mozes,* 239 F.3d at 1078). But the district court never actually said that they did so, and we cannot find enough in the record to support the conclusion that Iain and Norene arrived in the United States with the shared intention of abandoning Australia and establishing a new habitual residence here.

In considering the parties' intent, the district court focused on Norene's testimony that she and Iain looked at real estate in San Francisco and Seattle when they arrived in the United States in 2010. Norene testified that she and Iain "talked extensively" about the housing market, that she and a friend looked at a few houses in San Francisco (while Iain remained in the car), and that she and Iain met with a real estate agent in Seattle. Elsewhere in its opinion, the district court also noted that it was crediting Norene's testimony that she and Iain had always intended to return to the United States after their 1998 move. The district court seemed to view this intention to return as further evidence that the trip was understood to be a permanent move, notwithstanding the fact that Iain and Norene had been living in Australia for 12 years by the time they came to the United States in 2010.

While parts of Norene's testimony thus show that the couple might have been considering relocating to the United States, this is a perilously thin basis for inferring that their trip in 2010 was truly intended to be the start of that permanent move. Moreover, other uncontroverted evidence undermines this inference. For instance, the bulk of the family's possessions, as well as Chubba the family dog, remained in Australia; Iain and Norene were in the process of rebuilding their house in Australia; and Norene herself stated—both in testimony and in emails to friends—that she intended to stay in the United States until June 2011 at the latest, and that she did not make up her mind to remain in the United States until she received the January 21 letter. The evidence that Iain and Norene mutually intended ***1121** to abandon Australia and take up residence in the United States is simply too contradictory and underdeveloped to support the district court's habitual residence finding. Nor were the children in the United States for so long prior to the filing of the petition for return that their lives "bec[a]me so firmly embedded in the new country as to make [them] habitually resident" in the United States regardless of their parents' lack of mutual intent to establish a habitual residence here. *Mozes,* 239 F.3d at 1078.

[10] [11] [12] Assuming that the children's habitual residence was Australia, Iain must still show he was "actually exercis[ing]" his custody rights at the time of the retention. Art. 3. The standard for finding that a parent was exercising his custody rights is a liberal one, and courts will generally find exercise whenever "a parent with *de jure* custody rights keeps, or seeks to keep, any sort of regular contact with his or her child." *Bader v. Kramer,* 484 F.3d 666, 671 (4th Cir.2007) (internal quotation marks omitted). Indeed, "a person cannot fail to 'exercise' [his] custody rights under the Hague Convention short of acts that constitute clear and unequivocal abandonment of the child." *Friedrich,* 78 F.3d at 1066.

As the Sixth Circuit has explained, sound policy reasons support this liberal standard. U.S. courts are not well equipped to determine whether the courts of a child's habitual residence would conclude that a parent with *de jure* custody rights has nevertheless forfeited those rights "because he or she was not acting sufficiently like a custodial parent." *Id.* at 1065. Moreover, any determination that a parent has failed to behave in a sufficiently parent-like fashion comes dangerously close to an adjudication on the merits of the parents' custody dispute, which (to repeat) is something the Convention expressly reserves for the courts of the child's habitual residence. *Id.;* see also Arts. 1 & 19. Finally, the "confusing dynamics" of domestic strife "make it difficult to assess adequately the acts and motivations of a parent." *Friedrich,* 78 F.3d at 1065.

Although it acknowledged the liberal nature of the standard, the district court nevertheless found that Iain had "abandoned" his children. In support of this rather extreme conclusion, the court noted that Iain did not return to the United States after July 2010, that he ceased supporting Norene financially after January 21, 2011, and that his January 21 letter was mainly concerned with "the negotiation of support payments and property settlement."

