Kearns P

Baker J

Costello J

THE HIGH COURT

[2014 No. 10792P]

BETWEEN

P. P.

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE

DEFENDANT

JUDGMENT of the Court delivered on the 26th December, 2014

The facts of this tragic case may be simply stated. The plaintiff resides outside Dublin and is the father of N.P. who was born on the 10th July, 1988 and who died on 3 December, 2014 aged 26 years of age. She was pregnant and her pregnancy was at the gestational age of 15 weeks at the time of her death. N.P. had two children who are now aged six and four years respectively. Both resided with her outside Dublin. She was not married but at the time of her death was engaged to M.J., the father of her unborn child.

On the 27th November, 2014, N.P. was admitted to a hospital outside Dublin complaining of persistent headaches and nausea. On the night of the 29th November,

2014, N.P. sustained a fall while in hospital and was later found to be unresponsive and was urgently incubated. Later that day, N.P. was transferred into the care of a Dublin hospital where, on the 2nd December, 2014, at a meeting with medical clinicians in that hospital, the plaintiff was advised that his daughter's medical condition was such that there should not be an attempt at resuscitation in the event of her suffering cardiac arrest. The condition of N.P. was the subject of ongoing review by clinicians in the Dublin hospital in the course of the period from her admission up to the 8th December, 2014 when she was discharged back into the care of the hospital outside Dublin. On the 3rd December, 2014 in Dublin, a medical clinical determination had been made that N.P. had suffered brain stem death. The plaintiff was advised of this fact on the 3rd December, 2014.

Since the 8th December, 2014 the said N.P. has been under the medical care of the clinical staff at the hospital outside Dublin. She is in the intensive care unit of the hospital where she is being supported by mechanical ventilation and being fed by a nasogastric tube. She has been maintained on very heavy doses of medication for a number of conditions including pneumonia, fungal infections, high blood pressure, fluid build-up and fluctuations in the production of urine. She has been receiving physiotherapy twice daily for secretions from her chest and her joints and muscles are being cared for. The plaintiff was advised by the medical staff at the hospital that it was intended to maintain this regime of treatment for the duration of the pregnancy of N.P. On the 17th December, 2014 a tracheostomy operation was carried out on N.P. to facilitate the continuation of maternal organ supportive measures in an attempt to attain foetal viability.

The plaintiff believes that these measures are unreasonable and should be discontinued. The endorsement of claim in the plenary summons states the plaintiff's

belief that prolonged somatic support measures are experimental in nature and that they have no proper basis in medical science or ethical principle. He thus believes that prolonged somatic support of N.P. is unlawful and/or should be discontinued.

The matter first came before the High Court on Monday, 15th December, 2014 when a discussion as to the appropriate method of progressing the court application was discussed between me, as President of the High Court, and Mr. John Rogers, senior counsel for N.P.'s father. At that stage the proposal was that N.P. be taken into wardship and that P.P., as father of N.P., be appointed committee of the person and estate of the said N.P. The Court agreed to "fast track" a wardship application, making same returnable for Tuesday, 23rd December, 2014. The Court made an order on the 15th December, 2014 restricting publication of any information about the case which would identify the parties, including the names of any of the hospitals involved in the care of N.P. That order continues in effect.

On giving the matter further consideration, the plaintiff's legal advisors took the view that a preferable procedure in the circumstances of this case was to bring plenary proceedings in which the Court could be asked to exercise its inherent jurisdiction. The present proceedings accordingly issued on the 19th day of December, 2014.

A "case directions" hearing took place on Monday, 22nd December, 2014 where the following matters were agreed:-

(i) That a full hearing of the case would take place on Tuesday, 23rd December, 2014 as an exercise by the High Court of its inherent jurisdiction;

(ii) That any issue as to wardship would remain to be considered after the plaintiff's application had been determined;

(iii) That the plaintiff, P.P. and the defendants in the plenary proceedings would be entitled to advance such evidence and submissions as they considered appropriate.

(iv) That the Court would allow and hear representations on behalf of the unborn child of N.P.;

(v) That the Court would receive and hear representations on behalf of N.P.;

At the conclusion of the directions hearing, the President indicated that, in view of the importance of the issue raised in the case, the High Court would sit as a divisional court to hear the plaintiff's application, the additional members of the court for that purpose being Baker J. and Costello J.

