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Trinity Term
[2018] UKSC 46
On appeal from: [2017] EWHC 2866 (QB)

Judgment

An NHS Trust and others (Respondents) *v* Y (by his litigation friend, the Official Solicitor) and another (Appellants)

before

Lady Hale, President
Lord Mance
Lord Wilson
Lord Hodge
Lady Black

Judgment given on

30 July 2018

Heard on 26 and 27 February 2018

Appellant (Mr Y)
Richard Gordon QC
Fiona Paterson
(Instructed by The Official Solicitor)

First & Second Respondents (NHS Trust) & (CCG)
Vikram Sachdeva QC
Catherine Dobson
(Instructed by Hempsons Solicitors)

Third Respondent (Mrs Y)
Victoria Butler-Cole
(Instructed by Bindmans LLP)

Interveners (The Intensive Care Society & The Faculty of Intensive Care Medicine) (written submissions only)
Alexander Ruck Keene
Annabel Lee
(Instructed by Bevan Brittan LLP)

Intervener (British Medical Association) (written submissions only)
Katharine Scott
(Instructed by Capital Law Limited)

Intervener (Care Not Killing Alliance Ltd) (written submissions only)
Charles Foster
(Instructed by Barlow Robbins Solicitors (Guildford))

Lady Black: (with whom Lady Hale, Lord Mance, Lord Wilson and Lord Hodge agree)

1. The question that arises in this appeal is whether a court order must always be obtained before clinically assisted nutrition and hydration, which is keeping alive a person with a prolonged disorder of consciousness, can be withdrawn, or whether, in some circumstances, this can occur without court involvement.

Terminology

2. The term “prolonged disorder of consciousness” encompasses both a permanent vegetative state (sometimes referred to as a persistent vegetative state, and often shortened to “PVS”) and a minimally conscious state (or “MCS”). “Prolonged disorder of consciousness” is commonly shortened to “PDOC” and that practice is followed in this judgment. Clinically assisted nutrition and hydration is now referred to as “CANH”, although it has been variously described in the past.

The facts

3. Mr Y was an active man in his fifties when, in June 2017, he suffered a cardiac arrest which resulted in severe cerebral hypoxia and extensive brain damage. He never regained consciousness following the cardiac arrest. He required CANH, provided by means of a percutaneous endoscopic gastrostomy, to keep him alive. The month after his cardiac arrest, Mr Y was admitted to the regional hyper-acute rehabilitation unit under the control of the first respondent NHS Trust so that his level of awareness could be assessed. In late September, his treating physician concluded that he was suffering from PDOC and that even if he were to regain consciousness, he would have profound cognitive and physical disability, remaining dependent on others to care for him for the rest of his life. A second opinion was obtained in October, from a consultant and professor in Neurological Rehabilitation, who considered that Mr Y was in a vegetative state and that there was no prospect of improvement. Mrs Y and their children believed that he would not wish to be kept alive given the doctors’ views about his prognosis. The clinical team and the family agreed that it would be in Mr Y’s best interests for CANH to be withdrawn, which would result in his death within two to three weeks.

4. On 1 November 2017, the NHS Trust issued an application in the Queen's Bench Division of the High Court for a declaration (1) that it was not mandatory to seek the court's approval for the withdrawal of CANH from a patient with PDOC when the clinical team and the patient's family were agreed that it was not in the patient's best interests that he continue to receive that treatment, and (2) that no civil or criminal liability would result if CANH were to be withdrawn. At a directions hearing on 3 November, Fraser J invited the Official Solicitor to act as Mr Y's litigation friend in the proceedings but, rather than adjourning the case for a hearing in the Court of Protection as the Official Solicitor sought, he ordered that the final hearing be expedited and listed before O'Farrell J in the Queen's Bench Division on 10 November.

5. On 10 November, O'Farrell J [2017] EWHC 2866 (QB) refused the Official Solicitor's renewed application for the case to be transferred to the Court of Protection. She considered that it would have been appropriate to transfer the case if the court were being asked to determine whether the withdrawal of treatment was in Mr Y's best interests, but that, in fact, the issue she had to determine was a purely legal issue. She concluded that it was not established that there was any common law principle that all cases concerning the withdrawal of CANH from a person who lacks capacity had to be sanctioned by the court. In her view, at para 52, "where the clinicians have followed the Mental Capacity Act and good medical practice, there is no dispute with the family of the person who lacks capacity or others interested in his welfare, and no other doubts or concerns have been identified, there is no requirement to bring the matter before the court." Such was the situation in Mr Y's case, she considered, and accordingly she granted the following declaration:

> "It is not mandatory to bring before the court the withdrawal of CANH from Mr Y who has a prolonged disorder of consciousness in circumstances where the clinical team and Mr Y's family are agreed that it is not in his best interests that he continues to receive that treatment."

6. The judge granted the Official Solicitor permission to appeal and certified the case, pursuant to section 12 of the Administration of Justice Act 1969, as appropriate for an appeal directly to the Supreme Court.

7. In case the result of the appeal was that proceedings should be brought in the Court of Protection, the judge gave directions so that any such proceedings could progress without delay. So it was that the Official Solicitor obtained a further expert report, from a different neuro rehabilitation consultant. However,

although CANH had been continued pending the appeal, on 22 December 2017 Mr Y died, having developed acute respiratory sepsis. The expert instructed by the Official Solicitor could only base his report upon documentation, including Mr Y's medical records. In the report, he referred to the difficulty in diagnosing vegetative and minimally conscious states, and gave his opinion that, had Mr Y survived, further assessments, over a longer period of time, would have been required in order to reach a reliable conclusion that he was in a permanent vegetative state.

8. Notwithstanding that, in view of Mr Y's death, the proceedings could no longer serve any purpose for him and his family, this court determined that the appeal should go ahead, because of the general importance of the issues raised by the case. Accordingly, the court has received full argument from Mr Gordon QC and Ms Paterson for the Official Solicitor, and Mr Sachdeva QC and Ms Dobson for the first two respondents (the NHS Trust which manages the regional hyper-acute rehabilitation unit at which Mr Y was a patient until he was discharged to a nursing home and the Clinical Commissioning Group which funded the nursing home). Written submissions were permitted from the four intervenors. Mrs Y understandably felt unable to participate in the proceedings at what is an exceptionally sad and difficult time for her and her family.

The opposing arguments in brief summary

9. I will look at the Official Solicitor's case in detail later, but it may help to introduce the issues now by means of the briefest of summaries. The Official Solicitor submits that, in every case, court approval must be sought before CANH can be withdrawn from a person with PDOC, thus ensuring that the patient's vulnerable position is properly safeguarded by representation through the Official Solicitor, who can obtain independent expert medical reports about his condition and prognosis, and make submissions to the court on his behalf if appropriate. The Official Solicitor derives this requirement essentially from the common law and/or the European Convention on Human Rights (ECHR), in particular article 2 and article 6. In his submission, his position finds support in the Mental Capacity Act Code of Practice, issued on 23 April 2007 pursuant to section 42(1) of the Mental Capacity Act 2005 ("MCA 2005"). He submits that it is irrelevant that neither the MCA 2005 nor the Court of Protection Rules specifically impose the requirement for which he contends.

10. The first and second respondents disagree, submitting that neither the common law nor the ECHR imposes a universal requirement to obtain court approval prior to the withdrawal of CANH.

The case law preceding the MCA 2005

11. The MCA 2005 was a watershed in the law relating to people who lack capacity. Before the Act, questions relating to the management of the property and affairs of adults who did not have capacity to make their own decisions, were dealt with in the old style Court of Protection, and questions relating to the care and welfare of such adults were resolved under the inherent jurisdiction of the High Court. The MCA 2005 established a new regime with, amongst other things, a new Court of Protection which has jurisdiction in relation to both property matters and issues relating to personal care. Nevertheless, an examination of the common law in relation to the treatment of patients such as Mr Y must commence with the pre-MCA 2005 cases, and I turn first to two centrally important House of Lords decisions, *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 and *Airedale NHS Trust v Bland* [1993] AC 789.

12. In *In re F (Mental Patient: Sterilisation)*, the House of Lords considered whether the court had jurisdiction to grant a declaration that it would not be unlawful for a sterilisation operation to be carried out on a woman who, because of mental incapacity, was unable to consent to the operation herself. Although not concerned with precisely the sort of life and death decision that is involved in the present litigation, the decision is relevant because their Lordships were required to determine a sensitive and difficult question relating to medical treatment of a mentally incapacitated adult. They determined that the court could, under its inherent jurisdiction, make a declaration that the proposed operation was in the patient’s best interests and therefore lawful. They also held that where the procedure was intended to prevent pregnancy rather than for the purpose of treating a disease, although not necessary to establish the lawfulness of the operation, it was highly desirable, as a matter of good practice, that a declaration be obtained before the operation took place.

13. The starting point for the reasoning was the established common law position that “a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force … without their consent”, and if he were to do so, he would commit the tort of trespass to the person (p 55), but that, in the case of a patient who lacked the capacity to consent to treatment, a doctor could lawfully operate or give other treatment provided that it was in the best interests of the patient.

14. There was a range of views as to whether, with an operation such as the proposed sterilisation operation, it was desirable/necessary to obtain a declaration from the court that the procedure was in the patient’s best interests.

All were in favour of a declaration being obtained but, for the most part, put the matter on the basis of good practice, rather than finding it to be a legal requirement that such a declaration first be obtained.

15. There was fairly general agreement with the approach of Lord Brandon of Oakbrook. At p 56, he identified six special features of the particular operation which were influential in his view that, whilst the lawfulness of the treatment did not depend upon the court's approval and it was not therefore strictly necessary as a matter of law to seek it, the involvement of the court was "highly desirable as a matter of good practice". The six features were:

> "first, the operation will in most cases be irreversible; secondly, by reason of the general irreversibility of the operation, the almost certain result of it will be to deprive the woman concerned of what is widely, and as I think rightly, regarded as one of the fundamental rights of a woman, namely, the right to bear children; thirdly, the deprivation of that right gives rise to moral and emotional considerations to which many people attach great importance; fourthly, if the question whether the operation is in the best interests of the woman is left to be decided without the involvement of the court, there may be a greater risk of it being decided wrongly, or at least of it being thought to have been decided wrongly; fifthly, if there is no involvement of the court, there is a risk of the operation being carried out for improper reasons or with improper motives; and, sixthly, involvement of the court in the decision to operate, if that is the decision reached, should serve to protect the doctor or doctors who perform the operation, and any others who may be concerned in it, from subsequent adverse criticisms or claims."

16. Lord Goff of Chieveley expressed his own view (p 79) that, as a matter of practice, the operation should not be performed "without first obtaining the opinion of the court that the operation is, in the circumstances, in the best interests of the person concerned, by seeking a declaration that the operation is lawful." In his opinion, the court's "guidance should be sought in order to obtain an independent, objective and authoritative view on the lawfulness of the procedure in the particular circumstances of the relevant case, after a hearing at which it can be ensured that there is independent representation on behalf of the person upon whom it is proposed to perform the operation."

17. Lord Griffiths would have been minded to make it a legal requirement to obtain the sanction of the High Court in all cases, and considered that the common law could be adapted to introduce such a requirement. However, he recognised that he would be “making new law”, and that the other members of the House considered that it was not open to them to take that course. He therefore accepted what Lord Brandon had proposed, “but as second best” (pp 70 to 71).

