Neutral Citation Number: [2025] EWHC 3140 (Fam)

Case No: FD25P00732

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/11/2025

**Before** :

**THE HONOURABLE MR JUSTICE HAYDEN**

- - - - - - - - - - - - - - - - - - - - -

**Between :**

**Barts Health NHS Trust**

**Applicant**

**- and -**

**(1) MC**
**(2) ML**

**Respondents**

- - - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - - -

**Claire Watson KC** (instructed by **Bevan Brittan LLP**) for the **Applicant**
**David Lawson** (instructed by **Irwin Mitchell LLP**) for the **First and Second Respondents**

Hearing date: 26th November 2025

- - - - - - - - - - - - - - - - - - - - -

# Approved Judgment

This judgment was handed down remotely at 2pm on 27th November 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

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. This is a deeply tragic case concerning LS, a twelve-year-old girl, who suffered an irreversible hypoxic ischaemic brain injury in consequence of asphyxiation. On 29th October 2025, LS had spent the early part of the day at the park with her family and friends, returning home at around 3pm. It was half term and from the accounts I have read, this was a pleasant and entirely unremarkable day.

2. Back at home and just before 5pm, LS's mother (MC) called her to come downstairs for prayers. Despite calling several times, there was no reply. At approximately 5.15pm, LS was found by MC, with her feet beneath her on the ground, her scarf attached to the banister at the bottom of the staircase. Her mother removed the scarf and immediately began CPR. In the meantime, LS's older brother called 999, before also assisting with resuscitation. A neighbour who is a doctor was also contacted and came to assist. The paramedics arrived in 10 minutes, but, despite extensive resuscitation, there was no return of spontaneous circulation for approximately 56 minutes.

3. LS was transported, initially, to Newham Hospital where a CT scan of her brain and a CT angiogram were performed. Sadly, but predictably, this showed severe hypoxic ischaemic brain injury with significant swelling of the brain and early signs of 'coning', the technical term to describe how the build-up of intracranial pressure in the skull results in the brain being pushed through the bottom of the skull into the spinal column. LS was stabilised and transferred to the Paediatric Critical Care Unit (PCCU) at Hospital A, where she continues to receive intensive care support, including invasive ventilation via an endotracheal tube.

4. On her admission to Hospital A, LS was *"neuroprotected"* for 72 hours, to prevent secondary brain injury. She was reviewed by the neurosurgeons at Hospital A and the Paediatric Neurosurgeons at Great Ormond Street Hospital. Both neurosurgical teams concluded that LS had suffered a profound brain injury for which surgery was not an option. On clinical examination, LS's pupils remained fixed and dilated, she displayed no cough or gag reflex, and there were no signs of spontaneous breathing. An aEEG (amplitude integrated Electroencephalogram) was performed on 30th October 2025, which revealed an absence of any electrical activity. An EEG performed on 31st October 2025 was reported to be featureless and *"does not show any discernible cortical rhythm consistent with diffuse cerebral dysfunction as seen in HIE"*.

5. In the light of LS's flat clinical presentation, the clinical team considered that brain stem testing was indicated to determine whether LS had died. This, I am satisfied, was explained to LS's parents both by Dr. H, Paediatric Intensive Care Consultant, and Dr. G, Adult Intensive Care Consultant, on 30th October 2025. The plan was to perform the tests on Monday, 3rd November 2025. To ensure that the brain stem testing could be optimally performed, this was delayed to 4th November 2025 to enable LS to recover sufficiently from a chest infection she had developed following her admission to Hospital A.

6. In *Guy's and St Thomas' NHS Foundation Trust v A & Ors* [2022] EWHC 2250 (Fam), I encountered circumstances which raised real and important questions concerning the conditions necessary for the confirmation of death, most particularly in the context of babies under six months of age and those with open fontanelles. The Trust applied to the High Court for a declaration that A, who was two months of age, was dead. They

also sought authorisation to withdraw his ventilation, ancillary care, and treatment. He had sustained a profound hypoxic ischaemic brain injury after a cardiac arrest that happened shortly after he was found limp in his cot with abnormal breathing. Brain stem tests had been conducted on four different dates, the last of which been performed by two doctors from a different Trust. Without exception, every test confirmed brain stem death. Over a week later, an experienced nurse on night duty discovered that the baby was beginning to breathe spontaneously.