EVIDENCE HEARD BY THE COURT ON 23 DECEMBER

Mr. P.P. gave evidence that he was the father of N.P. and that she was living with him for the previous two years. She had two children, a girl aged six and a boy aged four. P.P. had been married but his wife died in June, 2007. He described how, following the commencement of his daughter's pregnancy, she started to suffer from headaches and vomiting and attended a local hospital on the 27th November, 2014. When he telephoned the hospital to find out how she was getting on she seemed to be doing fine but was then transferred to a Dublin hospital. When he arrived to the Dublin hospital on the 29th he was told that his daughter had died. He was taken to see her remains in the ICU Unit and noted she was on a life support system. He was told by the medical staff that, for legal reasons, they felt constrained to put his daughter on life-support because her unborn child still had a heart beat. He found this very stressful. On each occasion since then when he has seen her, her appearance

appears to be deteriorating and her body has become very swollen. He was aware that an operation on his daughter's head had been carried out in the Dublin hospital to reduce the pressure but had been informed by the treating neurosurgeon that his daughter was dead and there was nothing he could do for her. He had discussed the situation with his sister-in-law who lived next door, who was virtually a mother to his daughter, and also with M.J., the father of the unborn child. All had agreed that the life-support machine should be turned off, both because his daughter was dead and the chances of the unborn child surviving were minimal. He wanted her to have a dignified death and be put to rest. His daughter's two children are aware that their mother is sick and believe she is being looked after by the nurses "until the angels appear". His granddaughter was very distressed by the appearance of her mother when she last saw her.

In cross-examination Mr. P. agreed that his daughter had never executed any living will or advance direction as to what might happen if she were to sustain serious illness or become incapable of communicating her wishes. He was aware she kept a Facebook page and was aware she had posted on that page a picture of herself and her partner, and also a photograph of her two children. He had also heard that she had a Facebook page showing an image of the scan of the unborn. He agreed that this latter fact suggested she was proud of this new pregnancy. She had no prior illness and would have been intent, had she not become ill, to carry her baby to full term.

M.J. then gave evidence to say his relationship with N.P. had been going on for four or five years. He confirmed he was the father of the unborn and that he supported the plaintiff's application that the ongoing somatic support for N.P. be withdrawn. In cross-examination he confirmed that he and N.P. had discussed different names for the new child. His views on what should be done for his partner

were influenced by the information he had received to the effect that even if the current measures were continued there was no reasonable prospect that the unborn child would survive.

Dr Brian Marsh is a consultant in intensive care medicine in the Mater Hospital. This form of specialised medicine deals primarily with the care of patients who require a higher level of intensive care management. He had extensive experience in this area having qualified in Ireland and having later trained in Australia prior to his return to Ireland. He explained the phenomenon of brain death and the tests deployed for brain stem testing. This particular patient had a cyst in her brain which was producing symptoms and which caused her to sustain a fall on the 29th November. Thereafter at 17.20 hours on the 3rd December an angiogram confirmed that there was no brain stem activity or blood flow through the brain at that point. He said this test confirmed she was brain dead. He believed the mechanism by which brain death had taken place had evolved over the preceding number of days. Thereafter breathing activity was achieved by means of a ventilator, but there was and is no intracranial circulation of blood. He told the Court that brain tissue has a very short period of ability to survive without oxygen. That organ itself ultimately undergoes a process of liquefaction. Having seen her the previous evening, he told the Court that the mother's condition currently is one of requiring considerable input from the medical and nursing team. She has problems with her blood pressure management and has ongoing infection. She is also in need of ongoing hormonal therapies. Her appearance is puffy and swollen.

In terms of the welfare of the unborn child, the most important consideration for its survival is the stage of gestation at which brain death occurs in the mother. In this instance it was fifteen weeks.

A study had been carried out in Germany (the "Heidelberg Study") which, while not consisting of scientific research, reported various outcomes of cases that have happened in individual hospitals internationally. That report indicated a very small subset with this particular gestational age. The study took in a 30 year period and involved about 30 cases in all. Only 7 fitted into the category of 17 weeks or less gestation at the death of the mother. Of those there were two survivors, one of whom died at 30 days post delivery. The paper itself made the point that the number of reported cases was too small to determine the rate at which intensive care support for the mother could result in a healthy infant. There were in addition, he believed, many cases where reports had not been submitted, probably because they had not had successful outcomes.

In his view the situation concerning N.P. will quite quickly become unsustainable. Over time her blood pressure will be difficult to sustain. There is an exponential decrease in function over a period of time. This particular patient has background infections and is no longer managing to retain normal body tone. He did not believe it practical to sustain the mother for up to 32 weeks - at which point the child would be viable. The child is in a very abnormal environment and it can become non-viable for a variety of reasons. In the present case there were fluctuations in blood pressure, infection, the latter comprising deep infection related to the ventricular drain which had been removed from the right frontal area of the skull. There is a wound on the top right hand side of N.P.'s head which has become infected and which has grown organisms. She has also had a urinary tract infection and indications of pneumonia. The presence of these infections is a complication additional to and above all the other problems inherent in the medical situation. In his opinion those infections shorten the potential ability to sustain the mother. He did not

believe that this unborn child could survive. The situation will quickly become totally unsustainable. In the circumstances he did not believe it appropriate to continue the present level of somatic support.

Cross-examined by counsel for the HSE he confirmed that he had co-authored a paper on "Maternal Brain Death" in which he noted that successful delivery of a live foetus had never been reported where pregnancies were less than sixteen weeks gestational age at the time of maternal brain death.

Cross-examined by counsel for theunborn child, Dr. Marsh agreed there had been, in fact, three survivors from the seven infants fitting into the relevant gestational category, but that the third had passed away after 30 days. A later report published in 2013 was of little value as it referred to one event only.

