

Neutral Citation Number: [2004] EWHC 2247 (Fam)

Case No: FD04C01788

IN THE HIGH COURT OF JUSTICE  
FAMILY DIVISION

Royal Courts of Justice  
Strand, London, WC2A 2LL

7th October 2004

Before:

THE HONOURABLE MR JUSTICE HEDLEY

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Between:

<b>Portsmouth NHS Trust</b>	<b>Applicants</b>
<b>- and -</b>	
<b>Derek Wyatt</b>	<b>1st Respondent</b>
<b>-and-</b>	
<b>Charlotte Wyatt by her Guardian (CAFCASS)</b>	<b>2nd Respondent</b>
<b>-and-</b>	
<b>Southampton NHS Trust</b>	<b>Intervener</b>

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**Mr David Lock (instructed by Mills & Reeve) for the Applicants**  
**Mr David Wolfe (instructed by Leigh & Day) for the 1st Respondent**  
**Mr Robin Barda (instructed by CAFCASS) for the 2nd Respondent**  
**Mr Michael Mylonas (instructed by Weightmans) for the Intervener**  
**Hearing dates : 30th September and 1st October, 2004**

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HTML VERSION OF JUDGMENT

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Mr Justice Hedley :

**Introduction**

1. On the basis of the unanimous medical evidence in this case, the issue in all probability is not whether this baby should live or die but how and when she should die. Charlotte has chronic respiratory and kidney problems coupled with the most profound brain damage that has left her blind, deaf and incapable of voluntary movement or response. It is very highly probable

that she will during this winter succumb to a respiratory infection that will prove fatal. That said the unanimous medical evidence also recognises that in this area there is no such thing as certainty of prognosis of survival.

2. The fundamental damage to her respiratory system and kidney function is highly probably irreparable. The permanent damage to the brain is certain and irreversible. According to the medical evidence, Charlotte demonstrably experiences pain; whether she can experience pleasure, no doctor knows though most doubt it. She can be maintained in her present condition and everyone agrees that she should be.
3. The difference comes were she to deteriorate to the state that she would require artificial ventilation as everyone recognises that she almost certainly will. The unanimous medical advice is that to give such treatment would not be in her best interests. The views of the parents are that such treatment should at least be instituted and that could best be prepared for by the carrying out of an elective tracheostomy, that is to say the creation of an airway through the neck into the lungs.
4. What is the role of the court in all this? Any civilised society must have the means by which intractable disputes, whether between the state and the citizen or between citizens themselves are to be resolved. That is the purpose of the courts and the system of civil and family justice in this country. This kind of dispute is to be resolved by a Judge of the Family Division and whilst the judge will be more aware than anyone of his own limitations in deciding as profound an issue as this, decision there simply has to be. It may well be that an external decision is in the end a better solution than the stark alternatives of medical or parental veto.

### **Charlotte**

5. Charlotte was born at Portsmouth Hospital on 21<sup>st</sup> October 2003 at 26 weeks gestation and weighing 458 grammes (about 1 lb.). She was placed in an incubator and has in fact never left hospital. It is the unanimous view of the doctors that she is most unlikely ever to do so.
6. She has suffered a long and complex medical history since her birth. She has had severe respiratory failure requiring ventilation for most of her first three months. She has pulmonary hypertension resulting from the damage to her lungs with recurrent urinary tract infections and worsening kidney function. However in July 2004 she suffered a severe infection for which she was admitted to the paediatric intensive care unit at Southampton Hospital. Since this time she has exhibited a profound and persistent deterioration especially in her respiratory and neurological functioning.
7. Charlotte has been seen and assessed by many consultants apart from those having her care at Portsmouth and Southampton. For reasons that I explained in a judgment on 30<sup>th</sup> September 2004 (and do not need to repeat here) all consultants and all other Trusts have been granted anonymity and will accordingly be referred to by letter. Trust B (an important paediatric tertiary centre) has made available three consultants. Dr A and Dr B are consultant paediatric intensivists whilst Dr C is a consultant paediatric neurologist. Dr F, a consultant paediatrician in respiratory medicine is employed by Trust A and Dr G (instructed by the parents) is a consultant paediatric intensivist and respiratory physician employed by Trust B. Although there were differences between them in relation to prognosis, there was no dispute as to Charlotte's present condition.
8. Charlotte's head size, weight and length were all below 0.4<sup>th</sup> centile which in practice means as small as they can be. Her weight is increasing but that is not matched by growth in head circumference or length. The implication of head growth at so slow a rate was explained by Dr C. She said that it was indicative of brain damage and there was no longer any possibility of significant brain growth. She does not respond to stimulation, experiences involuntary reflex movements which are the most likely explanation for gripping an adult finger. She is, however, able to and does experience pain and distress. She will have minimal cognitive

