Neutral Citation Number: [2022] EWHC 663 (Fam)

Case No: FD22F00020

**IN THE HIGH COURT OF JUSTICE**
**FAMILY DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/03/2022

**Before** :

**SIR JONATHAN COHEN**

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**Between :**

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| **NORTH WEST ANGLIA NHS FOUNDATION TRUST** | **Applicant** |
| **- and -** | |
| **BN** | **Respondent** |
| **- and –** | |
| **PS** | **2nd Respondent** |

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**Miss Emma Sutton** (instructed by **Browne Jacobson LLP**) for the **Applicant Trust**
**The second respondent, PS, appeared in person**

Hearing dates: 16 March 2022

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# Approved Judgment

I direct that copies of this version as handed down may be treated as authentic.

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SIR JONATHAN COHEN

This judgment was delivered in public. 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.

**Sir Jonathan Cohen:**

1. This is a very sad case concerning a woman, BN, who is a lady in her mid 40's and has no relevant medical history before events of March of this year. Due to the events set out below, North West Anglia NHS Foundation Trust made a Part 8 claim dated 11 March 2022 for a declaration that BN has died due to an irreversible absence of brain-stem functioning, and, as a consequence, sought authority for mechanical ventilation and all ancillary care and treatment to be withdrawn. The application was made as BN's foster mother, PS, at that time, disagreed.

2. The background is that on 2 March 2022 BN went to the hospital operated by the Applicant Trust, in an ambulance, suffering from migraine type headaches. She was seen in the emergency department and was returned home.

3. On the following morning, 3 March, she was again taken to hospital by ambulance and whilst in hospital awaiting investigation, she had what was plainly a collapse and became unresponsive and had seizure like activity while being resuscitated. She was intubated and taken to the intensive care unit for management. She was seen initially by Dr B, and then when she reached the intensive care unit by Dr A. They are both consultants in anaesthetics and intensive care and they between them have been responsible for BN's treatment over the course of the last fortnight. I have heard from Dr A today, and I am very grateful to him for his assistance to this court.

4. BN was initially the subject of a CT scan and the images were reviewed by a vascular consultant on call at Addenbrookes, which is part of Cambridge University Hospitals NHS Foundation Trust. The diagnosis suggested an aneurysmal subarachnoid haemorrhage and possible tonsillar herniation. To put this into slightly different words, the human brain has several layers and BN had suffered from a very severe bleed between the layers and there was a subarachnoid haemorrhage. So severe was the haemorrhage that the brain swelled and the swelling filled the narrow hole between the skull and the spinal canal. That sort of injury brings with it the high possibility of brain damage and irreversible damage of the brain-stem, and damage to BN's ability to react, be conscious and to breathe.

5. The clinical picture seen by the doctors confirmed the CT scan. BN was unresponsive and she could not breathe on her own. She did not react to light or respond to any verbal or physical stimuli. The Glasgow Coma Scale tests were carried out on 3 March 2022, and have been repeated at least twice a day since then. The Glasgow test comprises of 3 elements, (i) whether or not the patient will open his or her eyes, either voluntarily or with stimuli; (ii) whether limb responses can be obtained voluntarily or to stimuli; and (iii) whether a verbal response can be obtained.

6. Each of the tests is marked with the lowest mark of 1 and the highest of 4, 5, or 6, depending on the nature of the test. It follows therefore that the lowest possible response is 3. BN very sadly was completely unresponsive. There was no opening of her eyes, no responsiveness of her limbs, and no verbal response, and thus it was that she scored 3/15. She has remained in the intensive care unit and there has been no improvement of any sort.

7. The treating team took a second opinion, from, first of all, the consultant neurosurgeon at Cambridge University Hospitals NHS Foundation Trust. The

response received was that surgical intervention was futile. The doctor who gave that advice had seen the CT scan and the Glasgow Coma Scales Scores and had carried out discussions with the medical team. Normally the treating team would go no further than that, but, at the family's behest, as they wanted a further opinion, the treating team consulted with a neighbouring trust and spoke to the University Hospitals Coventry and Warwickshire NHS Trust, and were in communication with a consultant neurosurgeon there. The response received from him was the same as that as had been received from Cambridge University Hospitals NHS Foundation Trust.

8. It is now necessary to refer to the 2008 Code of Practice for the Diagnosis and Confirmation of Death, which shall I now call the 2008 Code, prepared by the Academy of Medical Royal Colleges. Section 2 of the 2008 Code defines death as follows:

*"Death entails the irreversible loss of those essential characteristics which are necessary to the existence of a living human person and, thus, the definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe. This may be secondary to a wide range of underlying problems in the body, for example, cardiac arrest".*

9. Section 2 goes on to further define the 2 overarching diagnoses; (1) death following the irreversible cessation of brain-stem function, and (2) death following cessation of cardiorespiratory function. With respect to (1), death following the irreversible cessation of brain-stem function. The Code states:

*"the irreversible cessation of brain-stem function whether induced by intra-cranial events or the result of extra-cranial phenomena, such as hypoxia, will produce this clinical state and therefore irreversible cessation of the integrative function of the brain-stem equates with the death of the individual and allows the medical practitioner to diagnose death."*

10. The Code draws attention to three aspects which should be noted:

*"First, the irreversible loss of the capacity for consciousness does not by itself entail individual death. Patients in the vegetative state (VS) have also lost this capacity (see section 6.9). The difference between them and patients who are declared dead by virtue of irreversible cessation of brain-stem function is that the latter cannot continue to breathe unaided without respiratory support, along with other life-sustaining biological interventions. This also means that even if the body of the deceased remains on respiratory support, the loss of integrated biological function will inevitably lead to deterioration and organ necrosis within a short time.*

*Second, the diagnosis of death because of cessation of brain-stem function does not entail the cessation of all neurological activity in the brain. What does follow from such a diagnosis is that none of these potential activities indicates any form of consciousness associated with human life, particularly the ability to feel, to be aware of, or to do, anything. Where such residual activity exists, it will not do so for long due to the rapid breakdown of other bodily functions.*

*Third, there may also be some residual reflex movement of the limbs after such a diagnosis. However, as this movement is independent of the brain and is controlled*

*through the spinal cord, it is neither indicative of the ability to feel, be aware of, or to respond to, any stimulus, nor to sustain respiration or allow other bodily functions to continue.*

*In short, while there are some ways in which parts of the body may continue to show signs of biological activity after a diagnosis of irreversible cessation of brain-stem function, these have no moral relevance to the declaration of death for the purpose of the immediate withdrawal of all forms of supportive therapy. It is for this reason that patients with such activity can no longer benefit from supportive treatment and legal certification of their death is appropriate".*

11. With respect to (2), death following cessation of cardiorespiratory function, the Code states:

*"**2.2 Death following cessation of cardiorespiratory function***

*For people suffering cardiorespiratory arrest (including failed resuscitation), death can be diagnosed when a registered medical practitioner, or other appropriately trained and qualified individual, confirms the irreversible cessation of neurological (pupillary), cardiac and respiratory activity. Diagnosing death in this situation requires confirmation that there has been irreversible damage to the vital centres in the brain-stem, due to the length of time in which the circulation to the brain has been absent".*

12. The carrying out of brain-stem testing is a procedure which is set out at appendix 1 of the 2008 Code, and establishes a template form to be completed by two appropriately qualified doctors. Its purpose is for the confirmation or otherwise of the cessation of brain-stem function by neurological testing of brain-stem reflexes. The tests that were carried out by the two doctors I have already named (Dr A and Dr B) are described in slightly, although not significantly, different terms to those as mentioned in Re M (Declaration of Death of Child) [2020] EWCA Civ 164. It would be helpful to set out the procedure that was carried out.

13. First of all, the tests have to be carried out not less than 24 hours after the patient comes off sedation or muscular relaxants and the tests are only carried out if there are no signs of life. The tests are also carried out after excluding any reversible signs or causes of coma, and they involve therefore establishing certain pre-conditions before the tests are carried out. It is important, and the template sets out in bold, that there is exclusion of reversible causes of coma and apnoea, and that attempts should be made to maintain relatively normal cardiovascular and respiratory physiological parameters in the preceding hours prior to testing. That means, for example, that the mean arterial pressure at the time of testing needs to be consistently greater than the measurement that is set out in the guidelines, and in addition, the carbon dioxide levels and oxygen levels again need to be as prescribed, as do the PH levels.

14. When those steps have been put in place, there are various other measurements that need to be taken and various "red flag" patient groups need to be excluded as being present before the tests are carried out. All those guidances were followed appropriately and accurately in this case, and there has been no suggestion to the contrary.

15. The tests have to be carried out twice, and again, in accordance with the proper procedures, the first set of tests were carried out by Dr A in the presence of his colleague Dr B, and the second tests were carried out by Dr B, and were observed by Dr A. The results of the tests are identical. The first test that was carried out was this *"do the pupils react to light"* - there was no reaction. Secondly, *"is there any eyelid movement when each cornea is touched in turn?"*. Thirdly, *"is there any eye movement seen during or following the slow injection of at least 50mls of ice cold water over 1 minute into each ear with the head fixed at 30*"*. Fourthly, *"is the gag reflex present"* (when the back of the larynx is stimulated). Fifthly, *"is the cough reflex response present when a suction catheter is passed down the trachea to the carina"*. Sixthly, *"is there any motor response in a cranial nerve or somatic distribution when supraorbital pressure is applied"* – described by Dr A as any change to the face when strong pressure is placed on the cranial nerve. This was also described by Dr A as being a particularly unpleasant test for the patient and one, who in a patient able to respond, would be likely to produce a response. The answers to all those tests was that there was no response.

16. There is then carried out the apnoea test to clarify if there is any spontaneous breathing by the patient. That requires raising in the pressures of the blood of carbon dioxide as that is the main stimulator in the body to start breathing. The patient is disconnected from the ventilator, carbon dioxide is raised, but for the duration of the test of in excess of 5 minutes, there was no sign of BN spontaneously breathing.

17. Those tests were carried out to completion and were concluded at 11.45 on 10 March 2022, and that, say the treating team, is the time and date of death; the doctors being satisfied that this demonstrated the irreversible cessation of brain-stem function. The tests were repeated some 45 minutes later which had exactly the same response.

18. The doctors say there is no benefit in further testing, that it is not humane to continue treatment in a patient who is brain-stem dead, that there are no further tests to be carried out and say, for the avoidance of doubt, that there is no prospect of:

    i) Consciousness ever being restored;

    ii) BN being able to breathe unaided;

    iii) BN having any perception of the world around her and

    iv) BN being able to respond to any stimuli.

19. If the patient is kept "alive" by artificial means there will be, in due course, derangement of blood pressure control, the endocrine system, and, even with the systems left on, she sadly will die. In short, there is nothing that the medical profession can carry out that would assist in any way, and the 2008 Code is clear that death can be diagnosed by establishing the cessation of brain-stem function and that no additional tests are required.

20. This has understandably been a very difficult process for BN's next of kin. Her foster-carer, PS, has been present throughout the hearing today, has been made a party to these proceedings by me, and has cross examined Dr A, and has addressed me with dignity, common sense and realism. By the end of the hearing, she did not oppose the

finding that is sought by the Trust, but made the understandable and proper request that she would like to be at the hospital when the systems are turned off and have the chance, with her daughter, to say a proper farewell to BN. I am grateful to Dr A for agreeing, notwithstanding whatever his preference might be, that the hospital would not seek to turn off the machines before 12 noon on Friday 18 March 2022 in order to allow PS and her daughter the opportunity she seeks.

21. In those circumstances, it seems to me, that I really have no alternative but to conclude that death has been diagnosed as 11.45 on 10 March 2022, and as submitted by Miss Sutton, that the testing was undertaken in accordance with the 2008 Code of Practice, and confirmed by second opinion, and that it is futile for the current care and treatment to continue.

22. I accordingly make the declarations in the terms sought by the Trust as set out in draft form by Miss Sutton, namely:

    i) BN died at 11:45 on 10 March 2022, irreversible cessation of brain-stem function having been conclusively established; she having lost the essential characteristics necessary to the existence of a living human person namely (1) the irreversible loss of the capacity for consciousness (i.e. a permanent absence of consciousness), along with the (2) irreversible loss of the capacity to breathe; thus the inevitable and rapid deterioration of integrated biological function.

    ii) Permission to a consultant or other medical professional at the hospital, part of North West Anglia NHS Foundation Trust to (1) cease to mechanically ventilate and/or to support the respiration of BN and (2) extubate BN (3) cease the administration of medication to BN and (4) not attempt any cardio or pulmonary resuscitation upon BN when cardiac output ceases or respiratory effort ceases.

    iii) The action(s) and/or inaction(s) of the clinicians employed by the hospital, as described in paragraph ii) above, are lawful.

23. I ought to conclude by expressing my profound sympathy for BN, and of course to PS, who must have found the events of the last fortnight extremely painful.