Cross-examined by counsel for N.P., Dr. Marsh also confirmed that any outcome would be heavily influenced by whether the infections worsen or improve.

Dr. Peter Boylan is a consultant obstetrician. He provided a detailed report to the Court dated the 22nd December. He had seen the medical records and traced the chronology of N.P.'s various hospital admissions and treatment. He was aware her Glasgow coma score was only 3/15 on admission to the Dublin hospital and that the CT scan result indicated a 6 x 4 cm cystic lesion in the left posterior fossa with mass effect and compression of the left hemisphere of the brain representing a catastrophic event. He believed a cyst had developed in N.P.'s brain over some period of time which had caused the headaches and dizziness and probably explained her fall. He noted that her pupils were bilaterally non-reactive and fixed, indicative that she was unconscious and had experienced very severe damage to her brain. He was aware that brain stem testing measures were put in place by the neurologist in the Dublin hospital. A study of the notes brought home that the doctors in the Dublin hospital

were clearly concerned, having regard to the mother's pregnancy, not to do anything that would "*get them into trouble from a legal point of view and were awaiting legal advice*". He was aware a cerebral angiogram had been carried out on the 3rd December which showed no evidence of intracranial flow and the appearance was consistent with brain death. Further confirmatory tests on the 4th December were to the same effect.

Dr. Boylan believed that the state of gestation on the 3rd December was more likely to have been thirteen weeks, rather than fourteen or fifteen. He adverted to the discussions which had taken place between the members of the multi-disciplinary medical team within the Dublin hospital, all of which emphasised and were focussed on the difficulties for medical practitioners as a consequence of the absence of medico-legal guidelines and because of difficulties arising from the 8th Amendment to the Constitution.

In describing somatic support, Dr. Boylan described how the unborn in the uterus is effectively in an intensive care unit. Ventilation is provided by the placenta which acts to provide oxygen and remove gases, carbon dioxide, just as the ventilator does for somebody after birth. The placenta also acts as the kidneys in the case of the unborn and therefore the unborn is effectively undergoing continual dialysis to remove waste products and various other things. The unborn receives intravenous nutrition by way of the placenta through the umbilical cord in the same way that the mother is herself receiving nutrition through a tube. Both are in effect in intra-dependent intensive care units. He believed it was a reasonable proposition to withdraw care having regard to the facts of this case. This would result in the mother's death which would inevitably be followed by the death of the unborn because its intensive care support would be withdrawn. However, this was entirely

different to an abortion because it is the withdrawal of ongoing support rather than the direct termination of life.

The present treatment regime was an extraordinarily rare situation. He could find no case where somatic support began at fourteen weeks or even thirteen weeks with a successful outcome. This form of somatic maintenance is still relatively experimental.

Of particular concern in the present instance is the open wound in the skull of N.P. where there is a large mass of dead tissue which will act as a focus for sepsis and infection of her blood stream, inevitably resulting in infection of the unborn resulting in a rupture of the membranes and a very pre-term delivery. A newborn, if it survived, would be likely to be significantly damaged. Dr. Boylan confirmed he supported the HSE position in this case that there was no reasonable prospect that the unborn child would be born alive if somatic measures in relation to the mother were maintained. Apart from all of the metabolic and endocrine cardiovascular difficulties, there was a major risk in the instant case of overwhelming infection.

In an ordinary case viability was generally accepted as being at approximately 24 weeks gestation, but the survival rate for a child at that stage is only 25% and of the survivors only 15% survive without handicap. He believed it should keep going until 32 weeks when the chances of intact survival are much greater. However this unborn child was being maintained in a regional hospital outside Dublin without facilities for neonatal intensive care of the extremes of prematurity. He believed the likelihood of a successful outcome for the unborn child in this case was very low. Maintaining somatic support for N.P.'s body over a number of months has a high likelihood of proving to be futile.

In cross-examination he accepted there were some discrepancies between the different records as to the gestational age of the unborn at the time of its mother's brain death. However, whether it was thirteen, fourteen or fifteen was not really of any great consequence in terms of the concerns he had raised. The most successful outcomes were those where the mother dies at 32/35 weeks from a brain haemorrhage and has immediately effectively post-mortem caesarean section. She can then be delivered without somatic support having to go on for a long time. The further back one goes into the earlier stages of pregnancy, then obviously the longer somatic support is going to have to continue and the greater potential therefore for complications to follow. He was further cross-examined by counsel for the mother in terms of what response should follow a request or instruction by the mother that somatic treatment continue in the best interests of her baby in the event of brain haemorrhage or a similar event. While no such request or instruction had been made in this case, Dr. Boylan stated this would make matters "an awful lot more complicated".

Dr. Timothy Lynch is a consultant neurologist at the Mater Hospital. He gave evidence that N.P. met the criteria for brain death based upon the clinical history (a large cerebellar cystic lesion causing acute hydrocephalus and compression of brain stem). The neurological examination of the 22nd December and the absence of blood flow on the four vessel cerebral angiography confirmed that assessment. The latter demonstrated a complete lack of blood flow in the intracranial vessels to brain stem or to either or both cerebral hemispheres.

