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Case No: COP 20036874

IN THE COURT OF PROTECTION

SITTING AT THE ROYAL COURTS OF JUSTICE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/07/2026

IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF MB

Before :

THE HONOURABLE MR JUSTICE CUSWORTH

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Between :

A HOSPITAL TRUST	**Applicant**
- and -	
(1) MB	**Respondents**
(BY HIS LITIGATION FRIEND, THE OFFICIAL SOLICITOR)	
and	
(2) EB	
and	
(3) ER	

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Mr Rylatt (instructed by Ward Hadaway LLP) for the **Applicant**
Mr Mathieson (instructed by **the Official Solicitor**) for the **Respondent**

Hearing dates: 16 July 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 17/07/2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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This judgment was delivered in public but a reporting restrictions order OR transparency order is in force. 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 OR the parties] must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Cusworth J:

1. This is a desperately sad situation. On 17 June 2026, whilst commemorating the 20th anniversary of his father's death with his mother and aunt, MB suffered a heart attack at a local Hotel. He is 53 years old. His heart stopped for 20-25 minutes before there was a return of spontaneous circulation. Since then, he has been receiving treatment and care in the ICU at the A Hospital. Every day during the four weeks that have passed since, his mother, EB, and his aunt, ER, have been by his bedside at the hospital.

2. I have before me an application by A Hospital NHS Trust ('the Trust'), represented by Mr Rylatt, seeking a declaration that it is lawful for the Trust to withdraw MB's mechanical ventilatory support. The respondents are MB himself, through his litigation friend the Official Solicitor, and EB and ER, who attended the hearing remotely from the hospital. Neither of these two, who have been joined to the proceedings as the second and third respondents respectively, have chosen to be represented at this hearing. They have taken that decision although they have been invited to be so by the Trust, and by the Official Solicitor, and by me at the beginning of the hearing which had been listed before me for one day on 16 July 2026.

3. I have heard evidence from two clinicians, Dr S, a consultant in critical care medicine, and Dr L, a consultant neurologist, who gave evidence together and were cross-examined effectively about their written evidence by Mr Mathieson, who has appeared for the Official Solicitor. In addition to their statements, I have seen letters from Dr H, consultant in palliative medicine, Professor M, professor of intensive care medicine, and Dr B, ICU consultant. I am handing down this judgment on the morning of 17 July.

4. **The second and third respondents, EB & ER**. Whilst I have not heard evidence from them today, ER has read to me two sets of written submissions, one from each of her and EB, which are eloquent and considered. Both are committed to the Catholic faith. They were clear that: '*it is not for us but for God to decide when life ends.*' They considered the sanctity of life to be of the utmost importance. They explained to me, clearly and with heartfelt passion, the important role that MB had played in both of their lives as son and nephew. I acknowledge fully the very strong feeling they have towards him of love and fealty. ER described the sort of conversations that she and MB used to

have touching on matters of history or world affairs. I am very clear how close knit this family has been, and how what has happened will have had a terrible impact on them. They told me that they were sure that if he could express a view, MB would have wanted to remain alive for as long as possible. They told me that they would provide for his care, and that they were sure that, if the situations had been reversed, MB would have cared for either or both of them in a similar situation.

5. I was very impressed by the passion and fervour with which they communicated their feelings to me, both about how they felt, and about what they thought that MB would have wanted. They have been given the opportunity to consider the position with a Catholic Priest by the Trust. As Dr S explained: '*They are a devout Catholic family and believe in miracles. They believe sufficient time has not been allowed for a miracle to happen. We have arranged for a Catholic Priest to attend, who has spent many hours with [the second and third respondents] The Catholic Priest explained that the Catholic Church would support our medical opinion and decisions, however [the second and third respondents] disagree with his viewpoint. The Priest explained that time has been allowed for a miracle and that removing the ventilatory support would still allow the opportunity for a miracle*.' ER asked the doctors whether there was any prospect that, if some more time were given, there may be some development in medical science which might lead to a better outcome for MB within a timescale that might benefit him – but sadly there was not.