All of those things may be true, but they do not add up to "unequivocal abandonment" of the children (as opposed, perhaps, to Norene). The district court overlooked Norene's undisputed testimony that Iain keeps "regular contact" with the children by speaking to them weekly over Skype. Further, in faulting Iain for failing to return to the United States after July 2010, the district court ignored Norene and Iain's testimony that they had always intended that Iain would return to Australia—both for work and to oversee the construction of their house—in July or early August 2010. The court also failed to mention that Norene testified that Iain had plans to spend Christmas in the United States in 2010, and that he canceled those plans only after Norene filed for divorce. Finally, just as the January 21 letter does not show that Iain consented to the children's remaining in the United States, it similarly does not show that Iain was interested exclusively in reaching a settlement regarding marital property. A letter that requests custody for the children's ***1122** entire summer vacation plus Christmas and asks for multiple visitation opportunities at other times of the year can hardly be characterized as indifferent to custody issues.

This leaves Iain's lack of financial support after January 21, 2011, as the sole basis for finding abandonment. This is not enough. Because non-exercise is evaluated at the time of the retention—which, as we have explained, must have occurred on January 21 or shortly thereafter—Iain's failure to provide support *after* the retention is irrelevant to whether he was exercising his custody rights when the wrongful retention began. See, *e.g., Baxter v. Baxter,* 423 F.3d 363, 369 (3d Cir.2005) ("[T]he record demonstrates that [the father] 'actually exercised' his custody rights under article 3 at the time of the removal and retention."); *Mozes,* 239 F.3d at 1084–85 ("Nor is there any doubt that [the father] was exercising his parental rights and responsibilities up until the time [the mother] sought custody."). Neither the district court nor Norene identifies any case in which a court has found abandonment based on a lack of financial support, let alone a case that finds that a parent may forfeit his rights under the Convention by failing to send money to the abducting spouse even as he works actively to have the children returned. Indeed, the cases that address some version of this issue have found that a parent does not fail to exercise his custody rights merely by failing to provide financial support for some period prior to the removal or retention. See *Baxter,* 423 F.3d at 369–70 (lack of financial support for several weeks prior to the retention did not indicate that father was not exercising custody rights); *Habrzyk v. Habrzyk,* 759 F.Supp.2d 1014, 1023 (N.D.Ill.2011) (infrequent financial support insufficient to show non-exercise); *In re Polson,* 578 F.Supp.2d 1064, 1072 (S.D.Ill.2008) (father was exercising custody rights even though he ceased to support family financially after mother filed for divorce). Finally, we note that whether one parent is required to pay support to the other is an issue on the merits of a divorce proceeding, and we are thus wary of allowing the presence or absence of financial support to factor too prominently in the analysis of the exercise of custody rights at the time of the removal or retention.

Using the appropriate standard, we cannot find on the current record that Iain's failure to provide financial assistance while Convention proceedings are pending amounts to a failure to exercise his custody rights.

D

[13] **[14]** **[15]** Finally, even if Iain had established a case for return under the Convention, he could have waived that right if he consented to, or acquiesced in, the children's remaining in the United States with their mother. Art. 13. Consent and acquiescence are analytically distinct defenses to return under the Convention. *Baxter,* 423 F.3d at 371. The consent exception applies when a petitioning parent, either expressly or through his conduct, agrees to a removal or retention before it takes place. *Id.* A parent's consent need not be formal, but "it is important to consider what the petitioner actually contemplated and agreed to in allowing the child to travel outside its home country." *Id.;* see also *Mota v. Castillo,* 692 F.3d 108, 117 (2d Cir.2012); *Larbie v. Larbie,* 690 F.3d 295, 308–09 (5th Cir.2012). Acquiescence is implicated if a petitioning parent agrees to or accepts a removal or retention after the fact. *Baxter,* 423 F.3d at 371. Unlike consent, acquiescence must be formal, and might include "testimony in a judicial proceeding; a convincing ***1123** written renunciation of rights; or a consistent attitude of acquiescence over a significant period of time." *Friedrich,* 78 F.3d at 1070. One way or another, the "exceptions [must] be drawn very narrowly lest their application undermine the express purposes of the Convention." 51 Fed. Reg. 10494, 10509 (Mar. 29, 1986). It is also worth remembering that the Article 13 exceptions are permissive: a court may order return even if it finds that the parent opposing the petition has established that one of the exceptions applies. Art. 13; 51 Fed. Reg. at 10509.