function but she will be able to experience pain of future treatment. She is very likely to develop epilepsy.

9. She requires very high levels of supplemental oxygen in order to be able to breathe. That means that she needs more than can be administered by nasal tube and in fact at present she needs to have her head covered with a transparent plastic box and receives (and needs) almost the maximum oxygenation that it is possible to give. If she is removed from the box she usually becomes visibly distressed and turns profoundly blue and takes a long time to return, on replacement, to her original condition. The problem is that these levels of oxygenation in themselves damage the lungs and that is why everyone recognises the near certainty of her needing ventilation to sustain physical life in the next few weeks or months.
10. Charlotte's kidney functions are also deteriorating and are incapable of repair. She will not be eligible for a transplant but will in due course, if she survives, require dialysis.
11. Prognosis is notoriously difficult. Should she survive, all accept Dr C's neurological prognosis and that in relation to her kidney function. All accept the chronic damage to her lungs and the pulmonary hypertension and the risks that poses to the cardio-vascular system which itself seems presently undamaged. All agree that she is highly likely to catch a respiratory infection which would require ventilation. The most optimistic prognosis for survival for 12 months is 25% although in oral evidence and when pressed the realistic figure was 5% or less. Hence my opening comment. That said, there can never be certainty.

#### **The Parents' Views**

12. The parents do not seriously question the medical description of Charlotte or its long term implications. Indeed I believe that they recognise the profoundly pessimistic medical prognosis and that that has a proper medical basis to it. Nevertheless they have not abandoned hope. They believe that they have some experience of Charlotte reacting to them and, although they recognise that there has been a recent serious deterioration in her condition, they believe that she still does so. They believe it is their duty to maintain life as they do not believe that she is yet ready to die.
13. In the course of his evidence to me Mr Wyatt, although accepting that his broad approach was 'life at all cost', did accept that there had to be limits. By that I think he meant that they would know when Charlotte was ready to die and would then allow her to do so. In fact he went further than that (and further than either of them had previously indicated) and said they would agree to a treatment plan and that, if after a few days of intensive ventilation no progress had been made, would contemplate agreement to its withdrawal. However, he made it clear that he would want to make that decision at the time and not irrevocably commit himself in advance. That is a view which it is not at all difficult to understand.
14. The parents had also spoken of hoping for a miracle. By that they meant not only the theoretical chance acknowledged by the doctors but also a miracle born of divine intervention. However, Mr Wyatt agreed with me that that would be wholly unaffected by any order that I might make.

#### **The Doctors' Views**

15. In coming to their views all the consultants were bound to take account of the British Medical Association Guidance "Withholding and Withdrawing Life Prolonging Medical Treatment". The current version was updated in 2001. That guidance is not binding on the court but it is guidance which is entitled to the closest attention and deep respect. As I have indicated, it was the unanimous medical opinion that artificial ventilation (if and when required) would not be in Charlotte's best interests. There was some disagreement as to whether this was because there was "no chance" or because there was "no purpose" but there was no disagreement over what was best.