18. *Airedale NHS Trust v Bland* [1993] AC 789 concerned a man who had been left in a persistent vegetative state after being injured in the Hillsborough disaster. He could see, hear, and feel nothing and could not communicate in any way. There was no prospect whatever that he would make any recovery, but if he continued to have the medical care that he was receiving, there was every likelihood that he would maintain his present state of existence for many years to come. Over three years after the accident, the family and the patient’s doctors having formed the view that, in these circumstances, it was appropriate to stop prolonging his life by artificial means, an application was made by the hospital authority for declarations that the measures keeping him alive, including artificial nutrition and hydration, could lawfully be discontinued, which would result in his death. The House of Lords held that the declarations could and should be granted, explaining why in a series of thoughtful speeches considering the moral and legal aspects of the issue.

19. It is important to set the decision in context. Recent developments in medical technology, including the development of life support systems, had made it possible for patients who would otherwise have died to survive. As Lord Browne-Wilkinson said (p 878C et seq), those recent developments had fundamentally affected previous certainties about what was life and what was death, and meant that the time and manner of someone’s death might no longer be dictated by nature but might instead be determined by a human decision. Wholly new ethical and social problems had been raised by the developments, and society was not of one mind about them. It was not a foregone conclusion that the withdrawal of artificial life support measures could be tolerated at all by the criminal and civil law, and the decision to endorse the declarations that had been granted by the President of the Family Division was only arrived at after an extensive review of the law, and then only on a narrow basis tied firmly to the facts of the case.

20. Their Lordships were at pains to emphasise that the case was an extreme one, it having been overwhelmingly established that the patient was, and would remain, insensate. They were conscious that there would be cases in which the

facts were less extreme and the issues, legal and ethical, even more difficult. They did not seek, in their decision, to provide a set of universal principles, dictating the answers in all other cases, and there was acknowledgment that some of the issues arising may more properly be for Parliament to determine. A sense of the delicacy with which the House was proceeding is conveyed by Lord Mustill's observation that "[e]very step forward requires the greatest caution" (p 899F).

21. In these circumstances, it is not at all surprising that their Lordships held that, for the time being, the guidance of the court should be sought before treatment and care of a patient were discontinued. Given the central importance that Mr Gordon attaches to what they said about this, the relevant passages will need to be cited in full in due course, but, before doing that, it is appropriate to underline the following three points of importance that are found in the speeches and have relevance not only to the decision in the *Bland* case, but also to subsequent decisions, including the present one:

> i) As has already been seen from *In re F (Mental Patient: Sterilisation)* (supra), it is unlawful to administer medical treatment to an adult who is conscious and of sound mind, without his consent; to do so is both a tort and the crime of battery. Such an adult is at liberty to decline treatment even if that will result in his death, and the same applies where a person, in anticipation of entering into a condition such as PVS, has given clear instructions that in such an event he is not to be given medical care, including artificial feeding, designed to keep him alive.
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> ii) Where a person, due to accident or some other cause, becomes unconscious and thus unable to give or withhold consent, it is lawful for doctors to give such treatment as, in their informed opinion, is in the best interests of the patient. Where it is no longer in the best interests of the patient to provide treatment, it may, and ultimately should, be discontinued (see, for example, p 867 of Lord Goff's speech, with which Lord Keith of Kinkel and Lord Lowry agreed).
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> iii) The argument that artificial feeding (in that case by nasogastric tube) was not medical treatment at all, but indistinguishable from normal feeding, was rejected. Regard had to be had to the whole regime which was keeping the patient alive, and in any event a medical technique was involved in the feeding.

22. I come now to look in more depth at what their Lordships had to say in the *Bland* case when explaining their position in relation to declaratory relief. It is useful to start with their recognition that the courts and the medical profession were working together in addressing the new situation that had arisen as a result of scientific advances. The medical profession had already been working on the issue and there was available a *Discussion Paper on Treatment of Patients in Persistent Vegetative State*, issued in September 1992 by the Medical Ethics Committee of the British Medical Association. On the basis of it, at p 870, Lord Goff paid tribute to the evident care with which the topic was being considered by the medical profession. In a passage which remains relevant today, he commented as follows on the respective roles of doctors and judges in life and death cases (p 871):

> "I also feel that those who are concerned that a matter of life and death, such as is involved in a decision to withhold life support in case of this kind, should be left to the doctors, would do well to study this paper. The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decisions to be made in individual cases must rest with the doctors themselves. In these circumstances, what is required is a sensitive understanding by both the judges and the doctors of each other's respective functions, and in particular a determination by the judges not merely to understand the problems facing the medical profession in cases of this kind, but also to regard their professional standards with respect. Mutual understanding between the doctors and the judges is the best way to ensure the evolution of a sensitive and sensible legal framework for the treatment and care of patients, with a sound ethical base, in the interest of the patients themselves. This is a topic to which I will return at the end of this opinion, when I come to consider the extent to which the view of the court should be sought, as a matter of practice, in cases such as the present."

23. At p 873, Lord Goff did return to the topic, saying:

“I turn finally to the extent to which doctors should, as a matter of practice, seek the guidance of the court, by way of an application for declaratory relief, before withholding life-prolonging treatment from a PVS patient. The President considered that the opinion of the court should be sought in all cases similar to the present. In the Court of Appeal, Sir Thomas Bingham MR expressed his agreement with Sir Stephen Brown P in the following words, ante, pp 815-816:

> ‘This was in my respectful view a wise ruling, directed to the protection of patients, the protection of doctors, the reassurance of patients’ families and the reassurance of the public. The practice proposed seems to me desirable. It may very well be that with the passage of time a body of experience and practice will build up which will obviate the need for application in every case, but for the time being I am satisfied that the practice which the President described should be followed.’

Before the Appellate Committee, this view was supported both by Mr Munby, for the Official Solicitor, and by Mr Lester, as amicus curiae. For the respondents, Mr Francis suggested that an adequate safeguard would be provided if reference to the court was required in certain specific cases, ie, (1) where there was known to be a medical disagreement as to the diagnosis or prognosis, and (2) problems had arisen with the patient’s relatives - disagreement by the next of kin with the medical recommendation; actual or apparent conflict of interest between the next of kin and the patient; dispute between members of the patient’s family; or absence of any next of kin to give their consent. There is, I consider, much to be said for the view that an application to the court will not be needed in every case, but only in particular circumstances, such as those suggested by Mr Francis. In this connection I was impressed not only by the care being taken by the Medical Ethics Committee to provide guidance to the profession, but also by information given to the Appellate Committee about the substantial number of PVS patients in the country, and the very considerable cost of obtaining guidance from the court in cases such as the present. However, in my opinion this is a matter which would

> be better kept under review by the President of the Family Division than resolved now by your Lordships' House. I understand that a similar review is being undertaken in cases concerned with the sterilisation of adult women of unsound mind, with a consequent relaxation of the practice relating to applications to the court in such cases. For my part, I would therefore leave the matter as proposed by the Master of the Rolls; but I wish to express the hope that the President of the Family Division, who will no doubt be kept well informed about developments in this field, will soon feel able to relax the present requirement so as to limit applications for declarations to those cases in which there is a special need for the procedure to be invoked."

24. Lord Keith said (p 859):

> "The decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge of his case. The question is whether any decision that it does not and that the treatment and care should therefore be discontinued should as a matter of routine be brought before the Family Division for endorsement or the reverse. The view taken by the President of the Family Division and the Court of Appeal was that it should, at least for the time being and until a body of experience and practice has been built up which might obviate the need for application in every case. As Sir Thomas Bingham MR said, this would be in the interests of the protection of patients, the protection of doctors, the reassurance of the patients' families and the reassurance of the public. I respectfully agree that these considerations render desirable the practice of application."

25. Lord Lowry said (p 875):

> "Procedurally I can see no present alternative to an application to the court such as that made in the present case. This view is reinforced for me when I reflect, against the background of your Lordships' conclusions of law, that, in the absence of an application, the doctor who proposes the cessation of life-supporting care and treatment on the ground

> that their continuance would not be in the patient's best interests will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings. A practical alternative may, however, be evolved through the practice of the Family Division and with the help of the Medical Ethics Committee, which has already devoted so much thought to the problem, and possibly of Parliament through legislation."

26. Lord Browne-Wilkinson said (p 885):

> "I am very conscious that I have reached my conclusions on narrow, legalistic, grounds which provide no satisfactory basis for the decision of cases which will arise in the future where the facts are not identical. I must again emphasise that this is an extreme case where it can be overwhelmingly proved that the patient is and will remain insensate: he neither feels pain from treatment nor will feel pain in dying and has no prospect of any medical care improving his condition. Unless, as I very much hope, Parliament reviews the law, the courts will be faced with cases where the chances of improvement are slight, or the patient has very slight sensate awareness. I express no view on what should be the answer in such circumstances: my decision does not cover such a case. I therefore consider that, for the foreseeable future, doctors would be well advised in each case to apply to the court for a declaration as to the legality of any proposed discontinuance of life support where there has been no valid consent by or on behalf of the patient to such discontinuance."

27. Lord Mustill did not say anything specifically on the topic, but he spoke of his "profound misgivings about almost every aspect of this case" (p 899), and, as the comment that I have already quoted above shows, he urged that matters should proceed with the greatest caution.

28. The practice of seeking declarations as to the lawfulness of medical treatment became firmly established in the years after *In re F* and the *Bland* case, as can be seen from the comment of Hale J, as Baroness Hale then was, in *In re*

S (Hospital Patient: Court's Jurisdiction) [1995] Fam 26, that it "has been followed in many cases" (p 31E).

29. The next case which needs to be considered is *R (Burke) v General Medical Council (Official Solicitor and others intervening)* [2006] QB 273. There, the court was called upon to determine issues in relation to a patient who was competent but suffering from a congenital degenerative brain condition. In contrast to the *Bland* case, the litigation was not brought in order to obtain the court's sanction for treatment being withdrawn, but in order to ensure that it would not be withdrawn. Nevertheless, the decision covers ground which is of relevance to the present issue.

30. The patient wished to ensure that the artificial nutrition and hydration that he would need as his degenerative condition progressed would not be withheld by the medical practitioners responsible for his care. He sought judicial review of the General Medical Council's 2002 guidance, *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making*, on the basis that it was incompatible with his rights at common law and under the ECHR in, inter alia, failing to spell out a legal requirement to obtain prior judicial sanction for the withdrawal of artificial nutrition and hydration. The Court of Appeal considered the principles applicable in such circumstances and found the guidance compatible with them. Giving the judgment of the court, the Master of the Rolls, Lord Phillips of Worth Matravers, considered whether there was in fact a legal requirement to obtain court authorisation before withdrawing artificial nutrition and hydration, as Munby J had determined that there was, in certain circumstances. The Court of Appeal did not agree that such a requirement existed. Summarising the legal position, the Master of the Rolls said (para 71):

> "We asked Mr Gordon to explain the nature of the duty to seek the authorisation of the court and he was not able to give us a coherent explanation. So far as the criminal law is concerned, the court has no power to authorise that which would otherwise be unlawful: see, for instance, the observation of Lord Lowry in *Bland's* case [1993] AC 789, 875H. Nor can the court render unlawful that which would otherwise be lawful. The same is true in relation to a possible infringement of civil law. In *Bland's* case the House of Lords recommended that, *as a matter of good practice,* reference should be made to the Family Court before withdrawing ANH from a patient in a PVS, until a body of experience and practice had built up. Plainly there will be occasions in which

> it will be advisable for a doctor to seek the court's approval before withdrawing ANH in other circumstances, but what justification is there for postulating that he will be under a legal duty so to do?" [Original emphasis]

31. Having considered, but rejected, the possibility that the Human Rights Act 1998 and the decision of the European Court of Human Rights ("the ECtHR") in *Glass v United Kingdom* [2004] 1 FLR 1019 had converted what was only a requirement of good practice into a legal requirement, the court said (para 80):

> "The true position is that the court does not 'authorise' treatment that would otherwise be unlawful. The court makes a declaration as to whether or not proposed treatment, or the withdrawal of treatment, will be lawful. Good practice may require medical practitioners to seek such a declaration where the legality of proposed treatment is in doubt. This is not, however, something that they are required to do as a matter of law."