[16] The district court found that Norene had established consent. The bases for this conclusion will by now be familiar: they are the January 21 letter, which the district court characterized as indicating Iain's "unconditional consent" to the children remaining in the United States, Iain's failure to visit the United States after July 2010, and his failure to provide financial support.

Our concerns with the district court's analysis will also be familiar. The January 21 letter cannot be read as an expression of consent, let alone unconditional consent, to anything. The letter is an opening offer, a single stage in a negotiation; it concedes nothing and in any event was rendered null by the parties' failure to come to an agreement. It is apparent that Iain did not "actually contemplate [or] agree" to the children's remaining in the United States without Norene's agreement to conditions that she consistently rejected.

Apart from the letter, the district court's remaining justifications are either clearly erroneous or irrelevant. As previously discussed, Iain was involved in the children's lives after July 2010, and the discussion of financial support is unrelated to Iain's consent or acquiescence in the children's remaining in the United States.

IV

Having concluded that the district court's decision in this case cannot stand, we are left with the question of how to proceed. Two options exist: an outright order for the children to be returned to Australia pursuant to the Convention, or a remand for further factfinding. Although we regret the need to prolong this case any further, we conclude that the latter is necessary. Several crucial issues were not fully developed in the previous proceedings, and these gaps in the record must be filled before a final decision is rendered. On remand, the district court must resolve at least the following questions, taking evidence as necessary:

> 1. What was Iain and Norene's mutual intent regarding the trip to the United States in June 2010? Was this intended as an extended vacation or as a permanent move?
>
> 2. What has been the precise nature of Iain's participation in the Illinois divorce proceedings, and to what extent, if at all, does this participation indicate that Iain either consented to or acquiesced in the children's retention in the United States?
>
> 3. To the extent the children have "attained an age and degree of maturity at which it is appropriate to take account of their views," Art. 13, what is the children's attitude to being returned to Australia? In conducting this inquiry, we caution that the district court must be attentive to the possibility that the children's views may be the product of "undue influence" of the parent who currently has custody. 51 Fed. Reg. 10510.

V

In returning this case to the district court, we emphasize again that this is a ***1124** dispute about which court system should resolve the underlying issue of child custody; it is not a dispute about which parent is preferable or the terms under which custody will be granted. We are confident that either the courts of Western Australia or the courts of Illinois are fully capable of resolving these matters. In that spirit, we REVERSE and REMAND the judgment of the district court.

All Citations

701 F.3d 1110, 89 Fed. R. Evid. Serv. 1272

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United States Code Annotated
Title 22. Foreign Relations and Intercourse
Chapter 97. International Child Abduction Remedies

22 U.S.C.A. § 9003
Formerly cited as 42 USCA § 11603

§ 9003. Judicial remedies

Currentness

(a) Jurisdiction of courts

The courts of the States and the United States district courts shall have concurrent original jurisdiction of actions arising under the Convention.

(b) Petitions

Any person seeking to initiate judicial proceedings under the Convention for the return of a child or for arrangements for organizing or securing the effective exercise of rights of access to a child may do so by commencing a civil action by filing a petition for the relief sought in any court which has jurisdiction of such action and which is authorized to exercise its jurisdiction in the place where the child is located at the time the petition is filed.

(c) Notice

Notice of an action brought under subsection (b) shall be given in accordance with the applicable law governing notice in interstate child custody proceedings.

(d) Determination of case

The court in which an action is brought under subsection (b) shall decide the case in accordance with the Convention.

(e) Burdens of proof

(1) A petitioner in an action brought under subsection (b) shall establish by a preponderance of the evidence--

(A) in the case of an action for the return of a child, that the child has been wrongfully removed or retained within the meaning of the Convention; and

(B) in the case of an action for arrangements for organizing or securing the effective exercise of rights of access, that the petitioner has such rights.