16. It was also the unanimous view of the doctors that it is very important in these cases to work in partnership with the parents and both to keep them fully informed and to enlist their consent at every turn. That, of course, is not only good practice but a proper acknowledgment of the law in that parents, by virtue of Sections 2 and 3 of the Children Act 1989 hold parental responsibility; that includes the right to consent to or refuse treatment. No-one else has it save the court where, as here, its jurisdiction has been invoked.
17. Although there was unanimity of view as to best interests amongst the doctors, there was not unanimity as to the way ahead. Most doctors simply wanted to be able to decline to re-ventilate the child. However, Dr G (and, more cautiously, Dr F) were prepared to contemplate going further with an elective tracheostomy and an initial attempt at ventilation. This he was prepared to do to accommodate parental views and to give them more time and information in order to come to terms with the advice that they were receiving. In addition he thought that an elective tracheostomy could fulfil a palliative function.
18. I tentatively suggested that there were four stages in which a clinician could be when in disagreement with parents. At one extreme was the position where a course of treatment was advised but rejected by the parents where the clinician concluded that it was an affront to professional conscience to withhold that treatment. The second stage was where the same circumstances existed but where the clinician although disagreeing with the parents could see that there was something to be said for their view. The third is the reverse of the second where the clinician advises against treatment which the parent wants but is able in conscience nevertheless to give it. The last stage is where to do what the parents want is not possible in good conscience. No doctor believed that an elective tracheostomy or initial ventilation came into the last stage although Dr A made it clear that he would not accept a referral on that basis; all doctors seemed to recognise that we were all at the third stage.
19. That is the position. All these views are held in good faith. Everyone believes that they are acting or advising in Charlotte's best interests. Yet there is an impasse. What is the judge to do, for the impasse must be resolved?

### **The Law to be Applied**

20. These and related issues have often been considered by the courts. I gratefully acknowledge the survey and analysis of the law undertaken by Munby J. in *R –v- GMC and others* [2004] *EWHC 1879 (Admin)* a case concerning Mr Burke. Without seeking to emulate, let alone rival, Munby J. I propose simply to set out the law that I intend to apply in this case.
21. 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. It is powerfully captured in the judgment of the Court of Appeal of Hoffman LJ in the *Bland* case – *Airedale NHS Trust –v- Bland* [1993] *AC 789*. At page 826 Lord Hoffman says this:

"I start with the concept of the sanctity of life ... [W]e 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.

Our belief in the sanctity of life explains why we think it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless.

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"

Lord Hoffman then goes on to point out, however:

"....what is not always realised, and what is critical in this case, is that they are not always compatible with each other."

22. Charlotte, of course, is a baby. Whilst the sanctity of her life and her right to dignity are to be respected, she can exercise no choice of her own. In those circumstances someone must choose for her. That is usually her parents but here it is the court. That choice must be exercised on the basis of what is in her best interests. It is the understanding and application of that concept that presents the true difficulty in this kind of case.
23. Best interests must be given a generous interpretation. As the President said in *Re A (Male Sterilisation)* [200] 1 FLR 549 at p. 555:

"...best interests encompasses medical, emotional and all other welfare issues"

In *Re S (Adult Patient: Sterilisation)* [2001] Fam 15 Thorpe LJ says at page 30:

"In deciding what is best .... the judge must have regard to .... welfare as the paramount consideration. That embraces issues far wider than the medical. Indeed it would be undesirable and probably impossible to set bounds to what is relevant to a welfare determination."

In my judgment the law is indeed expressed in the very wide form apparent from those quotations. The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests. That said, helpful attempts have been made to tease out this concept but they always have to be viewed as no more than attempts at illumination.

24. I have derived considerable assistance, if I may respectfully say so, from the judgments of the Court of Appeal in *In re J (a Minor) (Wardship: Medical treatment)* [1991] Fam 33. Two passages have in particular informed my understanding. At pp. 46-7 Lord Donaldson of Lynton MR says this:

"... there is a balancing exercise to be performed in assessing the course to be adopted in the best interests of the child ..."

This brings me face to face with the problem of formulating the critical equation. In truth it cannot be done with mathematical or any precision. There is without doubt a very strong presumption in favour of a course of action which will prolong life, but ... it is not irrebuttable. As this court recognised in *In re B.*, 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 itself ...