Testimony which the Court can only describe as devastating was then given by Dr. Frances Colreavy, who is a consultant in intensive care medicine. She had trained in Ireland and Australia but said she had never experienced a case of this nature

before where somatic treatment had been applied for 20 days to a person who is brain dead. She examined N.P. on the evening of the 22nd December and noticed the presence of eye and face make up which were used as the above mentioned two children visited their deceased mother for the first time that day. However, the whites of the eyes were so swollen that the eyelids could not close properly. There was evidence of ongoing infection with high fever, high white cell count, fast heart rate and evidence of a high output circulation. There was evidence of pus which required evacuation from a drain site on the right side of the head. This site has not closed and on examination there is a hole in the skull with brain tissue extruding. There was also evidence of a fungal infection at this site. There were huge amounts of fluid in the lungs with additional evidence of a urinary tract infection and the lower abdominal wall was noted to be inflamed. Serious infection is inevitable in this case due, in the opinion of Dr. Colreavy, to the presence of a rotting brain which is leaking to the outside, together with the drips, catheters and tubes required to extend somatic support, the administration of steroid therapy, liver dysfunction and prolonged stay in the ICU environment which is colonised with resistant bacteria. There is also evidence of cardiovascular instability requiring high doses of medication. There is evidence of hypertension relating to fluid overload with an attendant risk to placental perfusion. There is total body oedema (puffiness) abnormal function and a build up of fluid in the body. There were six syringe pumps beside the woman's bed for her various treatments. N.P. needed nutrition, bowel support, drugs for infections, a head wound needed to be dressed and she had to be turned to avoid pressure sores. Dr. Colreavy said that the pregnant abdomen looks unlike any other she had seen and she was worried that indicated an infection underneath. All the sources of infection had not been identified. In her view, continuing the somatic support was not appropriate

and amounted to "*experimental medicine*". She had found the mother's temperature to be 38.5 and previously even higher at 39° degrees. She would expect the temperature in the uterus to be even higher, perhaps about 40. The striae, the stretch marks of pregnancy, are very abnormally discoloured in this case and the abdomen itself looks very boggy and filled with fluid indicating that there could be inflammation or infection in the abdomen itself. There is also evidence of urinary infections and evidence of fungus at the tip of one of the tubes that are inserted into a vein to support the blood pressure and the circulation. She also has high blood pressure and is receiving very high doses of drugs to address this worrisome feature. Some of the infections are very resistant to antibiotics and some of the drugs being administered are not licensed for use in pregnancy situations. She did not believe it was realistic to consider that somatic support for the mother could continue to be provided until the foetus reached viability.

Dr. Peter McKenna is a consultant obstetrician attached to the Rotunda Hospital. He stated that N.P.'s last period was the 16th August and he thus calculated she was about fifteen weeks pregnant when declared brain dead on the 3rd December. He said that the woman's high temperature at 38.5 degrees and going up to 39 degrees was worrying. Babies are not designed to be incubated in anything other than the normal temperature. The higher the baby's temperature, the quicker the enzymes will work and the quicker you will get through the available oxygen. He was also concerned about poor control of the patient's blood pressure. If not properly controlled, placental function will be bad. He believed the vividly coloured stretch marks on the mother's abdomen could be caused by retained fluid. Very few drugs are licensed for use in pregnant women and it is not possible to say with any certainty what the effect of those drugs might be on the unborn child. He was aware of the

study conducted in Heidelberg confirming in his view that there was only one live birth from a period of gestation which was as early as that of the instant case. The few reported cases indicate that most approaches to managing brain dead mothers remain experimental. In terms of viability for delivery, he agreed with Dr. Boylan that the absolute minimum is 24 weeks at which point the outlook was poor. At 28 weeks the chances of survival are considerably greater. However that is a further ten weeks on from the present time. If this were a case where the brain injury had occurred at 24 weeks he would regard it as the logical thing to try and sustain the intrauterine environment for another couple of weeks.

He believed the chances of the foetus being born alive are small and the chances of intact survival if born alive were even smaller. Having heard the evidence of Dr. Colreavy, his view in that regard had hardened so that he now believed that further progress was becoming increasingly unlikely. He saw no justification for continuing it further. The level of care that would be demanded was extraordinary and the chances of a successful outcome were so poor that he would be reluctant to continue the therapy without the full and whole hearted support of the entire family.

Cross-examined about the Heidelberg report, he accepted that of the 30 cases addressed in that paper some eight cases fell into the approximate gestation period arising in the instant case. He was referred to a paragraph in the report which suggested that prolonged somatic support can lead to the delivery of a viable child with satisfactory Apgar score and birth rate, and that such children can develop normally without any problems resulting from intrauterine conditions. Dr. McKenna said that the percentage of successful cases could not be determined because there are no reports in existence describing failure of intensive maternal support from all medical centres. He believed that unsuccessful outcomes were not often reported.