(2) In the case of an action for the return of a child, a respondent who opposes the return of the child has the burden of establishing--

(A) by clear and convincing evidence that one of the exceptions set forth in article 13b or 20 of the Convention applies; and

(B) by a preponderance of the evidence that any other exception set forth in article 12 or 13 of the Convention applies.

(f) Application of Convention

For purposes of any action brought under this chapter--

(1) the term "authorities", as used in article 15 of the Convention to refer to the authorities of the state of the habitual residence of a child, includes courts and appropriate government agencies;

(2) the terms "wrongful removal or retention" and "wrongfully removed or retained", as used in the Convention, include a removal or retention of a child before the entry of a custody order regarding that child; and

(3) the term "commencement of proceedings", as used in article 12 of the Convention, means, with respect to the return of a child located in the United States, the filing of a petition in accordance with subsection (b) of this section.

(g) Full faith and credit

Full faith and credit shall be accorded by the courts of the States and the courts of the United States to the judgment of any other such court ordering or denying the return of a child, pursuant to the Convention, in an action brought under this chapter.

(h) Remedies under Convention not exclusive

The remedies established by the Convention and this chapter shall be in addition to remedies available under other laws or international agreements.

CREDIT(S)

(Pub.L. 100-300, § 4, Apr. 29, 1988, 102 Stat. 438.)

22 U.S.C.A. § 9003, 22 USCA § 9003
Current through P.L. 117-179. Some statute sections may be more current, see credits for details.

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Restatement (Third) of Foreign Relations Law § 485 (1987)

Restatement of the Law - The Foreign Relations Law of the United States | October 2022 Update

Restatement (Third) of The Foreign Relations Law of the United States

Part IV. Jurisdiction and Judgments

Chapter 8. Foreign Judgments and Awards

Subchapter A. Foreign Judgments: Law of the United States

§ 485 Recognition and Enforcement of Foreign Child Custody Orders

Comment:
Reporters' Notes
Case Citations - by Jurisdiction

(1) A court in the United States will recognize an order of a foreign court awarding or modifying an award of custody of a child, valid and effective in the state where it was issued, if, when the proceeding was commenced,

- **(a) the issuing state was the habitual residence of the child;**
- **(b) the child and at least one party to the custody proceeding had a significant connection with that state; or**
- **(c) the child was present in that state and emergency conditions required a custody order for protection of the child;**

provided that notice of the proceeding was given to each parent and to any other person having physical custody of the child.

(2) Ordinarily, a court in the United States may modify a custody order entitled to recognition under this section only if the rendering court no longer has jurisdiction to modify the order, or has declined to exercise its jurisdiction to modify it.

Source Note:

Uniform Child Custody Jurisdiction Act, 9 U.L.A. 111 (1979); Federal Parental Kidnaping Prevention Act of 1980, 28 U.S.C. § 1738A.

Comment:

a. Modifiability no bar to enforcement. This section, and § 486 concerning support orders, provide that a child custody order of another state that meets the prescribed jurisdictional standards must be recognized and enforced, even if it is subject to modification where rendered. The basic principles of §§ 481 and 482 are applicable, but distinct rules are applied in child custody cases to deter child-snatching, inconsistent judgments, and protracted litigation over custody. This section departs from older decisions of the United States Supreme Court in domestic cases, but it is consistent with the Uniform Child Custody Jurisdiction Act and other State and federal legislation in the United States as well as with an emerging international consensus. See Reporters' Note 7.

b. Presence of child. Subsection (1) rejects presence of the child as a sufficient jurisdictional basis for a custody order entitled to recognition, except for emergency orders, for example if a parent falls ill or dies and immediate action is required. A custody order made in the state of the child's habitual residence (Comment *c*) is entitled to recognition even if the child is not present in the state at the time of the order. Subsection (1) seeks to ensure that, to the extent possible, adjudication of child custody—whether on an initial petition or on a petition to modify—takes place in the state where the child's best interests can be judged on the best possible information, and to deter parents from bringing a child into another state and then seeking a custody order on the basis of the child's presence there.