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 increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's, and mankind's, desire to survive."

In addition Taylor LJ at p. 55 says this:

"Despite the court's inability to compare a life afflicted by the most severe disability with death, the unknown, I am of the view that there must be extreme cases in which the court is entitled to say: "The life which this treatment would prolong would be so cruel as to be intolerable." If, for example, a child was so damaged as to have negligible use of its faculties and the only way of preserving its life was by the continuous administration of extremely painful treatment such that the child either would be in continuous agony or would have to be so sedated continuously as to have no conscious life at all, I cannot think Mr Munby's absolute test should apply to require the treatment to be given. In those circumstances, without there being any question of deliberately ending the life or shortening it, I consider the court is entitled in the best interests of the child to say that deliberate steps should not be taken artificially to prolong its miserable life span.

Once the absolute test is rejected, the proper criteria must be a matter of degree. At what point in the scale of disability and suffering ought the court to hold that the best interests of the child do not require further endurance to be imposed by positive treatment to prolong its life? Clearly, to justify withholding treatment, the circumstances would have to be extreme ... I consider the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. I say "to that child" because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable."

Helpful though these passages are, it is in my view essential that the concept of "intolerable to that child" should not be seen as a gloss on, much less a supplementary test to, best interests. It is a valuable guide in the search for best interests in this kind of case.

25. In the course of argument the European Convention on Human Rights was referred to but no separate submissions were developed even though key rights are undoubtedly engaged. That was because although English domestic law has undoubtedly been significantly affected by the concept of Convention rights, it is recognised that in this case at least the convention now adds nothing to domestic law.
26. In my consideration of best interests there is an authority to which I need to refer once again. In *Re A (Male Sterilisation)* at page 560 Thorpe LJ says this:

"There can be no doubt in my mind that the evaluation of best interests is akin to a welfare appraisal. ... Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit. In the present case the instance would be the acquisition of foolproof contraception. Then on the other sheet the judge should write any counterbalancing dis-benefits to the applicant. An obvious instance in this case would be the apprehension, the risk and the discomfort inherent in the operation. Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously, only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant."

In that case he was dealing with an adult without capacity though it seems to me that with necessary variations (not the least of which is the weight to be given to the views of the parents) it can helpfully be applied to children as well.

#### **The Relevant Factors in the Assessment of Charlotte's Best Interests**

27. The court starts with the fundamental principles of the sanctity of life, the best interests of Charlotte which govern choice and her inherent right to respect for her dignity. Her parents say that all these point in the direction of renewed aggressive treatment in the event of further deterioration. The medical advice is that she should then be allowed to die peacefully in her parents' arms if that is the natural course and that she should be supplied with all necessary palliative care. There is this common ground: that as and when she comes to die she should do so peacefully with her parents.
28. Given that death is the one experience (other than birth) that all humanity must share, no view of life that does not include a contemplation of the place of death, even in a child, can be complete. As a society we fight shy of pondering on death yet inherent in each of us is a deep desire both for oneself and for those we love for a "good" death. It seems to me therefore that in any consideration of best interests in a person at risk of imminent death is that of securing a "good" death. It would be absurd to try to describe that concept more fully beyond saying that everyone in this case knows what it means – not under anaesthetic, not in the course of painful and futile treatment, but peacefully in the arms of those who love her most.
29. That, of course, is but one factor. I must consider her prospects of physical survival. On that I rely on the medical evidence. The strong probability is that she will contract a respiratory infection which will prove fatal irrespective of any treatment however aggressive. On the other hand that does not apply to every infection and aggressive treatment by ventilation may (and it is only may) restore her to her present condition; for no more than that can be achieved. In my view the prospects of her surviving 12 months are minimal though not non-existent. Even if she is recommended for tracheostomy, she may not survive transfer (for such an operation cannot be done at Portsmouth) or anaesthetic. If ventilated, she may not survive anaesthetic or her lungs may be fatally damaged by gas pressure or the pulmonary hypertension may cause a breakdown of the cardio-vascular system. All treatment is fraught with risk hence the prognosis of minimal prospects of survival. Yet no-one can say for absolute certain that she will not survive another year however much the probabilities are against it.
30. So far, I have been describing these factors as an outsider looking in on the life of a child. I have heard doctors unanimously describing her quality of life as terrible and the enduring of further aggressive treatment as intolerable. But both the quality of life and its tolerability have strong subjective elements to them. Those who have cared for a disabled child often have