32. Mr Burke made a complaint to the ECtHR under articles 2, 3, 8 and 14 of the ECHR (*Burke v United Kingdom* (Application No 19807/0) 11 July 2006). It was rejected as manifestly ill-founded.

33. The ECtHR expressed itself satisfied that "the presumption of domestic law is strongly in favour of prolonging life where possible, which accords with the spirit of the Convention" (p 8 of the decision). Dealing specifically with the argument that there was insufficient protection for someone in Mr Burke's position, because a doctor might reach a decision to withdraw artificial nutrition and hydration without being obliged to obtain approval from the court, the court saw no problem with a process which involved taking into account the patient's previously expressed wishes and those of people close to him, and the opinions of medical personnel, and approaching a court only "if there was any conflict or doubt as to the applicant's best interests". It appears to have been content to endorse what the Court of Appeal said:

> "the Court would refer to the Court of Appeal's explanation that the courts do not as such authorise medical actions but merely declare whether a proposed action is lawful. A doctor, fully subject to the sanctions of criminal and civil law, is only therefore recommended to obtain legal advice, in addition to

> proper supporting medical opinion, where a step is controversial in some way. Any more stringent legal duty would be prescriptively burdensome - doctors, and emergency ward staff in particular, would be constantly in court - and would not necessarily entail any greater protection."

The Mental Capacity Act 2005

34. Since 2007, the MCA 2005 has been the statutory context within which treatment decisions are taken in relation to those who lack capacity, essentially without input from the court, but with the possibility of an application being made to court should the case require it. It may be helpful briefly to review the main provisions of the Act which are relevant to the present issue, dealing first with provisions of general application and then coming, in para 39, to the provisions dealing with the court's involvement and, in para 40, to the provision requiring the Lord Chancellor to issue codes of practice.

35. I start with two provisions which place the best interests of the person who lacks capacity at the heart of the process. Section 1(5) provides that an act done, or a decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. Section 4 sets out how someone determining, for the purposes of the Act, what is in a person's best interests must go about the task. All the relevant circumstances must be considered, and the steps listed in the section must be taken. They include considering, so far as reasonably ascertainable, the person's wishes and feelings, and the beliefs and values that would be likely to influence his decision if he had capacity, as well as the other factors that he would be likely to consider if he were able to do so. Also to be taken into account are the views of various specified people who have some responsibility for or are interested in his welfare. There is a specific subsection, section 4(5), dealing with a determination that relates to life-saving treatment; it provides that in such cases, in considering whether the treatment is in the best interests of the person concerned, the person making the determination must not be motivated by a desire to bring about his death.

36. Section 5 allows carers, including health professionals, to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to consent. It provides a significant degree of protection from liability, provided that the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests. If these conditions are satisfied, no

more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so.

37. There are provisions of the Act which enable someone to cater in advance for the possibility that he or she will, in future, lose the capacity to make decisions about his or her own welfare. One such provision is section 9 which deals with lasting powers of attorney, under which the donor gives the donee authority to make decisions about the donor’s personal welfare. Such a power of attorney is subject to the restrictions in section 11(7), and thus subject to sections 24 to 26 of the Act (see immediately below). Although it will normally extend to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for the donor, section 11(8) provides that it will not authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect. Sections 24 to 26 deal specifically with advance decisions to refuse treatment. They enable an adult with capacity to decide in advance that if he later lacks capacity to consent to the carrying out or continuation of a specified health care treatment, that treatment is not to be carried out or continued. Such an advance decision applies to life-sustaining treatment only if the decision is verified by a statement from the person concerned that it is to apply even if his life is at risk, and the decision complies with certain formalities set out in section 25(6), which essentially requires it to be written, signed and witnessed.

38. Section 37 makes provision for a situation in which an NHS body is proposing to provide “serious medical treatment” for a person who lacks capacity to consent to it and there is no one, other than those engaged in providing care or treatment for the person in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in the person’s best interests. “Serious medical treatment” means treatment which involves providing, withholding or withdrawing “treatment of a kind prescribed by regulations made by the appropriate authority”, which in practice will relate to situations in which a finely balanced decision has to be taken or what is proposed would be likely to involve serious consequences for the patient. Before providing the treatment, the NHS body must instruct an independent mental capacity advocate (referred to as an “IMCA”) to represent the person, although treatment which is urgently needed can be provided even though it has not been possible to appoint an IMCA. In providing treatment, the NHS body has to take into account information provided or submissions made by the IMCA.

39. The provisions of sections 15 to 17 of the Act give the court power to make decisions about personal welfare and to make declarations and orders in respect

of a person who lacks capacity. Section 15 deals with declarations, including declarations as to the lawfulness or otherwise of any act which has been or is to be done. Section 16 enables the court, by making an order, to make personal welfare decisions for a person without capacity, and, by section 17, the court's power in this regard extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for the patient. Section 16(3) makes it clear that the court's powers under section 16 are subject to the provisions of the Act and, in particular, to section 1 and to section 4. What governs the court's decision about any matter concerning the patient's personal welfare is therefore the patient's best interests.

40. Section 42 provides for the Lord Chancellor to prepare and issue codes of practice on various subjects. Before preparing a code, the Lord Chancellor has duties to consult, and a code may not be issued unless it has been laid before both Houses of Parliament in accordance with section 43(2). Section 42(4) imposes a duty on someone acting in a professional capacity in relation to a person who lacks capacity to have regard to any relevant code. Section 42(5) provides that if it appears to a court conducting any criminal or civil proceedings that a provision of a code, or a failure to comply with a code, is relevant to a question arising in the proceedings, the provision or failure must be taken into account in deciding the question.

41. Before leaving this overview of the provisions of the 2005 Act, it is worth noting a provision which is *not* to be found amongst them. The Law Commission had recommended (see Law Commission Report No 231 on Mental Incapacity, published in 1995, particularly para 6.21) that the new statute should provide that the discontinuance of artificial sustenance to an unconscious patient with no activity in the cerebral cortex and no prospect of recovery should in every case require the prior approval of the court, unless an attorney or court-appointed manager had express authority to make the decision, albeit that flexibility for the future was to be incorporated by providing that the Secretary of State could, by order, replace the need for court approval with a requirement for a certificate from an independent medical practitioner duly appointed for that purpose. As the Explanatory Notes to the 2005 Act state, the Act has its basis in the Law Commission Report. However, it does not seem to have been thought appropriate to include in it a requirement of court approval. In a note provided by counsel for the appellant, it is suggested that the reason for this was that the government concluded that, rather than creating inflexible legal rules, the better course would be for the courts to continue to decide which cases should have their prior sanction, with the situations in which that was the case being set out in a code of practice (see Baroness Ashton of Upholland's statement during the

debate on the Bill in the House of Lords, Hansard (HL Debates) 25 January 2005, vol 668, col 1243).

Mental Capacity Act 2005 Code of Practice

42. The Mental Capacity Act 2005 Code of Practice ("the Code"), issued under section 42 of the MCA 2005, came into effect in April 2007. Chapter 5 of the Code has a section entitled "How should someone's best interests be worked out when making decisions about life-sustaining treatment?" It includes the following:

> "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."
>
> "5.33 … 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."
>
> "5.36 As mentioned in para 5.33 above, where there is any doubt about the patient's best interests, an application should be made to the Court of Protection for a decision as to whether withholding or withdrawing life-sustaining treatment is in the patient's best interests."

43. Chapter 6 of the Code is entitled “What protection does the Act offer for people providing care or treatment?” Healthcare and treatment decisions are dealt with from paras 6.15 to 6.19. Para 6.16 says that “major healthcare and treatment decisions”, such as major surgery or a decision that no attempt is to be made to resuscitate a patient, need “special consideration”. Health care staff are directed to work out carefully what would be in the person’s best interests, taking into account the views of people in various categories, and involving an IMCA where no one else is available to consult. Para 6.17 commends multi-disciplinary meetings as often the best way to decide on a person’s best interests. They bring together healthcare and social care staff to discuss the person’s options and may involve those who are closest to the person concerned. However, the paragraph stresses that final responsibility for deciding what is in the best interests of the person lies with the member of healthcare staff responsible for the person’s treatment, who should record their decision, how they reached it, and the reasons for it, in the patient’s clinical notes. As long as they have “recorded objective reasons to show that the decision is in the person’s best interests, and the other requirements of section 5 of the Act are met, all healthcare staff taking actions in connection with the particular treatment will be protected from liability.”

44. Para 6.18 then goes on to single out certain treatment decisions in the following terms:

> “6.18 Some treatment decisions are so serious that the court has to make them - unless the person has previously made a Lasting Power of Attorney appointing an attorney to make such healthcare decisions for them (see chapter 7) or they have made a valid advance decision to refuse the proposed treatment (see chapter 9). The Court of Protection must be asked to make decisions relating to:[20]
>
> - the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS)
>
> - cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person

> - the proposed non-therapeutic sterilisation of a person who lacks capacity to consent (for example, for contraceptive purposes)
>
> - cases where there is a dispute about whether a particular treatment will be in a person's best interests.
>
> See paragraphs 8.18-8.24 for more details on these types of cases."

Footnote 20 to para 6.18 refers to "procedures resulting from those court judgments" but the court judgments in question are not named.

45. Para 6.19 develops matters a little:

> "6.19 This last category may include cases that introduce ethical dilemmas concerning untested or innovative treatments … where it is not known if the treatment will be effective, or certain cases involving a termination of pregnancy. It may also include cases where there is conflict between professionals or between professionals and family members which cannot be resolved in any other way.
>
> Where there is conflict, it is advisable for parties to get legal advice, though they may not necessarily be able to get legal aid to pay for this advice. Chapter 8 gives more information about the need to refer cases to court for a decision."

46. Chapter 8 of the Code deals with the role of the Court of Protection. Commencing at para 8.18, there is a section headed "Serious healthcare and treatment decisions". Paras 8.18 and 8.19 read:

> "8.18 Prior to the Act coming into force, the courts decided that some decisions relating to the provision of medical treatment were so serious that in each case, an application should be made to the court for a declaration that the proposed action was lawful before that action was taken.

> Cases involving any of the following decisions should therefore be brought before a court:
>
> - decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
>
> - cases involving organ or bone marrow donation by a person who lacks capacity to consent
>
> - cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (eg for contraceptive purposes) and
>
> - all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.
>
> 8.19 The case law requirement to seek a declaration in cases involving the withholding or withdrawing of artificial nutrition and hydration to people in a permanent vegetative state is unaffected by the Act[30] and as a matter of practice, these cases should be put to the Court of Protection for approval."