In re-examination by counsel for the plaintiff, Dr. McKenna agreed that the instant case was not merely a rare case but an absolutely extraordinary one. Asked if he could conceive of any circumstances, having regard to the evidence given, where it would be justifiable on any medical basis to continue the somatic support being rendered, Dr. McKenna replied that on the basis of the evidence he had heard in Court, any continuance of the treatment would "be going from the extraordinary to the grotesque".

In reply to the Court, Dr. McKenna further confirmed that to the extent that a mother is suffering from various problems during a pregnancy, the baby also suffers and will react with distress to adverse developments and will not be unaware or unaffected by them.

Dr. David Mortell is the obstetrician who dealt with N.P. and her unborn child. While he had provided a report, it was simply intended to address what he was doing at any particular moment in time and what might happen perhaps in the future. Having heard the evidence of Dr. Colreavy, he was now aware of the "dreadful state that the patient is in". The mother's temperature is going up, there is infection and her blood pressure is difficult to control. He now had great concern about her somatic care and about her chances of survival. Since he wrote his original report there had been an ongoing evolving situation which was getting worse day by day. Asked if he believed in the light of Dr. Colreavy's evidence of deterioration in the mother's condition that somatic support remained a viable option, he replied that he did not. He honestly did not think there was any hope of the baby surviving with the "storm" that is going on around it and would give up all hope for the baby. The mother in the instant case has an open wound in her head, she has four or five tubes out of her body

and is deteriorating rapidly. He and his team would be prepared now to withdraw somatic treatment in consultation and in liaison with the family members.

He was cross-examined as to why he had changed his view as to the prospects for the unborn child from the more optimistic tone of his earlier report. He answered that the infection which has become evident over the past few days "*seems to be taking over*". He stated that if you have a dead brain that is infected it will be a constant seat of infection. He said that the brain itself is "*liquefying*" and thus pouring toxins into the blood stream. As this goes on, the deterioration of the mother's condition will undoubtedly affect the baby and he did not believe that its viability would continue. He believed that "*we have all the signs of the perfect storm and it does not seem to be improving*".

Finally, evidence was given by Dr. Stephen McNally, consultant neurosurgeon and national lead in neuro-oncology in the hospital to which N.P. had been transferred in Dublin in which he set out how on arrival she was incubated and ventilated. Her Glasgow coma score was 3/15 and her pupils were bilaterally fixed and dilated. She was taken directly to theatre from the A & E department at which time a right frontal bactiseal external ventricular drain was inserted. Intra operatively the cerebro spinal fluid was noted to be under high pressure.

On the 3rd December, 2014 a cerebral angiogram was performed which confirmed no intracranial flow to the anterior circulation and the basilar artery was narrow and displaced without any flow into the posterior cerebral arteries. These changes were consistent with brain death.

Having had to deal with the family of N.P., he found their frustrations and their humanity both touching and humbling. While he had seen some dreadful things in neurosurgery he had never seen this. It was very difficult not to be able to follow

the wishes of the family because of uncertainty as to the legal standing with regard to the unborn child. Legal advice had been sought but no opinion in writing had been received prior to the time for a transfer back to the hospital outside Dublin. He believed that, having regard to N.P.'s condition when admitted tohospital in Dublin, that she was "*probably gone*" by the time she arrived in their door.

ASSESSMENT OF THE EVIDENCE AND FINDINGS OF FACT

At the outset the Court would wish to pay tribute to the plaintiff and to the partner of N.P. for what can only be described as their immense courage and fortitude in dealing with the catastrophe which has befallen them and which has been compounded by the necessity of coming to Court to give evidence in this matter. It has been an enormous family tragedy, involving as it does a young 26 year old woman in the prime of life, who was undoubtedly looking forward to the successful outcome of her pregnancy.

This is not a case where at any time whatsoever N.P. indicated that she was desirous of obtaining an abortion. On the contrary, she had apparently posted on Facebook an image of an early scan of her baby to share her pleasure and excitement about the pregnancy with her friends. She had no reason to think her pregnancy was progressing other than completely normally. From such evidence as was available, the Court believes that N.P. would have fought long and hard to bring her unborn child to term. However, that intention, if such it was, falls well short of any expression by her that her present predicament and that of her unborn child should continue in the direction in which it is presently heading.

The entire medical evidence in this case goes one way only, and that is to establish that the prospects for a successful delivery of a live baby in this case are

virtually non-existent. The medical evidence clearly establishes that early gestation cases have a much poorer prognosis for the unborn child than those cases where brain death of the mother occurs at a later stage, usually improving after 24 weeks.

Based on the evidence it has heard, the Court feels able to make the finding of fact that N.P. suffered brain stem death on the 3rd December, 2014. This followed a fall which N.P. sustained on the 29th November, 2014 during a time when she was experiencing dizziness and severe headaches which were triggered by a cyst which had been developing in her brain for some time previously. Different views have been offered as to the precise stage of gestation of the unborn child at time of death, ranging from thirteen weeks to fifteen weeks. The Court believes, based on the evidence it has heard, that fifteeen weeks gestation is the appropriate finding in that regard.