7. I was told in that case that the Code of Practice for the diagnosis and confirmation of death was being considered and reviewed at a national and an international level. This has now resulted in the Code of Practice 2025, which has been rigorously complied with in this case. The first set of clinical tests were carried out by Dr. D, Locum Consultant in Paediatric Intensive Care and Dr. E, Paediatric Specialty Registrar (ST6), and the second set of tests were performed by Dr. D and Dr. F, Clinical Fellow in Paediatric Intensive Care, with Dr. B, Consultant in Paediatric Intensive Care observing the testing and updating the assessment documentation. Both sets of clinical tests confirmed the absence of brain stem function and death by neurological criteria was diagnosed and confirmed at 4.45pm on 4th November 2025. LS's parents were informed of the outcome of the tests and were informed of the conclusions.

8. The parents believe that they were not informed of the significance of the conclusions and dispute that they were told that intensive care support would be withdrawn the following day. I think the parents' recollection is obfuscated by the visceral intensity of their grief. They also interpret their Islamic faith as prescribing that if the heart continues to beat, the soul remains attached to the body, and accordingly, the person is

alive. Even though LS's heartbeat is preserved mechanically and could never be restored physically, the parents believe that their daughter is still alive. They would want her to be so. I respect their views and appreciate that they exist as part of the broad spectrum of Islamic belief as well as in the Judeo-Christian tradition.

9. The Trust, in my judgement, also understood and respected the family's views. It is an important feature of the history of this case, that they offered to arrange for a second team, independently, to repeat the clinical tests. MC declined the offer, reasoning that it was not the results or outcomes of the testing that they were disputing, but their interpretation as indicative of the cessation of all life. The opposition was theological, not medical.

10. This is a rehearing, ordered by the Court of Appeal on 23rd November 2025. That Court having concluded that LS's parents had not, at an earlier hearing, been afforded sufficient opportunity to engage meaningfully in the proceedings. The Court considered that they did not have time, properly to reflect on the application before the hearing commenced, and that they could not have been expected to respond, substantively, to a flurry of evidence arriving late in the day. The appeal was allowed on the basis that the earlier hearing had not been procedurally fair and required the setting aside of the Court's Declaration.

11. In this rehearing, the parents have broadened the ambit of their opposition to request a second opinion. They have also, diffidently, requested additional imaging of LS's brain to be undertaken, either a further CT scan or functional MRI scanning. In fact, functional MRI scanning is not available at this hospital.

**The Medical Evidence**

12. The 2025 Code of Practice is accompanied by a Lay Summary, prepared by the Academy of Medical Royal Colleges. This summary is, to my mind, an accessible document expressed in plain and sensitive language which does not compromise its intellectual rigour. It strikes me that, if it is not already the practice, parents or family members in these and similarly challenging circumstances should be made aware of it and directed to it by a member of the clinical team (https://www.aomrc.org.uk/wp-content/uploads/2025/01/Lay_summary_Code_of_Practice_diagnosis_death_010125.pdf). It is perhaps the ubiquitous experience of lay people meeting with doctors that the questions they most want to ask occur to them only after the meetings have concluded when they have had a chance to absorb what they have been told. This lay summary of the Code of Practice anticipates many of the questions likely to be asked.

13. The current version of the Code of Practice was updated by the Academy of Medical Royal Colleges in 2025 and states that:

> *"The purpose of the Code is to provide authoritative diagnostic criteria for any individual confirming death in the UK or the clinical foundation for writing profession-specific guidance. This will ensure that all deaths are diagnosed and confirmed in an accurate, standardised and timely manner."*

14. The definition of death is set out in Section 2 of the 2025 Code of Practice, which states:

> *"2.1 While biologically death is a process, it is necessary to define a point in the process where death can be diagnosed and confirmed in an accurate, standardised and timely manner.*
> *2.2 Death entails the loss of those essential characteristics which are necessary to the existence of a living human person. The definition of death should therefore be regarded as the*