Footnote 30 refers to the *Bland* case.

47. Just to complete the picture, para 15.36 says that "[t]here are some decisions that are so serious that the court should always make them" and refers the reader back to chapter 8 for more information about that type of case.

48. It will be noted that the Code of Practice does not seem to be entirely consistent in its approach to involving the court in serious treatment decisions, chapter 6 asserting that the Court of Protection "must" be asked to make certain decisions, and chapter 8 that certain decisions "should" be brought before a court. It will be necessary to return to this later.

Court of Protection Rules and Practice Directions

49. Court of Protection Rules are made by the President of the Family Division (who is the President of the Court of Protection), in exercise of powers conferred by the MCA 2005. Assistance is provided by an ad hoc Rules Committee which is chaired by the Vice-President of the Court of Protection, and includes judges of the Court of Protection, experienced solicitors and barristers, representatives of local authorities, court staff and the Official Solicitor.

50. The first set of rules were the Court of Protection Rules 2007 (SI 2007/1744). They were replaced by the Court of Protection Rules 2017 (SI 2017/1035) which came into force on 1 December 2017. Both sets of Rules have been supplemented by Practice Directions.

51. The Court of Protection Rules 2007 were accompanied by Practice Direction 9E. This was entitled "Applications relating to serious medical treatment" and set out the procedure to be followed where the application concerned serious medical treatment. Para 5 of the Practice Direction said that cases involving decisions about "the proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state" "should be regarded as serious medical treatment for the purposes of the Rules and this Practice Direction, and should be brought to the court". When the 2017 Rules replaced the 2007 Rules, this provision was revoked and no equivalent provision was introduced. As to the reasoning for this change, some insight is provided by the notes of a meeting in July 2017 of the ad hoc Court of Protection Rules Committee, which are headed *Further Note: Serious Medical Treatment - Practice Directions 9E and12A* (28 July 2017).

52. The notes state (para 7) that no final recommendation was formulated by the committee. However, it is recorded (para 4) that it had been concluded that Practice Direction 9E should not have included provisions as to what cases should be brought to court, since a practice direction cannot properly direct when an application should be made, and that accordingly any new practice direction should not include any equivalent provision. The final paragraph records that Charles J, as the chairman of the committee, would "recommend and so instruct work to be done to remove and not replace Practice Direction 9E". It appears that the committee had considered, but not generally favoured, a practice direction which took a different approach, for example recording what had been said in the decided cases. It was, however, common ground that the British Medical Association, the Law Society, the Ministry of Justice and the Department of Health (the reference, in the conclusions and recommendations section of the

note, to the Ministry of Defence must be a mistake) would create “a working group to address the underlying issues and the giving of guidance” which would “take account of developing authority and so would consider how the guidance produced could be readily updated”.

The case law: domestic decisions after MCA 2005

53. *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] AC 591 was the first case to come before the Supreme Court under the MCA 2005. It concerned a patient with multiple medical problems, who had a very limited level of awareness and lacked capacity to make decisions concerning his medical treatment. The hospital Trust applied for a declaration, under section 15 of the MCA 2005, that it would be lawful, as being in the patient’s best interests, for three particular life-preserving treatments to be withheld if his condition got worse. The family did not agree with the withdrawal of treatment and, at first instance, Peter Jackson J refused to grant the declaration. By the time of the Trust’s appeal to the Court of Appeal, the patient had suffered a dramatic deterioration; he was completely dependent on mechanical ventilation and was comatose or semi-comatose. The Court of Appeal allowed the appeal and granted the declaration. The patient subsequently died, following a cardiac arrest, but the Supreme Court nonetheless heard his widow’s appeal, which gave rise to questions concerning the proper approach to the assessment of a patient’s best interests in the post-MCA 2005 era. The appeal was dismissed, although Peter Jackson J’s approach to determining the patient’s best interests was preferred to that of the Court of Appeal.

54. Baroness Hale gave a judgment with which the other justices all agreed. She restated, now with reference to the provisions of the MCA 2005, the position as to invasive medical treatment of a patient. Although going over ground covered in the pre-MCA 2005 cases, it is worth setting out the relevant passages in full, since they establish the up-to-date legal context for the questions that arise in the present appeal. She said:

> “19. … Generally it is the patient’s consent which makes invasive medical treatment lawful. It is not lawful to treat a patient who has capacity and refuses that treatment. Nor is it lawful to treat a patient who lacks capacity if he has made a valid and applicable advance decision to refuse it: see the 2005 Act, sections 24 to 26. Nor is it lawful to treat such a patient if he has granted a lasting power of attorney (under section 10) or the court has appointed a deputy (under

> section 16) with the power to give or withhold consent to that treatment and that consent is withheld; but an attorney only has power to give or withhold consent to the carrying out or continuation of life-sustaining treatment if the instrument expressly so provides (section 11(8)) and a deputy cannot refuse consent to such treatment: section 20(5).
>
> 20. Those cases aside, it was recognised by the House of Lords in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 that where a patient is unable to consent to treatment it is lawful to give her treatment which is necessary in her best interests. Section 5 of the Mental Capacity Act 2005 now provides a general defence for acts done in connection with the care or treatment of a person, provided that the actor has first taken reasonable steps to establish whether the person concerned lacks capacity in relation to the matter in question and reasonably believes both that the person lacks capacity and that it will be in his best interests for the act to be done. However, section 5 does not expressly refer both to acts and to omissions, the giving or withholding of treatment. The reason for this, in my view, is that the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it."

55. Baroness Hale underlined further, in para 22, that the focus is on whether it is in the patient's best interests to give the treatment, rather than whether it is in his best interests to withhold it or withdraw it. She continued:

> "If the treatment is not in [the patient's] 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."

56. The court did not have to consider the issue that now falls for determination. However, it is worth noting that Baroness Hale spoke in approving terms, in para 47, of the sensible advice given by the General Medical Council in their guidance on *Treatment and care towards the end of life: Good practice in*

decision making (see below) and said that nothing in her judgment was inconsistent with it.

57. *In re Briggs (Incapacitated Person)* [2018] Fam 63 concerned a man in a minimally conscious state. His wife brought proceedings under section 21A of the MCA 2005 (as inserted by paragraph 9 of Schedule 2 to the Mental Health Act 2007) seeking a determination that it was not in her husband's best interests to continue to be given the CANH that he needed to survive. By virtue of having applied under section 21A, the wife was entitled to non-means tested legal aid. It was contended, against her, that the issue of her husband's treatment could not be raised under section 21A (which deals with the court's powers in relation to the authorisation of deprivation of liberty) and that the application should have been brought under other provisions of the Act, which would have resulted in only means tested funding being available. The question for the court was therefore whether section 21A was broad enough to cover the treatment application. The Court of Appeal held that it did not provide a route for determining questions in relation to medical treatment where, as in that case, the deprivation of liberty itself was not the real or essential issue before the court. An application for a welfare order under section 16 of the Act should have been made.

58. In the course of the judgment, King LJ (with whom both other members of the court agreed, Sir Brian Leveson P adding a few words of his own) made some observations about the issue that now concerns this court. Although obiter, they are still valuable, not least for their insight into what happens in practice. At the time, Practice Direction 9E remained in force, and King LJ observed, at para 24, that at first glance there seemed to be a tension between the practice direction, which appeared to say that *all* cases of withholding or withdrawing treatment in relation to a minimally conscious person should be brought before the court, and the Code which said that matters should be brought before the court where there was a doubt as to the person's best interests. Because the Code was a statutory code to which the MCA 2005 made it mandatory to have regard, she said that the Code must take precedence and then continued:

> "26. … In reality virtually all of these traumatic decisions are made by agreement between the families and the treating teams of the person involved. To suggest that every case should go before a judge (even where all concerned are in accord as to what was in the best interests of the patient) would not only be an unnecessary pressure on the overstretched resources of the NHS trusts and add to the burden on the courts but, most importantly, would greatly

> add to the strain on the families having to face these unimaginably distressing decisions. In my judgment, the practice direction provides valuable procedural guidance but should not be interpreted as introducing a requirement that all cases where a decision is to be made about the withdrawal of CANH must come before a court."

59. Having rejected the argument that medical treatment decisions could be taken, in a case such as that which the court was considering, under section 21A of the MCA 2005, King LJ set out in para 108 what, in her view, was the proper approach to a medical treatment case. In so far as relevant to the present appeal, she said:

> "(i) If the medical treatment proposed is not in dispute, then, regardless of whether it involves the withdrawal of treatment from a person who is minimally conscious or in a persistent vegetative state, it is a decision as to what treatment is in P's best interests and can be taken by the treating doctors who then have immunity pursuant to section 5 of the MCA.
>
> (ii) If there is a dispute in relation to medical treatment of an incapacitated person, and, specifically, where there is a doubt as to whether CANH should be withdrawn, then the matter should be referred to the court for a personal welfare determination under sections 15 to 17 of the MCA."

60. In similar vein, Sir Brian Leveson P said, at para 114, that "[i]f agreement between the authorities and the family is possible, litigation will not be necessary".

61. Finally, in terms of the post-MCA 2005 domestic case law, I would refer to two decisions of the Court of Protection. It is important to do so, because judges of the Family Division, who sit also in the Court of Protection, deal regularly with the very difficult welfare decisions which have to be taken as people approach the end of their lives, and this experience gives weight to their views.

62. In *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2011] EWHC 2443 (Fam); [2012] 1 WLR 1653, a case concerning a

woman in a minimally conscious state, Baker J expressed the view (paras 78, 82 and 257) that "all decisions about the proposed withholding or withdrawal of ANH from a person in a persistent vegetative state or minimally conscious state should always be brought to the court." By this, it can be seen from para 257 that he meant that such decisions "must" be referred to court. He considered that "the legal position has been clear since the decision in the *Bland* case" and, in so far as there was any difference between the Code (which might have suggested that applications to court were not necessary unless the doctor's assessment of the patient's best interests was disputed) and the position set out in Practice Direction 9E, it was the Practice Direction which reflected the law.

63. Our attention was invited to a fairly recent paper entitled *"A matter of life and death"* (2017) 43 J Med Ethics 427 written by Baker J from which it appears that, at least up to that point, he continued to be of the view that he expressed in *In re M*. He acknowledged that the time may come when applications to court were only necessary where there was a dispute, but did not believe that time had yet been reached. In his view, at p 434, medical science and the law were still evolving and until such time as there was "greater clarity and understanding about the disorders of consciousness, and about the legal and ethical principles to be applied, there remains a need for independent oversight", and "applications to the court should continue to be obligatory in all cases where withdrawal of ANH is proposed." He did, however, identify an urgent need for a more streamlined procedure for court resolution, avoiding undue cost and delay.

64. In *In re M (Incapacitated Person: Withdrawal of Treatment)* [2017] EWCOP 18; [2018] 1 WLR 465, the court was concerned with the withdrawal of CANH from a woman who was suffering from Huntington's disease and was in a minimally conscious state. Her family, her clinicians, and a specialist from whom a second opinion had been sought, were agreed that it was in her best interests not to continue with treatment, notwithstanding that that would result in her death, and a declaration was made to that effect.