different perceptions of 'quality of life' and 'intolerability' to those who have not. That is inevitable. I remind myself of Lord Taylor's words that the test is not whether life would be tolerable to the decider (or indeed the parent, clinician or anyone else) but "...whether the child in question, if capable of exercising sound judgment, would consider the life intolerable." That is a daunting (some may say impossible) task. It is, however, one from which the judge cannot turn aside.

31. Given the age of this child, key to any decision is the quality of her sensory faculties. Can she feel pain? Can she experience pleasure? Can she respond to human contact or human love? Is there any real prospect that her sensory faculties might develop further? The doctors defer to the opinion of Dr C, the paediatric neurologist. Her evidence (which I accept) establishes that Charlotte has no sense of sight or sound and is (and will remain) effectively without volition. That substantially precludes physical or emotional response to another human. It is clear that she can experience pain as the nursing evidence clearly demonstrates. It is not possible to assert that she could experience pleasure although neither can that be clearly denied. The parents believe that she can respond. Of course they recognise that they may be projecting their hopes on to Charlotte; on the other hand they do know her best. I think it highly probable that she does not experience pleasure though I cannot exclude it as a possibility. Certainly the medical evidence affords no basis for a belief that such sensory faculties as she has are capable of further development. An illustration of the problem is afforded by food. Dr C agreed with Mr Wolfe that Charlotte may be able at some stage to take some food by mouth and derive enjoyment. At the same time the very act of trying to do that may in fact incur discomfort and distress.

#### **The Views of the Parents**

32. Although this forms part of the consideration of best interests, it is a matter of sufficient importance to be dealt with in its own right. There is no doubt these parents have not relinquished hope and do not wish to accept Charlotte's death as inevitable. There is no doubt as to the genuineness of their view nor is there any doubt that they believe that they are in Charlotte's best interests. Moreover, there is no doubt that they have thought long and hard about the issues that confront them. Their views must be entitled to the greatest respect but what weight is to be attached to them?
33. There is no doubt that the law places final responsibility on the judge. This is not because parliament has expressly said so, though of course it could and indeed might, but because the court is discharging its historic duty of overseeing the best interests of those who, for whatever reason, cannot make decisions for themselves. So although I have no doubt about the law, it leaves me a little uncomfortable. Under Part IV of the Children Act 1989 the State is only entitled to intervene in private family life if it can establish a factual basis for doing so by at least showing a risk of significant harm attributable to the care being given to the child. Then, and only then, may a court consider the welfare of the child. Here, of course, no question arises as to the care given to this child; her condition is entirely organic. Nevertheless I am being asked to override the views of these parents as to what is best for their daughter and undoubtedly I have the jurisdiction to do so.
34. I think the only way I can allay my discomfort is to remind myself in my consideration of Charlotte's best interests that Mr and Mrs Wyatt know her best. I should pay proper attention to their intuitive feelings whilst reminding myself that they may project those on to Charlotte. In approaching the case in this way, bearing in mind the breadth of the concept of best interests, I think I come closest to giving proper weight to their views whilst discharging the responsibility placed on the court.

#### **The Guardian's Position**

35. In this case Charlotte has had her own representation through CAF/CASS. I have set out the position of the Hospital and the position of the parents. What then is the position of the Guardian who has of course been involved in the instruction of some of the experts and has reserved a final submission until all the evidence has been given?