At the outset of the hearing, counsel for the HSE supported the contention advanced by counsel for the plaintiff that the medical evidence to be called by both parties to the proceedings would indicate that there is no reasonable prospect that the unborn child will be born alive if somatic measures in relation to the mother are continued. The Court is satisfied that this contention has been borne out and substantiated by the evidence adduced by both the plaintiff and defendant. There is un-contradicted evidence from all of the medical experts that brain death at such an early stage of pregnancy precludes any realistic hope that the baby in this case might be born alive. The Court finds as a fact that there is no realistic prospect of continuing somatic support leading to the delivery of a live baby. While there have been instances where lengthy somatic treatment has led to the birth of a live baby, the evidence in this case, and, in particular, that of Dr. Colreavy, is persuasive to a conclusive degree that the ongoing somatic support for the mother is causing her body

increasingly to break down and that overwhelming infection from various sources will, as a matter of near certainty, bring the life of the unborn to an end well before any opportunity for a viable delivery of a live child could take place.

The Court emphasises that, having regard to its finding that the unborn child will not be born alive, this is not a case where the Court's view is to any degree influenced by any consideration that if the unborn child were to be born alive, it might nonetheless be impaired to a greater or lesser degree. This is not a case where the Court on the evidence is required to consider that possibility. This case turns on its own particular facts which are centred entirely on whether the unborn child can survive at all.

The Court is further satisfied on the evidence that, in addition to the ongoing trauma and suffering experienced by the family and partner of N.P. through the continuance of somatic support, such continuing support will cause distress to the unborn child in circumstances where it has no genuine prospect of being born alive. It would be a distressing exercise in futility for the unborn child. That consideration is important when it comes to considering what in this case is in the best interest of the unborn child.

LEGAL PRINCIPLES

Article 40.3 of the Constitution provides as follows:-

"*1° The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.*

2° The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.

3° The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

On behalf of the plaintiff it is submitted that Article 40.3.3 is irrelevant in the instant case in that the right to life of the unborn is not engaged in the particular circumstances of this case. Counsel argued that the objective of Article 40.3.3 was mainly - if not entirely - to copper fasten the protection provided in the statutory regime which outlaws the procuring of a miscarriage. In the instant case, there would be no deliberate interference with the unborn so as to procure a miscarriage. What had arisen in respect of this unborn is the death of its mother from brain injury – an "Act of God" which no one could have foreseen.. It was submitted that in such circumstances the right to life of the unborn is not engaged within the meaning of the Article.

A different submission is made on behalf of the Health Service Executive. It submits that Article 40.3.3 must be taken as meaning that both the born and the unborn enjoy a right to life and that the State therefore must respect the unborn's right to life and as far as practicable defend and vindicate that right. However, this obligation is not absolute. This is clear from the very wording of Article 40.3 and in particular the use of the expressions "as best it may" and "as far as practicable".

Counsel for the unborn submitted that Article 40.3.3 was engaged even though this was not a case concerned with abortion. Having regard to the wording of Article 40.3.3, this must mean that, given N.P. had died, the rights of the unborn child must take precedence over the understandable grief of the family of N.P. and her entitlement to a death with dignity. There were no "equal rights" to be placed in the balance in this case and therefore the overriding obligation was to vindicate the right

to life of the unborn as far as practicable. It was accepted, however, that in attempting to vindicate the unborn child's right to life in this case, the Court must consider what is in the best interests of the unborn.

It was urged on the court that there was a difference between the English and the Irish versions of article 40.3.3 . In English the wording is "as far as practicable" whilst the Irish is " sa mheid gur feidir e". It was argued that the Irish version means "as far as is possible" and that where there is a conflict between the two versions, the Irish version prevails, but if it is possible to reconcile the two versions this should be done. Counsel accepted that, even if this contention was correct, it could not mean that extreme or remote possibilities in medical treatment should dictate what should be done.

Counsel for N.P. argued that the court should infer what N.P.'s wishes were in relation to this pregnancy and strive to have the unborn delivered as a testament to her and as a sibling to her other children. In so far as reliance was placed by the Plaintiff on the fact that the treatment was experimental, it was pointed out that it had been accepted that it could be described as pioneering rather than experimental treatment. He submitted that while she had an interest in dying with dignity and minimal suffering, but that given what had occurred, a death without indignity was not possible and thus greater weight should be given to the continuance of the pregnancy than striving to achieve the lost opportunity of a dignified death. He also pointed out that in article 40.3.1 the obligation to respect the personal rights of the citizen is not qualified.