c. Habitual residence. "Habitual residence," increasingly adopted in European conventions on private international law, serves the same purpose as "home state" in the Uniform Child Custody Jurisdiction Act. By focusing on the child's own residence, it avoids the rule applicable in some states that automatically attributes to children the domicile of a parent. Habitual residence should be interpreted in light of the policy of deterring child-snatching. In general, a child is considered to have acquired a habitual residence in a state by living there for at least six months; residence in boarding schools, summer camps, and similar institutions away from home ordinarily is not "habitual residence."

d. Significant connection with state. Subsection (1)(b), adapted from Section 3(a)(2) of the Uniform Child Custody Jurisdiction Act, accepts other significant connections, such as the presence of close relatives or attendance at school in the rendering state as an alternative to jurisdiction based on habitual residence of the child. It is designed as an alternative to jurisdiction based on habitual residence of the child in circumstances where a family has moved frequently, where a child has been taken from its habitual residence by one parent and the other parent has also moved away, or where the child and one parent have returned to a previous home state with which they have had continuing connections. Jurisdiction under Subsection (1)(b) is subordinate to the basic preference for adjudication of custody in the home state of the child.

Under Subsection (2), a court asked to modify a custody decree should ordinarily refer the parties to the rendering court; but a court is not precluded from modifying the order in exceptional circumstances where requiring the parties to resort to the rendering court would cause hardship.

e. Recognition of custody orders not required to be recognized. In appropriate cases, a court in the United States may recognize a custody order even though recognition is not required. In particular, it might be appropriate for a court to recognize a custody order rendered many years ago and long observed without challenge, even if it would not meet the requirements for recognition set forth in this section. Courts should not apply the jurisdictional requirements of Subsection (1) to deny recognition to a custody decree where to do so would reward a person who has taken a child to another state in violation of an existing custody order, rather than petitioning the rendering court to set aside or modify the existing order.

Reporters' Notes

*1. Recognition of custody awards: rationale.*Until the mid-1970's, the courts of most states and of States of the United States held that foreign custody orders should not be given recognition, either because they were subject to modification and hence not "final," or because concern for the "best interests of the child" outweighed the policy of recognizing judgments. Increasingly, among member states of the Hague Conference on Private International Law (33 as of 1986, including the United States), it has been appreciated that failure to recognize foreign custody awards encourages "child-snatching," a serious problem both for stability of families, and for respect for law generally. The Uniform Child Custody Jurisdiction Act, 9 U.L.A. 111 (1979), adopted by all 50 States of the United States and the District of Columbia, calls for recognition of custody awards both of sister States and of foreign states, provided the rendering court had jurisdiction under the standards of Subsection (1). The proposed Hague Convention on the Civil Aspects of International Child Abduction of 1980, Reporters' Note 7, although not an agreement on recognition of judgments, also favors custody adjudication by courts of the state of the child's habitual residence. This section reflects an emerging international consensus that foreign custody orders should be respected, and that inconsistent custody orders by courts of different states must be avoided.

This topic is treated also in § 79 of the 1986 Revisions to the Restatement, Second, of Conflict of Laws, reflecting a substantial revision of the original version to take account of the UCCJA and PKPA, Reporters' Notes 2 and 3.

*2. The Uniform Child Custody Jurisdiction Act and foreign custody orders.*Section 23 of the UCCJA states that "[t]he general policies of this act extend to the international area," and calls for recognition and enforcement of foreign custody decrees if reasonable notice and opportunity to be heard was given to all affected persons. Thus, the same policies and practices that prevail in the United States with respect to custody decrees of sister-States should prevail with respect to decrees of Canadian provinces and of foreign states. See, generally, Katz, Child Snatching, The Legal Response to the Abduction of Children (1981); Hoff, Schulman, Volenik, and O'Daniel, Interstate Child Custody Disputes and Parental Kidnapping: Policy, Practice and Law, Ch. 10 (ABA Project, 1982).