6. In his letter Professor M recounted a conversation he had with EB and ER, on 1 July 2026, as follows:

> I only briefly summarised the key events during [MB]'s time on ICU. However, I spent some time outlining the key prognostic investigations again, namely the MRI scan, NSE results and EEG results. Most importantly though, I described to them my neurological examination findings, which were consistent with examinations performed during each day of [MB]'s ICU stay. I stressed to them that at the centre of all the investigations was [MB], and that [MB] had not responded to any stimulus since arriving on the ICU. I told them that when all of this is put together, it indicates a catastrophic and irreversible brain injury. I explained that [MB]'s brain injury was very much at the severest end of the spectrum of what we see on ICU. I said that in my opinion this is not the sort of injury that will recover in time and the neurological state [MB] is in today is likely to represent the best he will ever be. I explained to them that this meant [MB] would not wake up, and not be able to interact or communicate ever again.

Whilst upsetting for [MB]'s family and friend, they did understand this and said it was consistent with everything they had been told by the local team. [EB] said, 'all we can hope for now is a miracle isn't it.' I agreed but told her a miracle was highly unlikely to occur.

I then explained that in a case like [MB]'s, we have to put the patient at the centre of our decision making and determine what actions are in their best interest. Weighing up the burdens and benefits the interventions and treatments against the most likely clinical outcome for the patient. I told them that in [MB]'s case, with no chance of a neurological recovery to anything resembling the [MB] they knew before, continuing mechanical ventilation (an invasive but life-extending intervention) was (in my opinion) not in his best interest. They told me that this was also the view of the local team.

[EB] and [ER] were concerned because they did not want to have to decide what to do. We had a long discussion about the fact that they were not being asked to decide. I stressed that the decision was one being made by the medical team and was one I (as an independent doctor) agreed with. I told them that these decisions were always made by experienced medical teams, to insure the most appropriate decision is made, and to relieve the family of the burden of decision-making. However, [EB] and [ER] felt that even in the situation where they were being asked their opinion about the decision, the only answer they could give was to continue mechanical ventilation. They felt unable to agree to stop it and wanted that burden to be taken on by a court. That way they will have fully removed themselves from the decision-making process. They said they would respect the decision of the court and if that decision was to stop mechanical ventilation, they would support it.

7. **The medical evidence**. MB's current condition is described by Dr S in his statement as:

'(a) *Receiving mechanical ventilation. He requires this because his impaired neurological function would mean he would likely not breathe effectively. (b) With the sedation reduced, MB remains GCS 3, he previously became physiologically distressed and agitated, but now his blood pressure is controlled and only intermittently has high blood pressure and high breathing rate. (c) Medically treated myocardial infarction (heart attack), because the left anterior descending artery is not amenable to mechanical reperfusion. (d) He is fed through a nasogastric tube and is receiving low dose heparin to prevent blood clots. (e) He has required intermittent labetolol (a beta blocker which lowers heart rate and blood pressure) to manage high heart rates and high blood pressure (f) We have agreed with the family that we would not escalate MB's current care – i.e. MB will be given no further antibiotics, no increase in ventilatory support/oxygen, no administration of drugs to increase his blood pressure if he develops sepsis and a 'Do Not Attempt Resuscitation' order is in place*.'

8. In his evidence to me, Dr S set out the tests that MB had undergone since his admission to hospital. These have included 3 EEGs and an MRI scan. The first EEG took place 46 hours after the cardiac arrest and to Dr C, the consultant clinical neurophysiologist,

'*demonstrated "bilateral periodic discharges ("BIPLDS"). These are unreactive and usually associated with an acute vascular event. The unreactivity carries a poor prognosis'*. Dr L described it as demonstrating '*burst suppression'*. The third EEG carried out on 28 June was to Dr C '*flat and unresponsive. No cortical activity is observed. This is consistent with a severe, generalized, cortical insult'*. To Dr L, this EEG demonstrated '*suppression*'. The MRI scan, five days after the arrest, produced, according to one consultant radiologist '*appearances consistent with diffuse hypoxic ischaemic encephalopathy'* and to another was '*consistent with extensive cortical necrosis*' or death of the higher cortex. Dr L described the ischaemic changes as "*striking, involving practically the entire cerebral cortex, with swelling and hyperintensity on the FLAIR sequences...*' To Dr S, this is a poor prognostic marker. Finally, Neurone specific enolase ("NSE"), a protein released into the blood from damaged brain cells, from a sample taken on 18 June 2026 at 20:30, approximately 24 hours after MB's cardiac arrest was at 56µg/L, which is an acceptable level. A further sample taken on 20 June 2026 at 12:23, 68 hours after the arrest was 224µg/L, four times as high. The 68-hour sample is also described by Dr S as a poor prognostic marker. A rising NSE level is anyway considered to be a further poor marker.