In reply to the argument as to the meaning of "as far as is practicable", counsel for the HSE referred to the judgment of Finlay C.J. in *The Attorney General v. X* [1992] 1 IR 1 as follows:-

> *"Furthermore,the duty which is imposed upon the State under the terms of Article 40.3.3 of the Costitution which is being discharged by the courts in granting injunctions in the context with which I am now concerned, is a duty to vindicate and defend the right of the unborn to life "as far as is practicable". This duty, with that qualification, must it seems to me necessarily apply in any event to the discretions vested in the Court the principle that it cannot and should not make orders which are futile, impractical or ineffective"*

It was argued that the Supreme Court had construed the phrase to mean not futile, impractical or ineffective. In reply on behalf of the Plaintiff, the court was referred to the case relied upon by counsel for N.P., *O'Donovan v The Attorney General* [1961 IR 114 at page 130 of the judgment of Budd J as follows:-

> *"I have come to the conclusion that the word,"feidir", used in one combination or another, has shades of meaning according to the combination in which it is used or the context ranging from connoting what is possible in the widest sense to what is feasible or practicable".*

It was also pointed out that same phrase in both Irish and English is used in Article 40.3.1 and that the phrase should be given the same meaning in subparagraph 3 as in subparagraph 1. Article 40.3. 1 was considered by the Supreme Court *in Re a Ward of Court (withholding medical treatment) (No.2)* [1996]2 IR 79 and it was clear that the phrase was interpreted as meaning what was practicable rather than what was possible; the ward had been fed for 23 years, it was therefore possible to continue to treat her but the court held that discontinuing this treatment was nonetheless defending her right to life as far as practicable.

This court accepts on this latter point the submissions of counsel for the Plaintiff and HSE. The phrase has been considered by the Supreme Court on two occasions and it has never been given the interpretation urged by counsel for the unborn. It should be construed in harmony with Article 40.3.1 and this accords with the decision of Finlay CJ in *Attorney General v X*

It is the view of the Court that, while the ordinary common understanding of what in context was involved in the referendum which led to the present wording of Article 40.3.3, particularly insofar as it mandates due regard to the equal right to life of the mother, was to protect the legal position created in Ireland by s. 58 of the Offences Against the Person Act 1861, the provision, in its plain and ordinary meaning may also be seen as acknowledging in simple terms the right to life of the unborn which the State, as far as practicable, shall by its laws defend and vindicate. This does not mean that the Court discounts or disregards the mother's right to retain in death her dignity with receive proper respect for her autonomy with due regard to the grief and sorrow of her loved ones and their wishes. Such an approach has been the hallmark of civilised societies from the dawn of time. It is a deeply ingrained part of our humanity and may be seen as necessary both for those who have died and also for the sake of those who remain living and who must go on. The Court therefore is unimpressed with any suggestion that considerations of the dignity of the mother are not engaged once she has passed away.

However, when the mother who dies is bearing an unborn child at the time of her death, the rights of that child, who is living, and whose interests are not necessarily inimical to those just expressed, must prevail over the feelings of grief and respect for a mother who is no longer living.

The question then becomes one of how far the Court should go in terms of trying to vindicate that right in the particular circumstances which arise here. Some very considerable guidance in that regard can be derived from some well-known wardship cases. In *In re a Ward of Court (witholding medical treatment)* (N0. 2) [1996] 2 I.R. 79, the High Court held that the right to life ranked first in the hierarchy of personal rights, though it might nevertheless be subject to certain qualifications. Thus although the State has an interest in preserving life, this interest is not absolute in the sense that life must be preserved and prolonged at all costs no matter what the circumstances. In the course of her judgment in this case in the Supreme Court Denham J. stated (at p. 58):-

> "*In respecting a person's death, we are also respecting their life – giving to it sanctity. That concept of sanctity is an inclusive view which recognises that in our society persons, whether members of a religion or not, all under the Constitution are protected by respect for human life. A view that life must be preserved at all costs does not sanctify life. A person, and/or her family, who have a view as to the intrinsic sanctity of the life in question are, in fact, encompassed in the constitutional mandate to protect life for the common good; what is being protected (and not denied or ignored or overruled) is the sanctity of the person's life. To care for the dying, to love and cherish them, and to free them from suffering rather than to simply postpone death, is to have fundamental respect for the sanctity of life and its end.*"

In *Airedale NHS Trust v. Bland* [1993] AC 789, Lord Browne Wilkinson set out the general principle in regard to withdrawing life support as follows:-

> "*In my judgment it must follow from this that if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with*

the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person."

In *Re A (A Minor)* [1993] 1 Med L Rev 98, the High Court granted a declaration that it would be lawful to disconnect from a ventilator a child who had been found to be brain dead. In this regard Johnson J. said:-

"*It would be wholly contrary to the interests of A., as they may now be, for his body to be subjected to the continuing indignity to which it was currently subject. Moreover it would be quite unfair to the nursing and medical staff of the hospital, who are finding it increasingly distressing to be caring for a dead child*."

At present the artificial measure which maintain the bodily functions of the mother in this case also maintain the unborn child. However, the question which must be addressed is whether even if such measures are continued there is a realistic prospect that the child will be born alive. In *Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications* (2001 Medico Legal Journal) the authors Asim Sheikh and Denis Cusack put the matter as follows:-

"*If maternal death occurs and all the reasonable, responsible and carefully considered evidence clearly suggests that the foetus cannot be maintained, then on the rationale of Bland and Re A there no longer exists a best interest to protect and the futile continuation of further treatment should no longer be permitted*."