*3. Federal Parental Kidnapping Prevention Act.*In 1980, Congress adopted the Parental Kidnaping Prevention Act in implementation of the Full Faith and Credit clause of the Constitution, thereby federalizing the standards for recognition and enforcement of sister-State custody decrees. The PKPA does not address custody orders of foreign states, but its standards are consistent with those of the UCCJA and of this section. See generally Foster, "Child Custody Jurisdiction: UCCJA and PKPA," 27 N.Y.Law School L.Rev. 297 (1981); Coombs, "Interstate Child Custody: Jurisdiction, Recognition, and Enforcement," 66 Minn.L.Rev. 711 (1982).

*4. Recognition of foreign custody orders in the United States.*Numerous decisions of courts in the United States have recognized foreign custody orders and have ordered persons in the United States to return children to the party to whom custody was awarded in the foreign state. The court may inquire into the best interests of the child, but the fact that a foreign court has passed on the question, and that the person in the United States acted in violation of a foreign decree, weigh heavily in favor of recognition and implementation of the foreign decree. See, *e.g.*, Miller v. Superior Court of Los Angeles County, 22 Cal.3d 923, 151 Cal.Rptr. 6, 587 P.2d 723 (1978); In re Marriage of Ben-Yehoshua, 91 Cal.App. 3d 259, 154 Cal.Rptr. 80 (1979); Taylor v. Taylor, 278 Pa.Super. 339, 420 A.2d 570 (1980), *certiorari denied*, 454 U.S. 1151, 102 S.Ct. 1020, 71 L.Ed.2d 307 (1982), all applying the UCCJA, as well as the cases cited in Reporters' Note 5. For a decision giving effect to an English order that denied the noncustodial parent any visitation rights except on English soil, see Oehl v. Oehl, 221 Va. 618, 272 S.E. 441 (1980). For a decision declining to respect the custody order of a Polish court, on the basis that the child was in the United States when the order of the Polish court was issued, see Rzeszotarski v. Rzeszotarski, 206 A.2d 431 (D.C.1972).

*5. Modification of custody orders.*Formerly, many courts in the United States and elsewhere undertook independent inquiry as to whether changed circumstances called for modification of a foreign custody order, rather than referring the parties to the rendering court. See Bodenheimer, "Interstate Custody: Initial Jurisdiction and Continuing Jurisdiction under the UCCJA," 14 Fam.L.Q. 203 (1981). This section, and the majority of recent cases reflecting the UCCJA and the Hague Convention, Reporters' Note 7, require parties seeking modification of a custody order to apply to the court that issued the initial order, even if the forum state has jurisdiction under the criteria of Subsection (1). See, *e.g.*, Commonwealth *ex rel.* Zaubi v. Zaubi, 492 Pa. 183, 423 A.2d 333 (1980); Woodhouse v. District Court, 196 Colo. 558, 587 P.2d 1199 (1978). However, where the rendering court no longer has jurisdiction because it is no longer the habitual residence of the child, and there are no longer other significant connections with that state, or where the rendering court has declined to exercise jurisdiction, the court of another state with jurisdiction is entitled to modify the original order. See UCCJA § 14. A court may also modify a foreign custody order without requiring prior application to the courts of the rendering state where both parents and the child have emigrated from the rendering state.