> *permanent loss of the capacity for consciousness combined with permanent loss of the capacity to breathe.*
> *2.3 The permanent cessation of brainstem function, whether as a consequence of cardiorespiratory arrest or devastating brain injury, will produce the permanent loss of the capacities for consciousness and for breathing and thus the clinical state of death. Therefore, a diagnosis of permanent cessation of brainstem function means the person has died and allows a competent individual to confirm the person's death."*

15. In Section 3 (2025 Code of Practice), neurological criteria are deployed to diagnose and to confirm death, *"...following devastating brain injury in patients on an intensive care unit who remain deeply comatose, have absent brainstem reflexes and are apnoeic with their lungs being mechanically ventilated, but in whom circulation and other bodily functions persist."*

16. Section 6 of the Code of Practice sets out the criteria to be applied and the process to be followed for the diagnosis and confirmation of death by neurological criteria. At paragraph 6.3:

> *"When correctly applied, neurological criteria unequivocally diagnose death, confirming the permanent loss of the capacity for consciousness combined with permanent loss of the capacity to breathe [2.2]. Certainty that the cessation of brainstem function is permanent [2.4] is assured by satisfying the criteria below."*

17. The Trust followed the 2025 Code of Practice in assessing whether brain stem death had occurred. Dr. D, a Locum Consultant in Paediatric intensive Care, was one of the doctors who performed the tests, and Dr. B, observed the tests being performed. This is in

compliance with the Code. Dr. D attended at Court to give evidence but was ultimately not required. Nonetheless, he remained to hear the whole of the evidence. The following paragraphs of Dr. D's statement, as summarised in the Applicant's position statement, require to be highlighted:

> *"(i) In accordance with paragraph 6.6 of the 2025 Code of Practice and Table A2 in Appendix 2, the diagnosis of death using neurological criteria was made by at least two doctors who have full registration with the GMC (or equivalent international professional body recognised by the GMC) for five years and at least one of the doctors was a consultant:*
>
> *(a) Dr. [D] is a Locum Consultant Paediatric Intensivist who performed the first set of tests with Dr. [E], Paediatric Specialist Registrar (ST6), both of whom have been registered with the GMC for over 5 years.*
>
> *(b) The second set of tests were performed by Dr. [D] and Dr [F], Clinical Fellow in Paediatric Intensive Care, who has been registered with the Brazilian Federal Council of Medicine (CFM) from December 2017 and the GMC from April 2024. It is acceptable for one or both doctors to be substituted in the second set of clinical tests (see paragraph 6.8 of the 2025 Code of Practice).*
>
> *(ii) All three doctors were competent to diagnose and confirm death using neurological criteria in the UK in accordance with paragraphs 3.8 and 3.9 of the 2025 Code of Practice. The 2025 Code of Practice does not require the doctors to be on the specialist register or to have specific training in brain stem death diagnosis.*

> *(iii) As required by paragraph 6.6 of the 2025 Code of Practice and Table A2 in Appendix 2, none of the doctors diagnosing and confirming death were acting on behalf of the organ retrieval and transplant service at that time and were not involved in the allocation of any of the patient's organs or tissues that may subsequently be donated for transplantation. The Specialist Nurse for Organ Donation was present to observe and to be immediately available to offer support to [LS]'s family when communicating the outcome of the testing; however, she did not carry out any of the testing nor did the observing doctor, Dr. [B].*
>
> *(iv) The preconditions set out in paragraphs 6.13 to 6.37 and Table A3 in Appendix 2 were all fulfilled.*
>
> *(v) Once satisfied that the preconditions had been met, clinical testing of brain stem reflexes was carried out in accordance with paragraphs 6.42 to 6.50 of the 2025 Code of Practice.*
>
> *(vi) Death was confirmed using neurological criteria at 4.45pm on 4th November 2025, which was the time of completion of the second set of clinical tests (paragraphs 6.51 and 6.52 of the 2025 Code of Practice)."*

18. I heard evidence from Dr. B, a Paediatric Care Consultant and the Clinical Director for Specialist Paediatrics at the Trust. Dr. B is also a Paediatric Clinical Lead for Organ Donation (PCLOD). In that role, she provides senior clinical oversight, governance and training in safe and lawful organ donation processes, particularly in relation to paediatric brain stem testing. In her evidence, Dr. B explained to me how brain stem testing is a *"highly regulated"* medical procedure utilised solely to determine death. The PCLOD ensures that clinicians undertaking brain stem testing are correctly trained, competent and

compliant with national standards, including the Academy of Medical Royal Colleges', A Code of Practice for the Diagnosis and Confirmation of Death 2025 Update. Dr. B's role requires her to ensure that brain stem testing remains entirely distinct and separate from any consideration of donation as a safety precaution to dispel any perception of undue influence.