65. Peter Jackson J responded to a request from the parties for clarification as to whether legal proceedings were, in fact, necessary prior to withholding or withdrawing CANH when an incapacitated person's family and clinicians agreed that CANH was no longer in the person's best interests. At the time he decided the case, Practice Direction 9E (which had been influential in Baker J's decision) was still effective, but his view differed from Baker J's. Notwithstanding the provisions of the Practice Direction, he held (paras 37 and 38) that, on the facts with which he was dealing, the decision about what was in M's best interests could lawfully have been taken by her treating doctors, having fully consulted her

family and having acted in accordance with the MCA 2005 and with recognised medical standards, without reference to the court. He pointed out that there was no statutory obligation to bring the case to court and gave his view that none of the cases and materials cited in his judgment sustained the proposition that a court decision was necessary as a matter of law rather than of practice. He did not consider that article 2 of the ECHR mandated court oversight, taking the view that the approach taken in M’s case fully respected her article 2 rights in a fashion contemplated in *Lambert v France* (2016) 62 EHRR 2. He drew attention to the fact that, overwhelmingly, treatment decisions up to and including the withholding of life-support are taken by clinicians and families working together in accordance with good practice, with no suggestion of mandatory court involvement, and expressed the view that it was anomalous to require it for a limited subset of cases (those involving PVS or MCS) which were not sufficiently different to justify different treatment. Identifying another anomaly, he also observed that there was no suggestion that the court should be involved where there was a valid and applicable advance decision, yet the grave consequences of the decision and the risk of error were no different in such cases from cases where there was no advance decision. He also referred to the deterrent effect of costly and time-consuming proceedings, “both on the individual case and on the patient population in general”. He considered that a mandatory litigation requirement may deflect clinicians and families from making true best interests decisions and in some cases lead to inappropriate treatment continuing by default. He gave M’s case as an example, in that she continued to receive CANH that neither her doctors nor her family thought in her best interests “for almost a year until a court decision was eventually sought”. He made quite clear, however, that the court is always available where there is disagreement, or where it is felt for some other reason that an application should be made, although this would only arise in rare cases.

Strasbourg jurisprudence

66. Since Mr Gordon relies upon the ECHR as one foundation for his argument that there is a requirement to apply to court for a declaration in every case, it is important to look at the case law of the ECtHR on the subject. I have already referred to the case of *Burke* in 2006. The case of *Lambert v France* (2016) 62 EHRR 2 is also very much in point, although it received only a passing mention in the appellant’s written case. If there were any doubt as to its significance, in *Gard v United Kingdom* (2017) 65 EHRR SE9, the ECtHR described it as “its landmark Grand Chamber case *Lambert*” (para 79).

67. *Lambert* concerned a man, VL, who had sustained serious head injuries, rendering him tetraplegic and completely dependent. He had irreversible brain

damage and was receiving artificial nutrition and hydration. Through “the collective procedure” established in France by the *Public Health Code* as amended by the *Act of 22 April 2005 on patients’ rights and end of life issues* (“the Public Health Code”), a decision was taken by Dr K to withdraw nutrition and hydration. VL’s wife, and ultimately also his parents, a half-brother and a sister, were involved in the decision-making process. His parents, half-brother and sister opposed the withdrawal of nutrition and hydration, and there was considerable litigation in France. This culminated in the Conseil d’État. Furnished with an expert medical report which concluded that VL was in a vegetative state, and after considering observations on the Public Health Code from a number of amici curiae, the Conseil held that Dr K’s decision was not unlawful.

68. The parents, half-brother and sister made an application to the ECtHR, arguing that there was a violation of (inter alia) articles 2 and 8 of the ECHR. By a majority, the court found that there was no violation of article 2, and that there was no need for a separate ruling on article 8.

69. In its judgment, it referred back to its previous decisions in *Glass* (2003) 37 EHRR CD66 and *Burke v United Kingdom* (Application No 19807/0) (supra), observing at para 143 that:

> “in addressing the question of the administering or withdrawal of medical treatment [in those cases], it took into account the following factors:
>
> - the existence in domestic law and practice of a regulatory framework compatible with the requirements of article 2;
>
> - whether account had been taken of the applicant’s previously expressed wishes and those of the persons close to him, as well as the opinions of other medical personnel; and
>
> - the possibility to approach the courts in the event of doubts as to the best decision to take in the patient’s interests.”

These factors were relevant to its decision about VL (and were set out again subsequently in para 80 of *Gard*), as well as the criteria laid down in the Council of Europe's *Guide on the decision-making process regarding medical treatment in end-of-life situations*. The Guide had been drawn up in the course of work on patients' rights and with the intention of facilitating the implementation of the *Oviedo Convention on Human Rights and Biomedicine* (see para 59 of *Lambert*), which has been ratified by 29 of the Council of Europe member states, but not the United Kingdom.

70. The ECtHR observed (para 165) that the comparative law materials available to it showed that, in those countries which authorise the withdrawal of treatment, and where the patient has not given any advance directive, there is a great variety of arrangements governing the taking of the final decision to withdraw treatment. The most common situation was that the final decision was taken by the doctor treating the patient, but it could be taken jointly by the doctor and the family, by the family or legal representative, or (as it is put in para 75) "even the courts". The ECtHR determined that the French legal provisions, as interpreted by the Conseil d'État, constituted a legal framework which was sufficiently clear to regulate with precision the decisions taken by doctors in situations such as VL's, and which ensured protection of patients' lives.

71. It is worth looking in a little detail at what was required by French law at the relevant time. By the Public Health Code (including the Code of Medical Ethics which is part of it), the decision to limit or withdraw treatment of a person who is unable to express his or her wishes is taken by the doctor in charge of the patient, after the implementation of "a collective procedure". The circumstances in which such a decision can be taken are set out in article R.4127-37 para I of the Public Health Code. I have included the provision in both French and English in order that the reference to "unreasonable obstinacy" in the English translation might be better understood; the ECtHR explains it in para 53 as continuing treatment to unreasonable lengths.

> "I. En toutes circonstances, le médecin doit s'efforcer de soulager les souffrances du malade par des moyens appropriés à son état et l'assister moralement. Il doit s'abstenir de toute obstination déraisonnable dans les investigations ou la thérapeutique et peut renoncer à entreprendre ou poursuivre des traitements qui apparaissent inutiles, disproportionnés ou qui n'ont d'autre objet ou effet que le maintien artificiel de la vie."

> "I. The doctor shall at all times endeavour to alleviate suffering by the means most appropriate to the patient's

> condition, and provide moral support. He or she shall refrain from any unreasonable obstinacy in carrying out examinations or treatment and may decide to withhold or discontinue treatment which appears futile or disproportionate or the only purpose or effect of which is to sustain life artificially."

72. Before taking the decision, the doctor is required to consult with the care team where there is one, and there has to be a reasoned opinion of at least one doctor acting as an independent consultant. The decision has to take into account any wishes previously expressed by the patient, in particular in the form of advance directives, the views of any person of trust that the patient may have designated and of the family or, failing this, of another person close to the patient. Reasons have to be given for any decision to limit or withdraw treatment, and the position has to be documented in the patient's file.

73. Whilst the matter had, in VL's case, been litigated in the courts, demonstrating that recourse could be had to court if necessary, court approval was not required by the French provisions. Although the applicants did not advance any argument that this rendered the system unsatisfactory for the purposes of article 2, they did complain about the decision-making process on other grounds, considering that the decision should have been a genuinely collective one or, at the very least, provision should have been made for mediation in the event of disagreement. This complaint led the court to consider what obligations there were concerning the decision-making process. Rejecting the complaint, it said (para 168) that "the organisation of the decision-making process, including the designation of the person who takes the final decision to withdraw treatment and the detailed arrangements for the taking of the decision, fall within the state's margin of appreciation."

74. The French process (as amended, although not substantially, in 2016) once more withstood scrutiny by the ECtHR in January 2018 in *Afiri and Biddarri v France* (Application No 1828/18) 23 January 2018. The court again re-iterated the elements set out in para 143 of *Lambert* (supra) and repeated the observations it had there made (para 168) about the organisation of the decision-making process.

Other guidance

75. Various medical bodies in the UK have produced codes relating to the withdrawal of life sustaining treatment. In chronological order, they are:

i) The BMA's *"Withholding and Withdrawing Life Prolonging Medical Treatment: Guidance for decision making"* (first published in 1999, 3rd ed 2007)

ii) The GMC's *"Treatment and care towards the end of life: good practice in decision making"* (published May 2010)

iii) The report of the Royal College of Physicians ("the RCP") entitled *"Prolonged disorders of consciousness: National clinical guidelines* (the report of a working party in 2013)

iv) An Interim Guidance document produced in December 2017 by the GMC, BMA and RCP entitled *"Decisions to withdraw clinically-assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden-onset profound brain injury"*.

76. The last document referred to in the previous paragraph was published after the decisions at first instance in the present case, the Court of Appeal's decision in *Briggs,* and Peter Jackson J's decision in *In re M*. It was not meant to override the existing guidance from each of the three bodies, but to supplement it, responding to the statements in those cases that there is no requirement for treating clinicians to seek court approval to withdrawing CANH, and to the withdrawal of Practice Direction 9E. It summarises the recent developments in the law, and also the views of the GMC, BMA, and RCP about good clinical and professional practice in the area. It is intended that before long it will be replaced with a new final guidance, which (the introduction to the Interim Guidance says) "will recommend safeguards to ensure that a robust and thorough assessment process continues to be followed prior to the withdrawal of CANH".

77. It is necessary to look in more detail at this body of professional guidance since it has a very important part to play in ensuring the proper protection of patients and in maintaining the confidence of the public in the health care system. Whatever impression might be conveyed by terms such as "guidance" and

“guidelines”, the practice set out in the various documents has significant weight. This is perhaps particularly so in relation to guidance emanating from the GMC, which has a special role in providing guidance for the medical profession. It was established by statute, the Medical Act 1983, with the over-arching objective of protecting the public, and is charged with setting and maintaining the standards that doctors across the UK must follow, where necessary taking action in relation to a doctor if he or she is found to be falling below the required standard. Its statutory powers under the Medical Act include power to issue advice for members of the medical profession on standards of professional conduct, standards of professional performance and medical ethics (section 35).

78. The GMC’s 2010 guide to good practice draws upon the domestic and European jurisprudence and covers the matters that one would therefore expect. I will not rehearse all those matters here, particularly given that guidance is continuing to evolve, and will simply give a broad indication of the nature and ambit of the document. It provides the doctor with a decision-making model, applicable where an adult lacks the capacity to decide about treatment and care. As part of the decision-making process, the doctor is to:

i) make an assessment of the patient’s condition,

ii) consider what treatments are clinically appropriate and likely to benefit the patient,

iii) find out about any valid advance decision made by the patient or anyone who has legal authority to decide for him,

iv) as far as practical and appropriate, consult members of the healthcare team and those close to the patient and, when deciding about treatment, take their views into account,

v) take steps towards the appointment of an IMCA where appropriate,

vi) attempt to resolve disagreements about what treatment and care would be of overall benefit to the patient, seeking legal advice on applying to court for an independent ruling if agreement is not reached.

79. The guide requires a record to be made of decisions about treatment, and of who was consulted in relation to the decisions. There is a section specifically addressing CANH, particularly stressing the need to listen to and consider the views of the patient and those close to them, and to explain the issues to be considered. The doctor is alerted to the need, in the event of disagreement about CANH, to ensure that the patient or someone acting on their behalf is advised on how to access their own legal advice or representation. Where the patient is not expected to die in any event in hours or days, but the doctor judges that CANH would not be of overall benefit to him, all reasonable steps must be taken to get a second opinion from a senior clinician who is not already directly involved but who should examine the patient. If that is not practically possible in exceptional circumstances, advice from a colleague must still be sought. As to patients in PVS or a condition closely resembling it, the guide says that "the courts … require that you approach them for a ruling". This is, however, modified in the Interim Guidance of December 2017 which proceeds upon the basis that there will be cases in which no court application is required.