*6. United States citizenship and custody disputes.*In a number of controversies over child custody, when foreign decrees awarding custody to a parent residing abroad have been recognized and enforced by State courts in the United States, the other parent, or someone acting on behalf of the child, applied to federal court for an injunction against sending a child born in the United States to live with a parent residing abroad, on the ground that to do so would deprive the child of the benefits of United States citizenship. Federal courts have usually declined to grant injunctions in these circumstances. See, *e.g.*, Bergstrom v. Bergstrom, 623 F.2d 517 (8th Cir. 1980); Schleiffer v. Meyers, 644 F.2d 656 (7th Cir.1981), *certiorari denied*, 454 U.S. 823, 102 S.Ct. 110, 70 L.Ed.2d 96 (1981); Zaubi v. Hoejme, 530 F.Supp. 831 (W.D.Pa. 1980) as well as cases collected in 20 A.L.R.4th 677 (1983). In the Bergstrom litigation, however, after the decision of the federal court of appeals, the State supreme court reversed the lower State court and permitted the Norwegian parent to retain custody only if she raised the child in the United States. Bergstrom v. Bergstrom, 296 N.W.2d 490 (N.D.1980). The International Court of Justice has upheld a decision by a state welfare agency at the child's place of residence against a claim that proceedings in the state of nationality of the child should take precedence. See Case Concerning the Application of the Convention of 1902 Governing the Guardianship of Infants (Netherlands v. Sweden), [1958] I.C.J. Rep. 55. Under a regulation of the United States Department of State, a United States passport may be denied to a child if a parent who has been awarded custody objects, or if a court has forbidden the child's departure from the state. 22 C.F.R. § 51.27(d). A federal district court ordered revocation of a child's United States passport where the child was taken out of the United States in violation of a custody order. Morgan v. Vance, 4 Fam.L.Rep. 2252 (N.D.Cal.1978).

*7. Hague Convention on Child Abduction.*The Hague Convention on the Civil Aspects of International Child Abduction focuses on custody rights in the state of the child's habitual residence, whether or not they have been subject to adjudication. The objects of the Convention are (a) to secure the prompt return of children wrongfully removed to or retained in any Contracting State, and (b) to ensure that rights of custody and of access under the law of one Contracting State are effectively respected in the other Contracting States (Art. 1). The Convention requires each Contracting State to establish a Central Authority to help locate an abducted child and to secure its return, if possible through voluntary procedures but if necessary with the assistance of the courts. The Convention states (in Art. 17) that the fact that a custody order has been issued in the requested state is not alone a ground for refusing to return a child as required by the Convention, but in applying the Convention the court may take account of the reasons underlying the custody order. For text and commentary, see Anton, "The Hague Convention on International Child Abduction," 30 Int'l & Comp.L.Q. 537 (1981); Note, "American and International Responses to International Child Abductions," 16 N.Y.U.J.Int'l L. & Pol. 415 (1984). The United States signed the Convention in December 1981, and the Senate gave its consent to ratification in 1986, but as of October 1987 the ratification process had not been completed, pending passage of implementing legislation.

Case Citations - by Jurisdiction

Fla.App.

Fla.App.1993. Cit. in sup. The trial court entered a nonfinal order declining to exercise jurisdiction over a child custody dispute between an Argentine father and an American mother. This court, denying the mother's petition for certiorari, held that it was proper to defer the dispute to Argentina, the children's home state. Pefaur v. Pefaur, 617 So.2d 426, 427.

Fla.App.1990. Cit. in case quot. in sup. (citing §§ 494-496 (T.D. No. 4, 1983), which are now §§ 484-486). During a domestic relations suit, a Guatemala family court entered an ex parte injunction freezing a former husband's bank accounts in Guatemala and Miami. The former husband filed a motion to appeal a temporary injunction issued by the Florida trial court, as requested on an ex parte basis by the Guatemala family court, freezing half of the funds contained in his Florida bank accounts. Affirming the temporary injunction, this court held, inter alia, that although the Guatemalan court's injunction was not a final judgment, Florida comity law did not preclude the Florida trial court from honoring the request of the Guatemalan court to enter the temporary injunction pending final disposition of the domestic relations suit in Guatemala. The court stated that public policy favored enforcement of the Guatemalan temporary injunction because the Guatemalan suit was a domestic relations suit seeking spousal support and the husband should not be able to escape his foreign-court imposed obligations by secreting the parties' marital assets in Miami banks. Cardenas v. Solis, 570 So.2d 996, 998, review denied 581 So.2d 163 (Fla.1991).

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