9. Dr S referred to *The European Resuscitation Council and the European Society of Intensive Care Medicine* guidelines (2025) concerning post-resuscitation care, which he tells me and I accept are universally acknowledged and followed. By those guidelines, a poor neurological outcome is likely where at least two of a possible six unfavourable signs are present. Of those signs, one is Suppression or Burst-suppression on EEG after 24 hours, another is NSE higher than 60µg/L at 48 or 72 hours. A third is diffuse and extensive hypoxic-ischaemic injury on MRI after 2 days. All three were clearly observed. Further, there was also seen to be a lack of pupillary reflexes, another marker, and a fifth test (a bilaterally absent N20 SSEP wave) was not carried out as there was deemed to be no need. In other words MB has sadly been found to exhibit four and probably five of the six signs set out in the guidelines, which renders a 'poor outcome' very likely.

10. Dr S continued that '*Poor prognosis equates to CPC 3-5: severe disability, conscious but dependent upon others for daily care because of significant brain injury, persistent vegetive state (awake but no evidence of awareness) and death. Given MB has four to five poor markers, and the MRI plus EEG results are so poor, it is likely that his prognosis would be on the severe end of this spectrum, i.e. categories 4-5'*. Asked by Mr Mathieson what the prospects were of consciousness but with severe disability, both doctors were clear that, given the severity of the injuries, there was no realistic chance of MB moving to CPC 3 – the range of probable outcomes is therefore very sadly from persistent vegetive state to death.

11. Unfortunately too, both doctors shared the same view about MB's prognosis in the event that the mechanical ventilation which is currently sustaining him were to be continued, as EB and ER are asking to happen. Dr S expressed it thus in his statement: '*It is my opinion that MB has suffered an irreversible brain injury whose neurological status would not meaningfully improve if current care was continued. It is my opinion that he would develop a new complication, such as a ventilator associated pneumonia, over the coming days to weeks. Given the treatment limitations the clinical team has agreed, this would lead to an uncontrolled death from septic shock.*' The probability of such pneumonia was put by the doctors at close to 100%. Whilst those treatment limitations could presumably be reconsidered if the decision were taken to continue with ventilation, they are clearly not clinically indicated, nor might changes produce any prospect of recovery for MB.

12. The alternative Dr S described as follows: '*If MB's ventilator support were withdrawn he would continue to require higher dose sedation to prevent severe physiological distress and acute heart failure. It is my opinion that his brain would be unable to reliably generate the muscle function necessary to breathe effectively and keep his upper airway patent. Therefore, if the ventilator was withdrawn, MB would likely develop respiratory failure which would lead to him dying over hours to days. If this were to occur, palliative care would be delivered on our Critical Care unit... In addition, we would obtain support from our hospital Palliative Care team. The core*

aspect of palliative care would be administering medications to prevent distress (opiates, benzodiazepines, anti-secretion medications).'

13. This means that the tragic reality for MB and for his family, is that there is now a stark choice for his care pathway. Either the current mechanical ventilation is continued, which would not produce any appreciable prospect of a better eventual outcome, but simply lead to his life ending in 'days or weeks' as the result of septic shock caused by pneumonia, or ventilation can be withdrawn and palliative care can be delivered in the Critical Care Unit. This may lead to death in 'hours to days', but it would be a calm, predictable and managed passing, rather than a far more distressing but still imminent death.

14. It is the case that Dr L is not of the opinion that MB is currently capable of suffering pain, such is the injury suffered by his brain. Although Mr Rylatt argues that this cannot be known for certain, I must proceed on the balance of probabilities, which on the basis of the medical opinion is that MB is not currently experiencing pain. However, I do take fully into account that physical harm can be experienced from medical interventions even where a person does not experience pain. In the case of a person with no or little awareness, consideration must be given to the burden of both their condition and their treatment. In *Parfitt v Guy's and St Thomas' Children's NHS Foundation Trust and another* [2021] EWCA Civ 362, Jonathan Baker LJ held:

> "The judge was entitled to conclude [P] could experience physical harm from her condition and medical treatment notwithstanding that she has no capacity to feel pain and no conscious awareness" (para 62).

15. **The Law.** This brings me to the rest of the law that I must apply in making this decision in MB's best interests, which has not been in issue before me.