36. In his written submission, confirmed orally, Mr Barda, Counsel for the Guardian, says this:

"...the Guardian has been anxiously looking for indications in the evidence of a glimmer of genuine hope for Charlotte to justify the painful and invasive treatment which would be necessary should her condition deteriorate and she require ventilation. Sadly the evidence as the case has gone on has tended to establish with increasing clarity the extent of Charlotte's disabilities and illness, the painful quality of life she currently endures, and the limits of any potential quality of life in the event that she survived invasive treatment."

In my view that is a fair reading of the evidence. However, I would want to make two qualifications: first, that the subjective element of quality of life is recognised; and secondly, that her condition can vary from day to day. As to the latter point, some described her as having 'good' and 'bad' days; the tenor of the evidence of Dr F and Dr G was that she had 'bad' and 'terrible' days – once again adjectives loaded with subjective content.

37. Mr Barda expresses the Guardian's final position thus:

"It is with great reluctance that the Guardian is driven to the conclusion that Charlotte's quality of life is so limited, so full of pain, so absent of the possibility of significant pleasure that in the event that her condition deteriorated to a level where she required ventilation such invasive and painful treatment would not be in her best interests."

It may, of course, extend her life but in his submission, in all these circumstances, it would be to no purpose. That then sets out the views of all the parties and I hope all the matters which the court is required to take into account.

#### **Court's Conclusions on Best Interests**

38. I have given this case my most anxious and closest attention. I am only too aware of my own limitations in making so momentous a decision. Yet in the end I have come to a clear view. Subject to two observations that I wish to make at the end of this judgment, I do not believe that any further aggressive treatment, even if necessary to prolong life, is in her best interests. I know that that may mean that she may die earlier than otherwise she might have done but in my judgment the moment of her death will only be slightly advanced. I have asked myself: what can now be done to benefit Charlotte? I can only offer three answers: first, that she can be given as much comfort and as little pain as possible; secondly, that she can be given as much time as possible to spend physically in the presence of and in contact with her parents; thirdly, that she can meet her end whenever that may be in what Mr Wyatt called the TLC of those who love her most. Although I believe and find that further invasive and aggressive treatment would be intolerable to Charlotte, I prefer to determine her best interests on the basis of finding what is the best that can be done for her.

39. In reaching that view I have of course been informed by the medical evidence as to the prospects and cost to her of aggressive treatment. I hope, however, that I have looked much wider than that and seen not just a physical being but a body, mind and spirit expressed in a human personality of unique worth who is profoundly precious to her parents. It is for that personality of unique worth that I have striven to discern her best interests. It is my one regret that my search has led to a different answer than that sought by these parents.

#### **The Relief to be Granted**

40. I propose to grant relief broadly along the lines contended for by the Hospital and Guardian although I said that I would put over any argument about the exact wording until I had given judgment. It is not necessary for me to consider injunctive relief or any positive declaratory relief in the light of the conclusions to which I have come on best interests. I say no more than

that the former (at least in mandatory terms) is currently precluded by the Court of Appeal decision in *Re J (a Minor)(Child in Care: Medical treatment) [1993] Fam 15* whilst the latter raises very considerable practical difficulties.

41. I said that I had two further observations to make. First this relief is only permissive, it does not relieve them of the right or responsibility for advising or giving the treatment that they and the parents think right in the light of the circumstances as they develop. All it does is to authorise them, in the event of disagreement between the parents and themselves, not to send the child for artificial ventilation or similar aggressive treatment. Secondly, I would like to ask the treating doctors (without in any way suggesting an answer to them) to give further consideration to an elective tracheostomy on the basis of its possible contribution to Charlotte's palliative care as described by Dr G.
42. Perhaps uniquely this case has been heard throughout in public; yet the fact that it is unique demonstrates that this case affords no precedent as to the future hearing of family cases in public. That said it would be wrong for me to part with this case without a fulsome acknowledgment of the assistance that I have received from the witnesses and from counsel. Nor would it be right not to acknowledge (if they will not mind my saying so) the dignity which these parents have shown in their sorrow or the commitment that they have shown to Charlotte. Their acknowledgment of the medical care that Charlotte has received was a proper tribute to the treating staff and it is always refreshing to see a generous spirit displayed in adversity.