80. The December 2017 Interim Guidance starts by identifying that a best interests decision cannot be taken for the patient where he has made a valid and applicable advance decision to refuse treatment which covers CANH, or where an attorney appointed under a suitable lasting power of attorney makes the decision. It then goes on to say that where there is disagreement about best interests or the decision is finely balanced, an application should be made to court for a declaration as to whether CANH continues to be in the patient's best interests. Then, dealing with the remainder of cases, the guidance sets out the steps that should be taken to ensure that there is proper consultation prior to determining what is in the patient's best interests. These include ensuring that the RCP guidelines have been followed regarding assessment, with the assessment carried out by professionals with the appropriate training, that guidance in the Mental Capacity Act Code, and from the BMA, RCP and/or GMC has been followed, that there have been formal, documented best interests meetings with those who care for the patient and are interested in his or her welfare, and that an IMCA is consulted where necessary. The doctor is told to find out as much as possible about the patient's values, wishes, feelings and beliefs. A second clinical opinion should be sought from a consultant with experience of PDOC who has not been involved in the patient's care and who should, so far as reasonably practical, be external to the NHS Trust/Clinical Commissioning Group ("CCG"); the consultant should examine the patient and review the medical records and the information that has been collected. There should be very detailed records kept, both a clinical record (covering many specified matters) and a record of discussions, meetings and so on.

81. The RCP document is lengthy, covering the diagnosis and management of patients with PDOC. There is a section devoted to assessment, diagnosis, and monitoring, in which the doctor is alerted to the challenges in making an accurate diagnosis and the need for evaluation by a multi-disciplinary team of expert clinicians, with the family and close friends of the patient having a key role, and is told that the diagnostic assessment process should follow a structured approach, elements of which are described in some detail. Another section of the document covers ethical and medico-legal issues, also in detail.

82. The BMA guidance is similarly substantial, its aim being to "provide a coherent and comprehensive set of principles which apply to all decisions to withhold or withdraw life-prolonging treatment" (Introduction p xiii).

83. It should be noted that the Faculty of Intensive Care Medicine ("FICM") and the Intensive Care Society ("ICS") have also issued joint recommendations in the form of *"Guidelines for the provision of intensive care services"*; these include recommendations about end of life care.

The submissions on behalf of the Official Solicitor

84. Considerations of human dignity and the sanctity of human life are, quite rightly, central to the Official Solicitor's case. His submission is that only by requiring judicial scrutiny in every case concerning the withdrawal of CANH from a patient suffering from PDOC can human life and dignity be properly safeguarded. An important part of the protection is, he submits, the oversight of an independent and neutral person such as the Official Solicitor, who can investigate, expose potential disputes, and give the patient a voice in the decision-making, and it is court proceedings that enable the Official Solicitor to be involved. Medical guidance on its own is, in his submission, insufficient protection, and so, until other protective mechanisms are devised, the common law and/or the ECHR dictate that an application to court must be made.

85. I do not understand the Official Solicitor to go so far as to submit that *In re F (Mental Patient: Sterilisation)* and *Bland's* case specifically impose a common law requirement for a court application in every case. His argument is less direct. In his written case, Mr Gordon says that it "is abundantly clear from those cases … that the House of Lords implicitly accepted the link between the need for common law protection of patients' rights and necessary mechanisms (not yet sufficiently advanced) to give full protection of those rights." That, in his submission, is what led them to say that for the time being a declaration should

be sought, it being the only suitably protective mechanism so far available. Since, in the Official Solicitor’s view, the necessary mechanisms have still not been developed, there remains no satisfactory alternative protection for patients. In those circumstances, it is artificial, he submits, to distinguish between a statement of good practice, and what is required by common law, as they are in fact one and the same, necessitating court involvement in every case. The passing of the MCA 2005 has not changed matters, it is submitted, and the common law is not undermined by the absence of an express statutory provision in it requiring court involvement. Indeed it is asserted that, on the contrary, “[i]t was clear that Parliament intended that judicial scrutiny of any decision to withdraw CANH should continue for the foreseeable future.”

86. In terms of recent support for his position, Mr Gordon seeks to rely upon something that Baroness Hale said in *In re N v (An Adult) (Court of Protection: Jurisdiction)* [2017] AC 549, para 38. Whereas I intend to address the bulk of the Official Solicitor’s submissions later, this one can be dealt with straight away. I did not include *In re N v (An Adult) (Court of Protection: Jurisdiction)* in my résumé of the authorities as it is not on the point which requires determination here. The issue related to the powers of the Court of Protection where a public body, the local commissioning group, refused to provide or fund a care package for an incapacitated adult which his parents thought would be in his best interests. At para 38, introducing her discussion of that very different issue, Baroness Hale said:

> “… Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P’s best interests for the act to be done. *This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court…*” (My italics)

It seems to me over-ambitious to seek to rely upon the italicised sentence, taken out of context, as support for the existence of the common law requirement for which Mr Gordon contends.

87. Turning to the ECHR, the Official Solicitor seeks to invoke article 2 (right to life), article 6 (right to a fair trial), article 8 (right to respect for private and family life) and article 14 (prohibition of discrimination) as further support for the assertion that court involvement is a necessary component in securing the patient’s rights. The jurisprudence of the ECtHR makes clear, he says, that if

there is doubt as to the medical position or the patient's best interests, there must be a real remedy and, in cases such as the present, only a court application will reveal whether there is doubt. Here, without the Official Solicitor's full participation in the present proceedings, it was impossible to know whether or not there *was* any dispute about the medical evidence or about Mr Y's best interests, and as a result Mr Y's article 6 rights were eroded to the point that his article 2 rights were afforded no effective protection.

88. An argument is also advanced in reliance upon article 14, which it is said will be breached because a patient in Mr Y's position unjustifiably has less protection than an adult who has capacity and is terminally ill, the latter having the protection in relation to assisted dying afforded by section 2 of the Suicide Act 1961 (which makes it an offence to do an act capable of encouraging or assisting a suicide).

89. It is important to note some of the special features of PDOC cases which in the Official Solicitor's submission necessitate court involvement. He stresses the particular vulnerability of patients with PDOC, the difficulty in assessing the level of a person's consciousness, and the dangers of a wrong diagnosis or a wrong conclusion about what is in the person's best interests. He invites attention to examples of diagnostic errors in the decided cases where, for example, a patient has been thought to be in a permanent vegetative state but found later to be in a minimally conscious state. He submits that, although decisions about withdrawing treatment have to be made in relation both to patients with PDOC, and patients in intensive care with life-limiting illnesses or injuries, the two categories of patient are different. The patient with PDOC may be clinically stable and may live for a prolonged period with only appropriate nursing care, hydration and nutrition, whereas the patient in intensive care may require more active medical intervention and support and may face death within hours or days. Furthermore, it is suggested that there is a particular concern about the morality of withdrawing CANH, which many might see as basic care, as opposed to certain other types of treatment.

90. Lord Brandon's reasoning at p 56 of *In re F (Mental Patient: Sterilisation)* (supra) (where he identified a number of special features which made the involvement of the court highly desirable) applies equally to PDOC cases, it is submitted. Similarly in point is Lord Lowry's concern, expressed in the *Bland* case (supra), that without court oversight, the doctor will be judge in his own cause. In addition, there is a danger, it is said, that the doctor may persuade family members who might not have the resources (emotional or financial) to question the doctor's decision. Far from the need for independent scrutiny having

diminished since the *Bland* case, Mr Gordon submits that it has increased as the growing understanding of disorders of consciousness has revealed the shortcomings of the assessments that have to be carried out.

Discussion

91. 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. As Baroness Hale said at para 35 of *Aintree University Hospitals NHS Foundation Trust v James* (supra):

> "The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive."

And yet there may come a time when life has to be relinquished because that is in the best interests of the patient. The situation of Mr Y, and the ordeal through which his family has been going, serve as a solemn reminder of how illness may confront any one of us at any time and of the difficulties that face the patient, his family, and the medical staff whose job it is to do the best that they can for them. As Lord Browne-Wilkinson said in *Bland's* case (p 877), the questions for us are questions of law, "[b]ut behind the questions of law lie moral, ethical, medical and practical issues of fundamental importance to society." The weight of that consideration anchors the legal decisions which I would make.

92. Before turning to the central questions in the case, it is worth restating the basic position with regard to medical treatment, because it is upon this foundation that everything else is built. Although the concentration is upon the withdrawal of CANH, it must be kept in mind that the fundamental question facing a doctor, or a court, considering treatment of a patient who is not able to make his or her own decision 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 the patient's best interests. Accordingly, if the treatment would not be in the patient's best interests, then it would be unlawful to give it, and therefore lawful, and not a breach of any duty to the patient, to withhold or withdraw it. For a recent authoritative statement to this effect, see the *Aintree* case, although I would add that if a doctor carries out treatment in the reasonable belief that it will be in the patient's best interests, he or she will be entitled to the protection from liability conferred by section 5 of the MCA 2005 (see para 36 above). It is also important to keep in mind that a patient cannot require a doctor to give any particular form of treatment, and nor

can a court (see, for example, *R (Burke) v General Medical Council* at paras 50 and 55, and the *Aintree* case at para 18).

93. I turn then to the core issue, commencing with a consideration of what, if any, requirements are imposed by domestic law. This consideration must start with the *Bland* case. In my view, there can be no question of the House of Lords there having imposed a legal requirement that in all cases of PVS (or any other form of prolonged disorder of consciousness) an application must be made to the court before CANH can be withdrawn. The scene had been set in *In re F (Mental Patient: Sterilisation)*, where consideration was given to whether it was necessary to seek a declaration before carrying out a sterilisation operation on a woman who could not consent to the procedure herself. This was the case in which Lord Brandon set out the six features which made it highly desirable to seek the involvement of the court as a matter of good practice, five of which features the Official Solicitor relies upon in his present argument. That none of their Lordships in *In re F* considered that they were laying down a common law requirement to apply to the court is put beyond doubt by the speech of Lord Griffiths. It will be recalled that he would have been inclined to make it a legal requirement to seek the sanction of the court in all cases, and thought that the common law could be adapted to do so, but was deterred because the other members of the House considered that this would be making new law and inappropriate. *In re F* was very much in the minds of their Lordships in the *Bland* case, as can be seen from their speeches, and the approach they took to the question of court involvement was similar to that taken in *In re F*. There was no suggestion that the common law was now being developed in the sort of way that Lord Griffiths had eschewed in *In re F*. It was made quite clear that it was “as a matter of practice” that guidance should be sought from the court by way of declaratory relief, the practice of applying being “desirable”. It was contemplated that the President of the Family Division would keep matters under review and it was hoped that he would, in time, be able to limit applications for declarations to cases where there was a special need; this would have been difficult had the House of Lords created a legal requirement of a declaration in every case.