<u>Mental Capacity</u>

16. Section 1(2) of the Mental Capacity Act 2005 ("MCA 2005") provides the fundamental principle that "a person must be assumed to have capacity unless it is established that he lacks capacity". Section 2(1) MCA 2005 in turn defines a person who lacks capacity as:

> *"… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."*

17. Section 3(1) MCA 2005 provides that, for the purpose of s2(1) MCA 2005, a person is "unable to make a decision" if they are unable to:
    a. Understand the information relevant to the decision;
    b. Retain that information;
    c. Use or weigh that information as part of the process of making the decision; or
    d. Communicate the decision.

18. Whether a person lacks capacity in respect of a specific decision is determined "on the balance of probabilities" (s2(4) MCA 2005). In *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80, and then restated in *North Bristol NHS Trust v R (by her litigation friend, the Official Solicitor)* [2023] EWCOP 5, at [41], MacDonald J summarised the principles that flow from sections 1-3 MCA 2005. I adopt and follow all of those principles. In this case, however, all parties agree that MB lacks capacity according to the relevant tests.

Best Interests

19. Where a person lacks capacity to decide for themselves, any decision must be made in their best interests (s1(5) MCA 2005). In the context of decisions as to whether to withdraw life-sustaining treatment, the Supreme Court in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 (at §22) identified the ambit of the court's inquiry as follows:

> "… the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

20. The question for the court is not whether it is lawful to withdraw or withhold treatment, but whether it is lawful to give it. It is lawful to give treatment only if it is in a patient's best interests.

Presumption in favour of life-sustaining treatment

21. The starting point for analysis is a strong presumption that it is in a person's best interests to stay alive, considering their rights under Article 2 (the right to life), Article 3 (protection from inhuman or degrading treatment) and Article 8 (the right to respect for private and family life) of the European Convention on Human Rights ("EHCR"). In *W v M* [2011] EWHC 2443 (Fam), Jonathan Baker J (as he then was) expressed that this presumption can be "simply stated but [is] of the most profound importance" and "carries very great weight in any balancing exercise" (§222). Lady Black in *An NHS Trust v Y* [2018] UKSC 46 further stated that:

> "Permeating the determination of the issue that arises in this case must be a full recognition of the value of human life, and of the respect in which it must be held. No life is to be relinquished easily." (§92).

22. The strong presumption of maintaining life, however, can be displaced by evidence that it would be contrary to a person's best interests to continue receiving life-sustaining treatment. Having enunciated this point, Lady Hale in *Aintree v James* [2013] UKSC 6 continued that:

> "36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts. As Hedley J wisely put it at first instance in *Portsmouth Hospitals NHS Trust v Wyatt* [2005] 1 FLR 21, "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" (para 23). There are cases, such as *Bland*, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those who life may continue for some time."

The statutory checklist

23. Section 4 MCA 2005 sets out the 'statutory checklist' for the determination of best interests:

> *'... (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
> *(3) He must consider—*
> *(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
> *(b) if it appears likely that he will, when that is likely to be.*

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare,

(c) any donee of a lasting power of attorney granted by the person, and

(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)…"

24. The MCA 2005 Code of Practice ("the Code"), issued pursuant to s.42 MCA 2005, provides guidance in respect of best interests decision-making around life-sustaining treatment. This includes that:

"5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment."

"5.32. As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment."

> "5.33 Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide what is in the person's best interests."
>
> "5.38. In setting out the requirements for working out a person's 'best interests', section 4 of the MCA 2005 puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account – whether expressed in the past or now. But their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests…"
>
> "5.41 The person may have held strong views in the past which could have a bearing on the decision now to be made. All reasonable efforts must be made to find out whether the person has expressed views in the past that will shape the decision to be made. This could have been through verbal communication, writing, behaviour or habits, or recorded in any other way (for example, home videos or audiotapes)."

25. "Best interests" are not just medical best interests, but are widely defined. In *Aintree v James* [2014] AC 591, Lady Hale stated at §39:

> *"The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be".*

26. At §45, she added:

> *"The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. .... But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being".*

27. The quality of life should not be judged by the values of others but from the particular perspective of the patient: the judge must arrive at an objective assessment of whether

continuation of life-sustaining treatment is in this patient's best interests, seen through the "prism of the subjective position of the patient" (*Barnsley Hospital NHSFT v MSP* [2020] EWCOP 26 at [33]). It is not for others to say that a life which a patient would regard as worthwhile is not worth living (*Re J* [1991] Fam 33).