To like effect are the comments of the authors of "Maternal Brain Death – An Irish Perspective" (Farragher, Marsh and Laffey – Irish Journal of Medical Science, Vol. 174 - No. 4, p. 55) where they say:-

> "*In contrast, if the available medical evidence suggested that there is no realistic prospect of delivery of a live baby then maternal somatic support would be considered futile, and not be permitted*."

They conclude:-

> "*The right to life conferred on the foetus from the earliest stages of gestation in this State may only be usefully be exercised if there exists some expectation of successful delivery of a live baby. If no realistic prospect of success exists, then maternal somatic support would be considered futile, and should not be permitted. It seems reasonable to consider prolongation of maternal somatic function to be futile if the pregnancy is of less than sixteen weeks gestation at the time of maternal brain death, given the absence of reports of successful delivery of a live foetus in these pregnancies. This might be an appropriate cut-off point in this context. However, the fact that this is an arbitrary cut-off point must be emphasised*."

In a number of cases where the High Court was exercising its wardship functions, it approached the issue of whether or not to permit withdrawal of life support by reference to the best interest of the child or ward. This is the *parens patriae* jurisdiction exercised formerly by Lord Chancellors of Ireland prior to 1922 which is now vested in the President of the High Court by virtue of the Courts (Supplemental Provisions Act) 1961. It arose in the case of S.R. (A Ward of Court) [2012] 1 I.R. 305 and this Court finds the exposition of the "best interests principle" appropriate for application in this case also in terms of what was stated (at p. 323):-

"*In determining whether life-saving treatment should be withheld, the paramount and principal consideration must be the best interests of the child. This gives rise to a balancing exercise in which account should be taken of all circumstances, including but not limited to: the pain, suffering that the child could expect if he survives; the longevity and quality of life that the child could expect if he survives; the inherent pain and suffering involved in the proposed treatment and the views of the child's parents and doctors. I agree with the views expressed by Lord Donaldson M.R. in Re J. (Wardship: Medical Treatment) [1991] Fam 33 that the proper test in such a case is to ask what the ward would choose if he were in a position to make a sound judgment. It follows that the decision maker should not impose his own views on whether the quality of life which the child would enjoy would be intolerable, but should determine the best interests of the child subjectively.*

It is accepted that, given the importance of the sanctity of human life, there exists in circumstances such as in the present case a strong presumption in favour of authorising life-saving treatment.

This presumption is not irrebuttable, and can be deviated from in exceptional circumstances. It should also be stated that the courts could never sanction positive steps to terminate life. The court will, in exceptional circumstances, authorise steps not being taken to prolong life, but could never authorise a course of action which would accelerate death or terminate life.

The medical evidence in the instant case is that intubating and ventilating SR invasively is not in his best interests. It would involve unnecessary pain and discomfort and would be futile. Ultimately it would appear that such treatment would prolong SR's suffering without any long-term benefit to him."

In those circumstances the Court acceded to the application brought by the applicant hospital to refrain from further incubating or ventilating a six year old child who had suffered catastrophic brain damage from a near drowning incident when just under two years of age.

Given that the unborn in this jurisdiction enjoys and has the constitutional guarantee of a right to life, the Court is satisfied that a necessary part of vindicating that right is to enquire as to the practicality and utility of continuing life support measures. Seen in this way, the facts of this case are even stronger than those in the *S.R* case. This unfortunate unborn has suffered the dreadful fate of being present in the womb of a mother who has died, and in which the environment is neither safe nor stable, and which is failing at an alarming rate. We accept the evidence of the medical witnesses that - from a medical viewpoint - normal bodily parameters are maintained within extraordinarily fine limits, and that in this case there is no real prospect of maintaining stability in the uterine environment, having regard to the degree of infection, the fluctuating temperatures in the body of the mother, the difficulty in maintaining a safe blood pressure and the amount of toxic medication being administered to the mother which is not licenced for pregnancy. The somatic support being provided to the mother is being maintained at hugely destructive cost to both her remains and to the feelings and sensitivities of her family and loved ones. The condition of the mother is failing at such a rate and to such a degree that it will not be possible for the pregnancy to progress much further or to a point where any form of live birth will be possible. As Dr. Mortell put it, while the unborn child is not yet in distress, it is facing into a "perfect storm" from which it has no realistic prospect of emerging alive. It has nothing but distress and death in prospect.

To maintain and continue the present somatic support for the mother would deprive her of dignity in death and subject her father, her partner and her young children to unimaginable distress in a futile exercise which commenced only because of fears held by treating medical specialists of potential legal consequences. Highly experienced medical practitioners with the best interests of both mother and unborn child in mind do not believe there is any medical or ethically based reason for continuing with a process which Dr McKenna described as verging on the grotesque on the particular facts in this case.

The Court is therefore satisfied, in the circumstances of this case, that, in the best interest of the unborn child, it should authorise at the discretion of the medical team the withdrawal of ongoing somatic support being provided for N.P. in this tragic and unfortunate case. It will accordingly make a declaration and order to that effect.

This case raised issues of great public importance. The Court will therefore grant to the plaintiff the costs of the proceedings and will also make similar orders for the costs of the representatives of both N.P. and of the unborn child.