19. Despite her experience and the fact that Hospital A is a major trauma centre in London, performing these tests is, Dr. B tells me, rare. By way of illustration, she has carried out the tests approximately once a year in her career as a consultant. Brain stem testing had initially been arranged to take place on 3rd November 2025. However, as LS developed a chest infection post admission, this was delayed until 4th November 2025, when her clinical examination and oxygen requirements indicated that her chest had improved sufficiently to reliably complete the testing. Prior to the testing Dr. B met with LS's parents. I am satisfied that Dr. B told the parents the reality of LS's situation, namely that she had a devastating brain injury. It was explained to them that the clinicians were not seeing any responses either to cares or suctioning. There was no attempt at spontaneous breathing. Dr. B, whose evidence I accept on this point, tells me that she asked the parents if they understood what brain testing was. Both replied that Dr. A had explained this fully to them in the meeting the day before. MC has some medical training, albeit many years ago, and in evidence, I was entirely satisfied that she understood what the brain stem testing involved. Dr. B also explained the preconditions required, some of which I have indicated above, but which also include consideration as to the mechanism of injury, scans and other factors, e.g. the presence of sodium levels in the blood.

20. Dr. B was very clear that should there be no response to the test, the diagnosis of death would be made and the time of completion of the second test would be recorded as LS's time of death. It was put to Dr. B that she did not tell the parents that would also necessitate withdrawal of life support. Dr. B was prepared, as I understood her evidence, to accept that she may not have done this, perhaps assuming that was already understood. In any event, I am entirely satisfied that MC was shocked when confronted by the reality of what was required. As I have said, the circumstances were tragic.

21. A question has arisen as to whether LS's C-Reactive Protein (CRP) markers were high at the time of the brain stem testing, and whether this would have impacted upon the outcome. Dr. B responded thus:

> *"The rise in CRP denotes inflammation. It is a non-specific marker that rises with infection and other inflammation. As set out above the testing was delayed by 24 hrs to treat a chest infection. The day the brain stem testing was carried out [LS] had been stable overnight and remained stable throughout testing. A chest infection can affect testing if the patient is too unstable for the apnoea test, however, this was not the case with [LS]. Prior to the testing being undertaken, [LS] had undergone a chest physiotherapy session to ensure that her secretions were cleared. This is to ensure that, during the apnoea part of the test, [LS] would be optimised physically for being taken off the ventilator and a potential period of apnoea. This was particularly important in [LS]'s case as there had been concerns about [LS]'s chest the day before and she was being treated proactively in case of any potential infection. Physiologically, [LS] was saturating well and there were no concerns which would mean that brain stem testing should have been further delayed."*

22. The clinical tests confirmed that LS's brain had died and that her legal time of death was 4.45pm on 4th November 2025. MC was unable to accept it. The Lay Summary contains the following explanation:

> *"Neurological criteria are only ever used when the treating doctors suspect that the person has died. The person will have suffered a devastating brain injury from which they won't recover. The injury is usually caused by head trauma, bleeding, or loss of blood flow to the brain, which deprives the brain of the oxygen and nutrients it needs to keep functioning. The injury will be so serious that they will be in an intensive care unit. They will need mechanical ventilation and other intensive care interventions just to keep their heart beating and oxygen going to their body. If the brain injury worsens, which can happen when the brain continues to be deprived of oxygen and nutrients, this can lead to permanent damage to essential areas of the brain. The most important of these areas is the lower part of the brain, called the brainstem. If the brainstem become so damaged that it permanently ceases to function, even though heartbeat, circulation and other organ functions can be artificially maintained, the person will have died. The person can never again wake up, have any form of awareness or consciousness associated with human life or have any ability to feel. Nor will they ever be able to breathe again."*

23. I have quoted it here because it expresses some quite complex concepts in easily comprehensible terms. I am satisfied that it mirrors what Dr. B told the parents following the test. MC, in particular, immediately made it clear that she would not consent to the intensive care support being withdrawn. She also later declined an opportunity for the test to be repeated by individuals not connected with Hospital A. MC struggled to explain, in

the witness box, why she had taken this view. Ultimately, she told me that she did not believe in the test.