Wishes and feelings

28. The weight to be attributed to P's wishes and feelings will differ depending on such matters as how clearly the wishes and feelings are evidenced, how frequently they are (or were previously) expressed, how consistent P's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views).

29. In *Re N* [2015] EWCOP 76 Hayden J said at §28:

> *"…. where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interests'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them".*

30. Hayden J added, in *NHS South East London Integrated Care Board v JP (by his litigation friend, The Official Solicitor)* [2025] EWCOP 4 (T3):

> a. *'However cogent and compelling the medical evidence may be, it is always important to recognise that medicine evolves and develops…today's medical shibboleths may become tomorrow's heresies. It is important therefore, where necessary, even for a strong consensus of medical opinion to be put to the assay, especially where the consequences of accepting the opinion are so profound…It is judges not doctors who are charged with the responsibility of deciding cases.'* (§14)
>
> b. *'In resolving a best interests decision, the judge must always consider the broader evidential canvas and the imperative to determine, to the extent that it may be possible, what the protected party (P) would want for themselves. JP did not make any advanced decision, and so it is his family who must be the conduit by which his views are understood and articulated in the courtroom.'* (§15)

Views of Others

31. In *NHS South East London Integrated Care Board v JP and others* [2025] EWCOP 8, Hayden J found as follows:

> "18. It is important to say something of the relevance and weight to be afforded to the views of family members, when evaluating best interests. Grief, which does not await death, frequently ambushes families in these challenging circumstances. Sometimes, their own sense of loss can become the prevailing emotion. This is of course entirely normal and natural. Those charged with the task of identifying what P would likely have wanted must be alert to the reality and focus of their enquiry. The views of family members, their own wishes, feelings, religious and cultural beliefs, are, in themselves, of little, if any, relevance. I emphasise that their views are being sought solely to illuminate the likely wishes and feelings of P. Their evidence is garnered to assert P's autonomy, not to subjugate it. This case is, as my earlier judgment seeks to demonstrate, a striking example of this point. To some extent, many of the family members here identify as Pentecostalists, certainly many have strong Christian faith. Their views, however, on these difficult ethical issues vary widely. I have placed emphasis on the evidence of those family members who have eschewed their own religious and cultural views and concentrated on the views and beliefs of JP."

<u>List of Issues</u>

32. A helpful list of issues requiring determination in applications concerning the withdrawal of clinically-assisted nutrition and hydration ('CANH'), which both counsel suggest might be extended with appropriate amendments to the withdrawal of other life-sustaining treatments, were set out by Cobb J (as he then was) in *PL (by her litigation friend, SL) v Sutton CCG & Anor* [2017] EWCOP 22 at [9]. Whilst there is obviously some overlap with the statutory checklist, I will set out those issues:

    a. What is [P's] current condition? What is [P's] level of consciousness or cognisance? What is [P's] awareness of the world around them?

    b. Does [P] have the mental capacity to make a decision about the continuance of CANH? If assessed to lack capacity presently, is there a prospect that they could develop the capacity to make that decision?

    c. If they lack capacity, is it in their best interests that the court should confirm the continuing delivery of CANH? In answering this question, the court should consider:

        i. [P's] previous stated views on life-support, and on sustaining life artificially, in the event that they are totally dependent on others, and incapable of functioning in many essential domains of their life;

ii. The quality of [P's] life at present; whether there is any or any significant enjoyment in their life; whether they experience pain and/or distress, and if so how that is managed;
iii. [P's] prognosis if CANH were to continue for the foreseeable future; whether there is any real prospect of recovery of any of their functions and improvement in the quality of their life;
iv. The prognosis for [P] if CANH were to be discontinued: what would the palliative care package include, in the event that the CANH were to be discontinued, and where would her palliative treatment optimally be delivered (i.e. would P need to move from their current residential care home?);
v. The prognosis for [P] if the court were to authorise the discontinuance of nutrition but not hydration;
vi. The views, wishes and feelings of the family and [P's] carers;
vii. [P]'s dignity;
viii. The sanctity of life generally."