94. The position was underlined in *R (Burke) v General Medical Council* (supra) where the Court of Appeal expressly rejected the argument that there was a legal duty to seek a declaration from the court before withdrawing artificial nutrition and hydration from a patient in PVS, affirming that the House of Lords in *Bland’s* case had “recommended” “as a matter of good practice” that reference be made to the court. Mr Gordon submits that the Court of Appeal was not there addressing the same issue as this court must now address, namely the protection of “the vulnerable class of patients with PDOC”, and that it had only been addressed on the situation of PVS patients “in passing”. I do not consider that

Burke's case can be removed from the picture in this way. It seems to me to be an accurate statement of the legal position and of relevance to the issue before us.

95. Accordingly, when the Mental Capacity Act 2005 came into force in 2007, there was no universal requirement, at common law, to apply for a declaration prior to withdrawing CANH. Mr Sachdeva, for the respondents, argues that it would be inconsistent with the statutory regime established by Parliament in the MCA 2005 to have such a requirement. The Act makes provision for decisions to be taken on behalf of those who lack capacity, based upon what is in their best interests, without involving a court. By section 5, subject of course to the impact of any relevant lasting power of attorney or advance decision to refuse treatment, a clinician who treats a patient in accordance with what he reasonably believes to be the patient's best interests does not incur any liability, in relation to the treatment, that he would not have incurred if the patient had had capacity to consent and had consented to it. Provision is made for the court to make decisions about personal welfare where necessary, but the Act does not single out any sub-class of decisions which must always be placed before the court, and there is no requirement for the Official Solicitor to be involved in best interest decisions relating to serious medical treatment.

96. There is an attraction to Mr Sachdeva's argument that the MCA 2005 is a complete statutory code but, had there been a common law requirement of court involvement by the time it was passed, I think I might nonetheless have been prepared to accept that it could have survived the silence of the Act on the subject. However, as there was no pre-existing common law requirement, the point does not arise for decision. The absence of any requirement in the statute of the type for which the Official Solicitor contends is nevertheless of interest, given the recommendations of the Law Commission Report No 231 which brought it to attention as one of the possible options, and given that the Act is based upon that report.

97. In contrast to the statute itself, the Mental Capacity Act 2005 Code of Practice does speak of applications to court in cases such as the present, but is contradictory in what it says about them. Paras 5.33 and 5.36 speak in terms of an application being made if there is any doubt or dispute about the doctor's assessment of the patient's best interests. Although para 6.18 suggests that the court "has to make"/"must be asked to make" the decision about withholding or withdrawing artificial nutrition and hydration from a patient in PVS, that statement seems to have been derived from the case law, which dealt only in terms of good practice, not of legal obligation. And paras 8.18 and 8.19, to which para 6.18

invites reference, say that an application “should” be made to the court and that “as a matter of practice” such cases “should be put to the Court of Protection for approval”, referring to a “case law requirement to seek a declaration”, the source of which is given as the *Bland* case. A Code in these rather ambiguous terms, plainly attempting to convey what the cases have so far decided, cannot extend the duty of the medical team beyond what the cases do in fact decide is incumbent upon them. Whatever the weight given to the Code by section 42 of the MCA 2005, it does not create an obligation as a matter of law to apply to court in every case.

98. Practice Direction 9E which accompanied the Court of Protection Rules 2007 said that decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from a person in a persistent vegetative state or a minimally conscious state “should be brought to court”. It is understandable that the ad hoc Rules Committee decided that, in so far as the practice direction purported to direct which cases had to be brought to court, it went beyond its proper scope; a practice direction cannot establish a legal obligation when none exists already, see *U v Liverpool City Council (Practice Note)* [2005] 1 WLR 2657, para 48. In any event, as no equivalent practice direction accompanies the Court of Protection Rules 2017, it is not necessary to delve into the matter further.

99. No requirement to apply to court can be found in the post-MCA 2005 case-law either. The decision of Baker J in *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* does not assist because it proceeded upon the basis that the *Bland* case had established that all decisions about the proposed withholding or withdrawal of CANH had as a matter of law to be brought to court and I would not interpret the *Bland* case in this way.

100. The view of King LJ, expressed obiter in the Court of Appeal in *In re Briggs* [2018], that treating doctors can take a decision without recourse to court where there is no dispute about it should, however, be accorded weight. This is so even allowing for the possibility raised by Mr Gordon that the court may not have had full argument on the subject and may not have been referred to all the relevant passages in the Code, as King LJ spoke only of one of the less prescriptive provisions. It is important to note the views of those who, like her, have long experience in the Family Division where life and death issues are regularly litigated.

101. Peter Jackson J’s judgment in *In re M (Incapacitated Person: Withdrawal of Treatment)* (given after the Court of Appeal’s decision in the *Briggs* case) is

also of assistance, particularly for the judge's analysis of why, in his view, the decision as to what was in M's best interests could have been taken without reference to the court. Mr Gordon points out that the Official Solicitor was not formally involved in that case and that there was no oral argument on the topic. However, as Peter Jackson J set out in para 30, he did invite and receive a "substantial skeleton argument" prepared by leading and junior counsel on behalf of the Official Solicitor which, he said, "(among other things) trenchantly asserts that an application to court should be made in every case of proposed withdrawal of CANH, unless there is a valid advance directive." There is no doubt, therefore, that Peter Jackson J will have been made aware of the arguments that ran counter to the view he ultimately formed. Mr Gordon advances four respects in which he says the judge went wrong, namely: (1) he failed to recognise that PDOC patients are distinct from other patients, (2) he mistakenly attributed the delay to the proceedings when the majority of it appears to have been caused by other factors, (3) he failed to see that matters are very different when an advance decision has been made pursuant to section 24 of MCA 2005, and (4) he failed to recognise that if there is no requirement for court involvement, the article 2 requirement identified in *Lambert v France* for regulations compelling hospitals to adopt appropriate measures for the protection of patients' lives will not be satisfied. For the most part, these are issues which arise as part of the Official Solicitor's argument before this court and the reasons why I do not find them compelling will therefore appear in due course.

102. There being, therefore, in my view, no requirement in domestic law for an application to court of the type that the Official Solicitor says is imperative for the protection of patients, the next question is whether the ECHR generates a need for an equivalent provision to be introduced. To my mind, the answer is a clear "No".

103. The first port of call is the "landmark Grand Chamber case" of *Lambert v France* on the French collective procedure which, it will be recalled, provided for the doctor to take the decision, with no application to court required, yet satisfied the ECtHR as being sufficiently protective of the articles 2 and 8 rights there engaged. I set out in a little detail earlier (para 71) what the French procedure required and it bears a significant resemblance to the procedure set out in the medical guidance in this country. In each case, the context for the decision is similar in that the French article R.4127-37 para I says that the doctor can decide to withhold or discontinue treatments "qui apparaissent inutiles, disproportionnés ou qui n'ont d'autre objet ou effet que le maintien artificiel de la vie", and para 5.31 of the Mental Capacity Act Code speaks of cases where "treatment is futile, overly burdensome to the patient or where there is no prospect of recovery." The French code requires the doctor to consult with the care team, and to take into

account any wishes expressed by the patient and the views of people close to him, and the same is required by the MCA 2005 and the medical guidance here. An independent consultant's opinion is required in France and should also be sought in this country. The court is available if necessary in France as it is here.

104. As I have said, *Lambert v France* was not a central feature of the Official Solicitor's written case, but as he developed his argument in oral submissions, Mr Gordon sought to distinguish the decision on the basis that France has a formally prescribed procedure "with guarantees" and we do not. To comply with the ECHR, a system must have a prescribed procedure, he says, and the sort of professional guidance that we have in this country will not suffice.

105. The ECtHR has repeatedly set out certain factors that it considers relevant to the question of administering or withdrawing medical treatment. They can be found in para 143 of *Lambert v France* (see para 69 above), and also in *Glass v United Kingdom*, *Burke v United Kingdom*, *Gard v United Kingdom*, and *Afiri and Biddarri v France*. The first of those factors is "the existence in domestic law and practice of a regulatory framework compatible with the requirements of article 2", which no doubt is (quite properly) the foundation of Mr Gordon's submission that a prescribed procedure is required. Where I differ from Mr Gordon is in his assertion that the system in this country is not what the ECtHR was looking for. True it is that in France there is a comprehensive legislative framework, set out in the *Code de la santé publique*, whereas the same cannot be said for our domestic law. However, we too have provisions designed to protect the human rights of patients and their families, and I have no difficulty in viewing the combined effect of the MCA 2005, the Mental Capacity Act Code, and the professional guidance, particularly that emanating from the GMC, as a "regulatory framework".

106. The basic protective structure is established by the MCA 2005, which I have described above. An advance decision about life-sustaining treatment can be taken in accordance with sections 24 to 26 and will be respected. Similarly, a proper role is established for lasting powers of attorney by section 9 and the other sections associated with it. Where the decision is taken by a doctor, section 5 establishes the conditions that must be satisfied if the doctor is to be protected from liability. It directs the focus firmly to the best interests of the patient, and that imports the provisions of section 4 which include taking into account the perspective that the patient would have on the decision if he had capacity and the views of those with an interest in the patient's welfare. Section 4(5) imposes the safeguard that the person making the decision must not be motivated by a desire to bring about his death. Section 37 makes provision for an IMCA to represent

the patient where appropriate, and sections 15 to 17 ensure that application can be made to court for a decision about the patient's welfare where necessary.

107. Notwithstanding the contradictions in it with which I have already dealt, the Code contains valuable guidance, and regard must be had to it by virtue of section 42. The passages that I referred to earlier are only a small fraction of the Code but it will be noted from them that, for example, it commends multi-disciplinary meetings when making healthcare and treatment decisions, and speaks about recording decisions and the reasons for them. It also expressly provides (see para 5.31, quoted above) that when making decisions regarding life-sustaining treatment, healthcare and social care staff should refer to relevant professional guidance. Given the statutory framework within which the GMC operates, I would single out its guidance to the medical profession as undeniably part of the established regulatory framework. As I have set out above, it has provided its own individual guidance in 2010, and has joined with the BMA and RCP to provide supplementary Interim Guidance in 2017, with final guidance planned for 2018.

108. The second of the factors to which consistent reference has been made by the ECtHR is whether account has been taken of the patient's previously expressed wishes and those of people close to him, as well as the opinions of other medical personnel. The MCA 2005 requires this to happen, and is reinforced by the professional guidance available to doctors.

109. The third factor that features consistently in the ECtHR's evaluation is the possibility of approaching the courts in the event of doubts as to the best decision to take in the patient's interest and, of course, that possibility exists in this country. As Peter Jackson J said in *In re M (Incapacitated Person: Withdrawal of Treatment)* at para 38, "those considering withdrawal of CANH should not hesitate to approach the Court of Protection in any case in which it seems to them to be right to do so". The opportunity to involve the court is available whether or not a dispute is apparent, and is of particular benefit where the decision is a finely balanced one. No one would discourage an application in any case where it is felt that the assistance of the court would be valuable. And if a dispute has arisen and cannot be resolved, it must inevitably be put before the court.

110. Mr Gordon characterises *Lambert* as a case about the facts, which tells us nothing about first principles. He submits, also, that the article 6 argument that he advances was not put to the court in this or any of the other ECtHR cases. This is not how I see the case of *Lambert* or the ECtHR jurisprudence generally. The

Lambert decision forms part of a consistent line of Strasbourg decisions and it tells us, in my view, that the ECtHR does not regard it as problematic, in principle, that a decision to withhold or withdraw CANH from patient with a prolonged disorder of consciousness should be made by a doctor, without obligatory court involvement.