24. Following the handing-down of the Court of Appeal decision, the case was listed before me for Directions on 21st November 2025. On the parents' application, I endorsed the instruction of a further expert to comment on the following:

> *"1. The validity of brain stem testing which has already taken place. and in particular whether the requirements in paediatric cases were satisfied that two clinicians be nominated to review the evidence of brain death prior to testing, that these same clinicians satisfied the requirements for expertise laid out by the Code.*
>
> *2. The potential for recovery if ventilation was to continue for a further 2-3 weeks (or longer period).*
>
> *3. The likelihood that the administration of steroids to [LS] could have impacted on the result of the brain stem tests.*
>
> *4. Whether [LS]'s CRP markers are likely to have impacted on the results of the brain stem testing.*
>
> *5. Provide an explanation for the movements [LS] has been making, i.e. What is the reason for the movements, and are they inconsistent with the death by the neurological criteria? Why are the movements happening now, but were not happening prior to the brain stem tests? [ML] and [MC] have videos of this movement, which you may find helpful to view.*
>
> *6. Provide an explanation for the activity [ML] and [MC] observed on the scans, as outlined above, and the possibility that this was evidence of brain stem activity.*
>
> *7. Whether there has been any improvement in [LS]'s condition and whether there has been increasing somatic homeostatic stability, including the ability to thermoregulate. If so, does this show that the brain stem is functioning at least in part?"*

25. The instructed expert was Dr. Simon Nadel, a Consultant in Paediatric Intensive Care and Visiting Professor in Paediatric Intensive Care Medicine at St. Mary's Hospital, London and Imperial College London. He arrived at the clear opinion that the brain stem testing carried out on 4th November 2025 was valid and demonstrated lack of brain stem reflexes, confirming brain stem death. Dr. Nadel had also been asked to consider movements in LS's fingers and limbs, observed by both the family and the treating clinicians. Dr. Nadel agreed with the view articulated by Dr. C, Consultant in Paediatric Neurology at the treating hospital, that the observed movements are non-purposeful, or *"reflexive"*, as they have been called, and likely to be neuromuscular in origin. In his report dated 25th November 2025, Dr. Nadel stated the following, *"a further full clinical evaluation of brain stem function may prove beneficial to reassure [LS]'s parents"*. He also went on to say that *"if there continues to be doubt, I suggest to repeat the CT brain angiogram or carry out an MRI / MRA of the brain"*. It is necessary to state that extensive efforts have been made, with no fruition, to reassure LS's parents. Ultimately, for reasons that I will turn to below, their objection is predicated on their religious beliefs, which in MC's case, are uncompromising. I hope she will not take that phrase as a criticism, in her evidence she expressed her faith as requiring strict compliance.

26. The medical opinion as to brain stem death is, therefore, unanimous. Dr. Nadel was clear that the further clinical evaluation he discussed was not necessary to diagnose brain stem death but only required for the purpose of providing some reassurance for the parents. LS died on 4th November 2025. It is now 27th November 2025, she has been dead for over three weeks. In that period, her organs have been artificially maintained by invasive intubation, ventilation and other medications. There cannot be further protraction of this parlous situation. To do so would be to fail to respect the young girl LS was. A girl whom,

her mother told me, *"brought energy in to the room"*. It also fails to recognise the continuing distress this has caused, in particular, to the nursing team.