33. The concept of "dignity" – the penultimate factor on this list - has received mixed treatment from the courts. It is a concept which does not lend itself to precise or agreed definition and which contains a significant element of subjectivity: *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin). At §36 of *Re IN (Withdrawal of CANH)* [2023] EWCOP 32, Poole J commented on its status as a free-standing concept, with which remarks I agree:

> *'In this context I do not find it helpful to co-opt the notion of "dignity" - to suppose that the managed withdrawal of life-sustaining treatment as opposed to continuing such treatment enhances innate human dignity. He would not be in "anguish" as his daughter has said she fears. The plan for palliative care is designed to prevent that. For some, there is dignity in a managed death, for others there is dignity in fighting for life and survival. Human dignity is a very important concept in decisions about end of life care and it is recognised and respected by application of the principles in the MCA 2005 and the authorities, and by an intense focus on IN's best interests.'*

34. **This case.** First, I will consider how the factors in the checklist at s.4 MCA 2005 apply in this case. It is regrettably clear that MB will never regain capacity in this matter, and his condition is such that he will never be able to participate in the making of this decision. I make it very clear however, that the decision which I must now take is not in any way motivated by a desire to bring about his death, although the reality of his situation is that whichever decision I now take the evidence is that he is likely to be dead within weeks. Whilst I have no direct evidence of his wishes and feelings, I do

have evidence from EB and ER about his religious beliefs, including the importance to him of the sanctity of life. However, what I do not have evidence about is how he might react if he understood the unfortunate choices which the court is tasked with making on his behalf. Whether he would prefer a few additional weeks of unconscious ventilated existence, leading almost certainly to pneumonia and septic shock, or rather a death which is quicker, but also calmer and subject to significant palliative assistance.

35. I do take the views of his mother and his aunt carefully into account. I commend them for their courageous cooperation with those caring for MB despite the intense grief which they must be experiencing, especially in the circumstances of his collapse at the very point of commemoration of his own father's death 20 years earlier. ER spoke to me both on her own behalf and on behalf of EB with commendable clarity and honesty about her feelings and those of MB's mother. I agree with the Official Solicitor that the depth and sincerity of their views are very clear.

36. However, I must also take account of the Official Solicitor's views in this matter, speaking as she does on MB's behalf. Appropriately, no final view had been articulated to me by Mr Mathieson until such time as he had been able to cross-examine the doctors and rigorously test their evidence. Having done so, however, the view expressed was very clear, to the effect that it is in MB's best interests for me to grant the application made by the Trust, and that conversely it is not in his best interests for ventilation to continue. Mr Mathieson noted the clear medical evidence – that of the experienced doctors treating MB - that there is no real possibility that MB might progress to CPC 3, which is severe disability but not extending to a persistent vegetative state. Now over four weeks on from the cardiac arrest which has precipitated the damage to MB's brain, the prospects of any sort of unexpected recovery have receded. The algorithms work on the basis of recovery not probably happening after 72 hours, not 29 days, so any element of doubt has now very sadly long gone. The Official Solicitor has concluded that there is no prospect here of a stable life continuing for MB whilst waiting for some currently unanticipated medical breakthrough. Rather with continued ventilation there is only the prospect of an uncontrolled death, with any treatment in the meantime futile and carrying no prospect of recovery.

37. As I indicated above, EB and ER made clear to me that for them it is not for us but for God to decide when life ends. I must agree with the priest who pointed out to them that, if there is to be a miracle, it is just as likely to come after the ending of MB's ventilation, as whilst that process continues. Man's hand is withdrawn, and MB is then in the hands of God alone.

38. Turning to some of the factors in Cobb J's list at [9] in *PL (by her litigation friend, SL) v Sutton CCG* (above), not already considered, I have dealt with the unfortunate choices available given that a terminal diagnosis awaits for MB either way. The intense focus on his best interests however brings me to one very clear conclusion. Although I take into account as of the utmost importance in this as in every case the sanctity of life, the choice now for MB is little more than the manner of his death, the one which is uncontrolled perhaps a few more weeks later than that which would be subject to proper palliative care, but those weeks being weeks of ventilation without consciousness, and subject to the burden of treatment, if not the experience of conscious pain.

39. In those circumstances, I am very clear that MB's best interests very clearly now lie in granting the application by the Trust and in making a declaration that it is lawful for them to withdraw MB's mechanical ventilatory support. Although not its purpose, this will have the effect of making likely MB's death. The Trust should therefore take this step in consultation with EB and ER so that they can be as fully involved in the process of MB's death as they wish. They deserve a huge amount of credit for their bravery and determination, for MB's sake, in ensuring that this application has come before me. I do hope now that, once they have understood my decision, they will support it, as they have indicated to Professor M that they would, when they spoke to him on 1 July.

40. That is my judgment.