111. If there be any doubt about the implications of this for the present case, reference to *Burke v The United Kingdom* removes it. The ECtHR was there required to consider our domestic provisions, even before they were bolstered by the MCA 2005, specifically focusing on the GMC guidance then in force. Breaches of articles 2, 3, 8 and 14 were alleged, and it was one of the applicant's complaints that the GMC guidance failed to spell out a legal requirement to obtain prior judicial sanction. The ECtHR proceeded upon the basis that article 2 imposes positive obligations on the State to make regulations compelling hospitals to adopt appropriate measures for the protection of their patients' lives, yet no suggestion was made that such regulations were lacking in the United Kingdom. The argument that there was insufficient protection because a doctor might decide to withdraw CANH without being under an obligation to obtain the approval of the court was expressly rejected, and I have already cited (see para 33 above) what the ECtHR said in so doing. Recognising the practical realities, it observed that a "more stringent legal duty" would be "prescriptively burdensome", resulting in some medical staff being "constantly in court", and "would not necessarily entail any greater protection".

112. As for the Official Solicitor's article 6 argument, even if that particular argument was not put before the ECtHR in terms, the question of hearing rights was an obvious component in the arguments that were advanced in *Burke's* case, and there is no reason to suppose that the outcome would have been different if there had been a specific article 6 complaint. The same might be said of *Lambert's* case, where article 6 was indeed referred to, but only by way of a complaint that the doctor who took the decision was not impartial, not as part of a wider argument that court involvement is required in every case.

113. Moreover, I would accept Mr Sachdeva's argument that what engages article 6 is a disagreement or a question of law and/or fact in dispute, and that, in the light of the safeguards to be found in the MCA 2005 and the Code, together with the professional guidance, there is no basis for the Official Solicitor's suggested approach of engaging article 6 by *assuming* in every case that there is a dispute.

114. Of the Official Solicitor's ECHR arguments, it only remains to deal with article 14. It is not in point, in the present case, in my view. The analogy that Mr Gordon seeks to draw between someone in Mr Y's position and a person with capacity who seeks assistance in bringing his or her life to an end is not a proper analogy. There is, as Mr Sachdeva says, a critical distinction in both the domestic and the Strasbourg jurisprudence, between an act which constitutes the intentional taking of life and therapeutic abstention from treatment. We are presently dealing with the latter, whereas assisted dying concerns the former. It is worth observing also that an article 14 argument was advanced in *Burke's* case before the ECtHR and was rejected as manifestly ill-founded. The argument was to the effect that the applicant was treated less favourably on account of his disease than others who need CANH but are not suffering from a disease that causes them to lose competence to influence their treatment. The court observed that neither a competent nor an incompetent patient can require a doctor to give treatment that the doctor considers is not clinically justified, thus no difference of treatment arises. In so far as a competent patient is able to participate in the consultation process and an incompetent patient is not, the court said that the patients are not in a relatively similar situation.

115. It remains to stand back from this intense focus upon the law, in order to consider the issue in its wider setting. In so doing, it is necessary to exercise the restraint that is required of a court when it ventures into areas of social and ethical uncertainty, and especially when it does so in the abstract, setting out views which will be of general application (as is necessarily so in this case) rather than resolving a clearly defined issue of law or fact that has arisen between the litigants appearing before it. Lord Goff remarked, in the passage at p 871 of the *Bland* case which I have set out at para 22 above, upon how frequently doctors have to make decisions which may affect the continued survival of their patients, and how experienced they are in this respect. Judges have also developed experience in dealing with life and death decisions, but it is experience of a different sort from that of the medical team which actually treats the patient, and of the professional bodies responsible for regulating and guiding them, and this limitation must be recognised and taken into account. It has been of particular assistance to have, from the written submissions of the intervenors, an insight into the practicalities of caring for patients who are critically ill, and also some idea of the large number of patients who might be affected in some way by the decision in the instant case.

116. It is important to acknowledge that CANH is more readily perceived as basic care than, say, artificial ventilation or the administration of antibiotics, and withholding or withdrawing it can therefore cause some people a greater unease. However, it was decided as far back as the *Bland* case that CANH is in fact to be

seen as medical treatment. It is not easy to explain, therefore, why it should be treated differently from other forms of life-sustaining treatment, and yet that is the consequence of the legal position for which the Official Solicitor contends.

117. Furthermore, the Official Solicitor's focus is on only one sub-set of patients who are, for one reason or another, unable to take their own decisions about their medical care and in respect of whom life-sustaining treatment is under consideration. This is a point that Peter Jackson J made in *In re M (Incapacitated Person: Withdrawal of Treatment)*, and it emerges with some force from the written submissions of the BMA and of the ICS and the FICM. It is not only those, such as Mr Y, who suffer an acute episode and are then stabilised, who may require CANH. The need for it can arise also, for example, in the advanced stages of a degenerative neurological condition such as Huntington's disease or multiple sclerosis, or in the advanced stages of dementia, where there may be a recognised downward trajectory. Presently, the BMA say, in the case of patients who have suffered a severe stroke, or are significantly cognitively impaired but conscious, or are suffering from a degenerative neurological condition or other condition with a recognised downward trajectory, decisions to withhold or withdraw CANH are made on a regular basis without recourse to the courts. The BMA can see no principled or logical reason for requiring court review in relation to patients with PVS and MCS but not for a patient with a different condition. Similarly, it can find no logical reason why one form of medical treatment, CANH, is treated differently from other forms of medical treatment such as artificial ventilation.

118. The submissions of the ICS and FICM are illuminating as to what occurs in units delivering critical care to patients. Most admissions to such units occur as an emergency, without the patient having made any advance decision about treatment, and possibly already so unwell that he or she has impaired consciousness or is unable to communicate wishes. Most decisions relating to medical treatment in the critical care setting, including as to whether life-sustaining treatment is withheld or withdrawn, have to be made without the participation of the patient. They are, we are told, "almost invariably taken on the basis of (in England & Wales) best interests and (in Scotland) benefit, on the basis of consensual decision-making as between the clinical team and the patient's family and carers". In that critical care setting, CANH is not considered differently from any other form of life-sustaining treatment. This is said to reflect "the reality in critically ill patients that it is the withdrawal of invasive or non-invasive ventilation, vasoactive medical and renal replacement therapy, and the 'double effect' from administration of medications to ensure patient comfort towards the end of life, that leads to the natural death of the patient, rather than cessation of CANH." It is likely, where CANH is withdrawn from a patient who is

clinically stable but suffering from a prolonged disorder of consciousness, that death will result from the withdrawal of CANH, so to this extent there is a difference between the two groups of patients. However, once CANH is seen as medical treatment, there is a parallel between the cases.

119. In any event, I have difficulty in accepting that there are readily apparent and watertight categories of patient, with PDOC patients clearly differentiated from, say, patients with a degenerative neurological condition or critically ill patients, in such a way as to justify judicial involvement being required for the PDOC patients but not for the others. The dilemmas facing the medical team and those close to the patient may well be very similar in each of these cases. It would be a mistake to think, for example, that the intensive care doctor simply does whatever is necessary to stop the patient dying, no matter what the cost to the patient, any more than does the doctor looking after a PDOC patient or the stroke patient or the patient with Huntington’s disease. In all of these cases, the medical team take their decisions as to treatment, whether it is CANH, or some other form of treatment such as artificial ventilation or cardio-pulmonary resuscitation or the administration of antibiotics, by determining what is in the patient’s best interests. In so doing, the doctors will often have difficult diagnoses to make, reaching a prognosis may be challenging, and the evaluation of the patient’s best interests may not be entirely straightforward. All these tasks may call for considerable professional skill and individual judgement.

120. Furthermore, although the Official Solicitor submits that it should be possible, with proper case management, to obtain a decision from the court speedily, giving an example of a case which was concluded within eight weeks, I fear that that is an over-optimistic view of the situation. I note that even in that case, the delay would have been about six weeks longer had it not been for the parties shortening their time estimate (it would seem in part by removing from it the time for the judge to prepare the judgment) and another case coming out of the judge’s list. Even allowing for Peter Jackson J to have over-estimated the precise period of delay in obtaining an order in *In re M (Incapacitated Person: Withdrawal of Treatment)*, the facts of that case exemplify the dangers. The pressure of business in the courts charged with handling such cases is significant and delays are almost inevitable.

121. As King LJ observed in *In re Briggs*, quite apart from the pressure that court cases place on the overstretched resources of NHS trusts, they add greatly to the strain on families facing acutely distressing decisions. In a case where all the proper procedures have been observed and there is no doubt about what is in the best interests of the patient, there is much to be said for enabling the family

and the patient to spend their last days together without the burden and distraction, and possibly expense, of court proceedings. In addition, I do not disagree with Peter Jackson J's observation that there is a risk that the need to go to court might deflect clinicians and families from making true best interests decisions and might lead in some cases to inappropriate treatment continuing by default. Equally, it is not inconceivable that it might, as the BMA suggest, generate a reluctance, in some cases, to start CANH because of the procedures attending its withdrawal.

122. The Official Solicitor submits that the challenges of diagnosis have increased since the *Bland* case, rather than the way becoming clearer as might have been expected. The difficulties in diagnosis are underlined in the submissions of the intervenors, "Care Not Killing", and the report of Professor Sturman which accompanies them, but are also apparent from other material available to us.

123. Medical science, continually developing, cannot always provide answers, and greater knowledge can produce yet more questions. Developments in this area of medicine include the ability to differentiate between vegetative state and minimally conscious state, and improvement in the outcomes for some individual patients. These changes inevitably create new challenges of diagnosis and management, new uncertainties, for the medical profession.

124. The situation is not, however, on a par with that which faced the House of Lords in the *Bland* case. The survival of patients such as Anthony Bland, then so unprecedented, is now a well-established feature of medical practice. The documentation supplied to us shows that the difficulty that there is in assessing the patient and in evaluating his or her best interests is well recognised. The process is the subject of proper professional guidance, covering vitally important matters such as the involvement in the decision-making process of a doctor with specialist knowledge of prolonged disorders of consciousness, and the obtaining of a second opinion from a senior independent clinician with no prior involvement in the patient's care. The second opinion, as contemplated in the guidance (see paras 79 and 80 above, for example), is, in my view, a crucial part of the scrutiny that is essential for decisions of this sort, and the guidance sets parameters which should ensure that it is an effective check, in that the clinician who provides the second opinion must (so far as reasonably practical in the circumstances of the case) be external to the organisation caring for the patient, and is expected to carry out his or her own examination of the patient, consider and evaluate the medical records, review information about the patient's best interests, and make his or her own judgement as to whether the decision to withdraw (or not to start)

CANH is in the best interests of the patient. Thus the interests of patients and their families are safeguarded, as far as possible, against errors in diagnosis and evaluation, premature decisions, and local variations in practice.

125. If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient’s welfare, a court application can and should be made. As the decisions of the ECtHR underline, this possibility of approaching a court in the event of doubts as to the best interests of the patient is an essential part of the protection of human rights. The assessments, evaluations and opinions assembled as part of the medical process will then form the core of the material available to the judge, together with such further expert and other evidence as may need to be placed before the court at that stage.

126. In conclusion, having looked at the issue in its wider context as well as from a narrower legal perspective, I do not consider that it has been established that the common law or the ECHR, in combination or separately, give rise to the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn. If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court. I would therefore dismiss the appeal. In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases.