



Neutral Citation Number: [2019] EWHC 1244 (Fam)

Case No: MAP1900343

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/05/2019

Before :

THE HONOURABLE MR JUSTICE HAYDEN

Between :

Manchester University Hospital NHS Foundation Trust	<u>Applicant</u>
- and -	
M	<u>1st Respondent</u>
(Acting by his Children’s Guardian	
- and -	
OA	<u>2nd Respondent</u>

Mr Burrows (instructed by **Hill Dickinson LLP**) for the **NHS Trust**
Ms Greenhalgh (instructed by **Manchester City Council**) for the **Local Authority**
Ms Kilvington (instructed by **Abbot and Co**) for the **M**
Ms Cordock (instructed by **Children’s Guardian**) for the **Guardian**
F (acting in person)

Hearing date: 13 May 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.

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THE HONOURABLE 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, once again, with a little girl called M who is now 15 months of age. I have had to consider issues relating to her medical welfare earlier this year. On 27th February 2019 I gave an ex-tempore judgment. This judgment must be read in conjunction with my earlier one. On that last occasion I was considering the Trust's application for a declaration that it was in M's best interest to receive haemodialysis.
2. It was a complex and sensitive application, which I described at, paragraph 26, as 'delicately balanced'. I am happy to read that it has been a very great success and M is thriving as well as possibly could have been expected. She remains in hospital and the plan is to address outstanding medical issues with the objective of enabling her to return to a life outside hospital. This is important to her general development, not merely her medical welfare.
3. In support of this application I have received a report from Dr Dean Wallace, consultant paediatric nephrologist, who I also heard from in evidence at the earlier hearing. He is present today and has been able to assist me, either through Mr Burrows or directly.
4. M has been undergoing 3-4 haemodialysis sessions every week since my judgment. I recall that her blood pressure was giving cause for concern in February and note that she has received a number of blood transfusions to treat anaemia. She has had a brief admission to the High Dependency Unit with a viral respiratory tract infection. I was pleased to see Dr Wallace was able to describe her as adapting '*beautifully*' to haemodialysis. It has transformed nutritional delivery and resulted in improvements to all aspects of her chemistry and mineral bone disease
5. What is contemplated today is a gastroscopy procedure. It has been impossible to move M towards normal feeding. Attempts to date have resulted in vomiting, which has inhibited growth and development, providing sub-optimal nutrition. This increases her risk of aspiration and the associated risk of pneumonia. Needless to say, she is uncomfortable.
6. Continuous overnight pump feed, with small daytime bolus feeds, have controlled the vomiting but the absence of the gastroscopy, allowing safe overnight pump feeding, has become a major limitation to her obtaining optimal nutrition and consequent release from the ward.
7. Unlike the haemodialysis, the advantages of this procedure are clear and compelling. I do not regard them as being in any way delicately balanced. On the contrary, it seems to me there is an urgent need for M to receive the procedure in order to capitalise on the improvements she is making.
8. She is plainly a little girl with a strong instinct to survive, who is a real fighter.
9. The gastroscopy allows safe delivery of continuous pump feed. The nasogastric tube, in short, does not.
10. To permit implementation of the overnight feeding regime and efficient delivery of nutrients is, I have been told, crucial for infants with this degree of renal disease.

11. The contemplated procedure opens up a life which is more regular and permits what has been referred to as a '*normalisation of a daytime routine*'. Importantly, it creates the opportunity for M to return to a life outside the hospital.
12. Also of significance, at this stage, is that fact the removal of the nasogastric tube and replacement with the far more discreet gastroscopy will alter the way that people will relate to M. Dr Wallace emphasised that she will not present to anything like the same degree as '*a sick looking infant*'. That, he points out, will inevitably change the way people respond to her.
13. I am not at all surprised that the entire medical team are in support of the procedure, Moreover, I am aware, from the previous hearing, that this is a team which is well coordinated, shares information in relation to M, in a way which undoubtedly promotes her best interests.
14. Both parents object to the procedure, though it is to be recorded that this has not been their consistent position. They have a strong belief in God which shapes their everyday approach to the world in a very direct way. For various reasons, with which I need not burden the judgment, the procedure has required to be postponed on two previous occasions. The parents see that as an indication from God that the procedure is not necessary. Their entirely understandable desire that M moves directly to oral feedings is simply not capable of being achieved without the interim process of gastroscopy for however long that may be.
15. Dr Wallace has told me the procedure is relatively common these days. It is the plan to test M with oral feedings, from time to time at those stages when she is well and robust, with the hope that this will lead to a gradual reintroduction of oral feeding.
16. I entirely understand the parents' concerns as to the extent and degree of medical intervention that has been necessary for M. It must be extremely difficult for them, as parents, to see her in such challenging times during the last 6 months. It is obvious that they have noted her improvements which have been greater than anybody really expected. I am sorry that they have not been able to agree with the procedure here. As I say, I understand their distress but, as is clear from my analysis above, the case for the procedure is absolutely compelling and not in truth receptive to any cogent contrary argument. This is not in any way to dismiss lightly the importance of the parents' faith, which I recognise is an enormous comfort to them. It is important that they understand that I have properly had regard to it but, in these circumstances, focusing as I must on M's best interests, I have not felt able to afford it significant weight.
17. Miss Kilvington, on behalf of the mother, with both sensitivity and judgement, has presented her objections. Though the father is unrepresented he allies himself entirely with the mother's position. It is important that I record, as I did in my earlier judgment ([2019] EWHC 468 Fam), that both parents suffer from Mental Health issues which do not make it easy for them to evaluate some of the medical issues. I do not in any way wish to diminish the contribution of the parents in M's life. It is manifestly important. However, I consider that time should not be lost trying to secure parental agreement when there are underlying difficulties of this kind. I would very much encourage the parents to reconcile, if they can, the medical achievements that have been made here with their faith. In M's future treatment I would urge them to do

all they can to work cooperatively with Dr Wallace and his team, who have already achieved so much for M.