27. Mr Lawson, on behalf of the parents, has invited me to encourage Hospital A to repeat the CT brain angiogram. I do not take up that invitation. I have concluded that LS died. I am, therefore, not exercising a *"best interests"* jurisdiction. Nonetheless, as Dr. B emphasised, *"this is about dignity"*. Undertaking a CT angiogram where the 'patient' is intubated and ventilated is, for obvious reasons, not a straightforward matter. Though there are not the same attendant risks here, given that brain stem death has occurred, it is inconceivable, to my mind, that an angiogram could be undertaken, the sole purpose of which would be to reassure the parents. That would compromise LS's dignity in death. In any event, having heard MC in evidence, I do not consider the scan would reassure her at all. Moreover, it is, again, inconceivable that the treating clinicians should be required to undertake a process which both they and I would regard as unethical.

28. The parents explained their perspective in their statement in these terms:

> *"From our Islamic faith, even if someone is declared clinically dead, we believe that as long as the heart continues to beat, the soul remains attached to the body. In Islam, the soul is understood to be connected to the heart, not the brain, and therefore the heart and mind are regarded as separate matters. Accordingly, because [LS]'s heart was still beating, we firmly believed that her soul was still present and that she remained alive."*

29. In the witness box, MC reiterated this position. She also told me that she converted to Islam as a young woman. She had been brought up as a Protestant but told me that she had been very close to her Catholic grandmother, whose religion appears to have been a

stronger influence upon her. MC told me that when she was younger, she considered other religions. She investigated Judaism, but felt it to be inaccessible to her, given the importance of the maternal line to Jewish identity. She also considered Buddhism, but that did not attract her. She discovered Islam, through colleagues at work, and told me of a point in her life when she was extremely low and how she was *"rescued"* by the Muslim faith. It was an experience that she described in transcendent, numinous and revelatory terms. Though she had been very controlled and measured in her evidence, it was only at this point that she became emotional and tearful. Her faith is manifestly important to her. She has studied the Quran and endeavoured to learn Arabic. She told me how important it was to her and to LS to have time to pray together. Her understanding of the medical evidence collides with the stronger pull of her faith.

30. MC told me that she had made enquiries with a hospital in another European country which might be able to accept and treat LS. She believed that their criteria for brain stem death were different from those in the UK. Ultimately, MC recognised that she had not been able to structure this into a choate plan to be considered by the Court.

**The law**

31. As I have discussed above, death is a process, culminating in a diagnosis, thus, there is no statutory definition. The House of Lords in *Airedale NHS Trust v Bland* [1993] 1 AC 789 accepted the concept of brainstem death as legal death:

> *"In the eyes of the medical world and of the law a person is not clinically dead so long as the brain stem retains function."* (per Lord Keith at para. 856C)

32. Lord Goff expanded the point, at para. 863F-G:

> *"…as a result of developments in modern medical technology, doctors no longer associate death exclusively with breathing and heartbeat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem, has been destroyed…"*

33. The legal position was confirmed by the Court of Appeal in *Re M (Declaration of Death of Child)* [2020] EWCA Civ 164 at para. 91:

> *"Firstly, as a matter of law, it is the case that brain stem death is established as the legal criteria in the United Kingdom by the House of Lords's decision in Bland. It is not, therefore, open to this court to contemplate a different test."* (per Sir Andrew McFarlane (P))

34. The President also emphasised, at para. 96, that once brain stem death has been diagnosed, the issue of best interests does not arise:

> *"Once a court is satisfied on the balance of probabilities that on the proper application of the 2008 Code (and where appropriate the 2015 Guidance), there has been brain stem death, there is no basis for a best interests analysis, nor is one appropriate. The court is not saying that it is in the best interest for the child to die but, rather that the child is already dead. The appropriate declaration is that the patient died at a particular time and on a particular date, without more."*

35. From the early stage of her admission to hospital, LS has shown no responses. The brain stem death tests have been thoroughly conducted and rigorously reviewed. I am left with no doubt, on this compelling evidence, that LS died on 4th November 2025 at 4.45pm and make Declarations to that effect.

36. As a postscript, I would wish the clinical team and the nurses to know that I am very much aware of the reality of what has been asked of them since 4th November 2025. I have been told and understand how ethically challenging this period has been. It is also clear to me, having listened to Dr. B, that they have provided sensitive, gentle care and with real compassion. They have maintained LS's dignity, in death, in circumstances where it could easily have been lost. This requires to be recognised as a very considerable professional achievement.