Neutral Citation Number: [2023] EWCOP 34

Case No: COP14090486

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/08/2023

Before :

MRS JUSTICE THEIS DBE

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Between :

	Kings College Hospital NHS Foundation Trust	**Applicant**
	- and -	
	X (by his Litigation Friend, the Official Solicitor)	**1st Respondent**
	- and -	
	Y	**2nd Respondent**

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Ms Victoria Butler-Cole KC (instructed by **Hill Dickinson LLP)** for the **Applicant**
Ms Katie Gollop KC (instructed by **The Official Solicitor)** for the **1st Respondent**
Ms Olivia Kirkbride (instructed by **Irwin Mitchell LLP)** for the **2nd Respondent**

Hearing date: 4th August 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 4th August 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE THEIS DBE

This judgment was delivered in public and the proceedings are subject to the Transparency Order dated 4th August 2023. The anonymity of X must be strictly preserved and nothing must be published that would identify X, either directly or indirectly. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Theis DBE :

Introduction

1. This matter concerns an application by Kings College Hospital NHS Foundation Trust ('the Trust') for permission to withdraw life sustaining treatment from a young man, X, age 27 years.

2. The tragic circumstances of this case are that X was involved in a car accident in January 2023. He suffered catastrophic injuries to his brain and brain stem, when the car he was travelling in hit a tree. By the time the paramedics arrived and he was free from the car, his brain had been deprived of oxygen for a considerable period of time. The paramedics were able to bring back his absent pulse and resuscitate him. He was taken to hospital by air ambulance and shortly after his arrival was admitted to the intensive care unit ('ICU'), where he has remained since. In addition to the significant brain damage he suffered caused by lack of oxygen, X sustained damage to his cervical spine and his spinal cord at the same high level. X is considered by all the doctors who care for him, together with those who have provided a second opinion, to be in a persistent vegetative state. The Trust consider that it is not in his best interests to continue treatment, as they do not consider there is any prospect of him recovering and, if anything, they have observed a decline in his condition. He is kept alive by mechanical ventilation, artificial nutrition and hydration and supportive round the clock nursing care involving washing, turning and suctioning of tracheal secretions.

3. X's father, Y, and members of his family do not support this course. They are devastated by what has taken place. Prior to this accident X was a larger than life character, in a long term relationship with two young children. He was devoted to his family, as they are to him. They want him to have more time and have observed some signs of response through opening his eyes and moving his head in response to requests. They feel strongly that X would have wanted his life to be sustained, so he could continue to fight to remain with his family. X's father, aunt, uncle and grandmother have been present during this hearing. They have listened carefully to the evidence and have conducted themselves with enormous dignity when the case and the evidence has involved someone so loved by them.

4. It is against this desperately sad background, that it is necessary for the court to consider the evidence and determine what is in X's best interests.

5. X is represented through his litigation friend the Official Solicitor. The Official Solicitor recognises this is a finely balanced case and fully understands why the family feel as they do, recognises the strength of that feeling but standing back, accepting the medical evidence and considering all the evidence, supports the application made by the Trust. As Ms Gollop K.C. submits, the determinative factor for the Official Solicitor was what is the benefit of continuing the treatment for X other than a continuation of his life that he is unaware of, and that is unlikely to change.

Relevant legal framework

6. There is no evidential issue between the parties that as a result of his injuries X lacks capacity and, as a consequence, the court is required to consider what is in his best interests having regard to the matters set out in s 4 Mental Capacity Act 2005.

7. The legal framework is helpfully set out in the written submissions of Ms Butler-Cole K.C. and Ms Kirkbride.

8. This requires the court to undertake a holistic evaluation of the relevant factors from X's perspective, including his past wishes and feelings, the beliefs and values that would likely to influence his decision if he had capacity, any other factors he would consider and the views of others, including his family.

9. The court needs to carefully weigh in the balance the medical treatment, whether it is futile in the sense of being ineffective or being of no benefit and where the patient will be unable to survive, even with treatment, such that continuation cannot be in the patient's best interests (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at [40]-[43]).

10. The court also needs to consider whether the medical treatment can cause physical harm to a patient, even if they have no conscious awareness and no capacity to feel pain. In *Parfitt v Guy's and St Thomas' Children's NHS Foundation Trust & Anor* [2021] EWCA Civ 362 the court approved of Poole J's welfare analysis in the judgment below, where he factored in that the patient's loss of conscious awareness does not mean that those interventions (suctioning etc) can be wholly disregarded. As he observed at [76] '*The fact that a person has no conscious awareness does not give their clinicians, or anyone else, licence to perform procedures on them irrespective of their benefit'*.

11. Ms Kirkbride summarised the issues the court needs to consider:

    (1) The best interests analysis must be considered from the perspective of the individual patient – it should be a holistic analysis and not just limited to the medical evidence.

    (2) There is a strong presumption of preserving life which must be carefully balanced.

    (3) The court must carefully consider X's wishes and feelings, again with an eye to the wide evidential canvas, looking at and taking into account X's views as expressed in the past.

    (4) The court must consider the issues of human dignity, factoring in and properly weighing in the balance the cultural and religious context.

The evidence

Medical

12. The evidence on behalf of the Trust is provided by Dr AC, an Intensive Care Consultant, who has overseen X's care in the ICU since he was admitted. She has provided two statements and gave oral evidence. In addition, there is a statement from Sister TS who has overseen the nursing care for X since he was admitted. She too gave oral evidence.

13. X suffered a severe hypoxic brain injury due to the period of time he was unconscious and his brain starved of oxygen.

14. Investigations conducted by the medical team revealed as a result of the injury X has no function above or below the brain stem. The medical evidence is that there is a limited amount of function which controls his blood pressure and heartrate, but there is no ability for him to regain consciousness, or to move again.

15. X has remained unconscious throughout the six months he has been in ICU. There are periods of instability related to the suctioning of his airways and cough assist, to help clear his airway secretions, and when he is being turned and repositioned in bed. Sister TS said in oral evidence that happened about 3 or 4 times a day, when they would have to pause the re-positioning to allow his heart rate to rise again. This results in his heart stopping for about 30 seconds, followed by spontaneous return of the heartbeat. Due to the extent of his spinal and brain stem injuries he is completely dependent on the ventilator, as he is not able to initiate a breath on his own.

16. X's brain does not appear on the EEG recordings to respond to painful stimuli, although it is impossible to assess his pain levels. He is observed to occasionally grimace and chews on his endo-tracheal tube, which is behaviour observed in patients in a vegetative state.

17. The medical team have undertaken various tests including 6 EEG tests over a six week period, the last one for over 18 hours, which revealed a deteriorating position. The last extended one revealed non reactivity and loss of normal sleep pattern. Dr AC considers this demonstrates how little reserve there is to maintain cerebral function and how precarious X's condition is. Ms Kirkbride asked about comments in one of the later EEG reports regarding response to stimuli, Dr AC responded that the wider clinical picture is what needs to be considered and this accords with the Royal College of Physicians National Clinical Guidelines 'Prolonged disorders of consciousness following sudden onset brain injury' section 2.2.2.

18. Dr AC describes in her statement that she has not experienced a patient with this combination of high spinal injury and hypoxic brain injury. In her experience such injuries usually result in death at the scene of the accident. She describes that X is only alive due to the interventions given and her opinion is he is in a persistent vegetive state. She states *'He is colonized with resistant bacteria. His arms and legs are in contractures. He has lost a lot of muscle mass and is not able to move. His skin is fragile and he has developed skin ulcers which are difficult to heal'.* In her oral evidence she recognised X's weight is not an issue, but said that is different to loss of muscle and agreed recent bed sores had healed. In her opinion, if ventilation is withdrawn X would die within a few minutes, as he is unable to breathe on his own.

19. In her opinion, if X continued as he is, she considers in the best case scenario he would remain in the same vegetative state in ICU for months before he dies, either from an event of cardiovascular instability or infection and severe sepsis. She is not able to predict his life expectancy. Patients in a vegetative state who are able to breathe independently tend to have a life expectancy in ICU of between 12 – 18 months. As X is unable to breathe independently, she considers his life expectancy is much less, as the risk of infection is higher with mechanical ventilation.

20. In her most recent statement Dr AC notes that X's pupils have stopped reacting to light and they have become fixed and dilated. She considers this is a clinical sign of further loss of brain stem function. Ms Kirkbride asked her about this in the context of the videos produced by the family, which appear to show X moving his head and opening his eyes. She said what she was referring to was reaction to the pupil to light, which is different from opening of his eyes as seen in the video. The second statement provides an update about the ceiling of treatment and the treating team's view that they would only consider further treatment/interventions if a clinical need became apparent. For example, if X's heart stopped beating he would not be given cardio-pulmonary resuscitation (CPR) as it would be very unlikely to be effective in re-starting his heart for more than a very short period. If he contracted an infection antibiotic medication would not automatically be given and it would require careful assessment of the consequent ICU interventions that would be required, like the insertion of a central venous line.

21. In Dr AC's opinion, the key factor is the neurological presentation. In her view X *'has no awareness of the world around him and no prospect of treatment or recovery from his brain and spinal injuries. He is in a vegetative state at the lowest end, on the border with coma. There has been no improvement in 5 months in ICU, but some signs of deterioration. In this sense there continues to be no possibility that he can benefit from the treatment on which he relies to stay alive and keep his heart beating.'*

22. Sister TS's statement provides details of the nursing care undertaken, including to prevent X having pressure sores. He requires turning 3-4 hourly, at a minimum, but that is dependent on his cardiovascular and respiratory stability. It requires four members of staff to do this as his head and neck have to be supported by one member of staff to maintain his airway and prevent dislodgment of the breathing tube. He receives continuous nutrition via a nasogastric tube via a feeding pump, which requires regular checking. As X is fully dependent on a ventilator he requires a high degree of care. There is frequent suctioning, he has no cough reflex so requires chest physiotherapy to clear secretions as well. This is to avoid the risk of respiratory infections. As she describes in her statement '*Staff find this a very emotional and tragic case. They sympathise with the family's situation and continue to deliver kind and compassionate care'*.

23. The Trust has sought a second opinion from a number of specialists.

24. Dr W is a Consultant Neurologist and reviewed X on five occasions between February and March 2023. She noted a deterioration in the EEGs that were performed over that time. She arranged for a second opinion from Dr B, also a Consultant Neurologist, who shared Dr W's view that the overall neurological prognosis remains *'very grave'* from either the brain injury, or the cervical cord injury. In his last review in April 2023 Dr B concluded there was no realistic prospect of a meaningful recovery.

25. X has also been assessed by the neurosurgical team. He has been reviewed by Mr A, Consultant Spinal Surgeon, who reviewed the MRI scan results. The consensus was the best possible outcome for X would be a minimally conscious state, quadriplegia and ventilator dependence.

26. A second opinion was sought from an external consultant in critical care at another hospital, Dr H (Consultant in Critical Care and Neuroanaesthesia). She has a special interest in neurotrauma. She concluded that she did not consider X would neurologically improve to a level where he is able to interact with his surroundings, comprehend language or have awareness of self. She considered his cardiovascular condition will likely deteriorate, which has implications for the viability of any care outside the ICU.

27. The Trust have looked for and considered the possibility of care outside the ICU. Professor TS is a Consultant in Rehabilitation Medicine and Director of the Regional Hyper-acute Rehabilitation Unit at another hospital. She examined X in April, talked to his treating team and considered the records including notes of discussions with the family. Her conclusion was that due to the combination of his profound injuries to both the brain and the spinal cord, he would not be able to be cared for outside a hospital or ICU setting. She has reviewed the videos that have been submitted by the family and provided a detailed analysis of the information she saw and concludes that in her opinion all of the movements observed are either spontaneous or reflexive and thus compatible with a vegetative state. She recognises the eyes may be sensitive to light but they open only fleetingly with frequent blinking. When his eyes open there is no evidence of tracking or fixation for any significant period of time. She notes *'It is entirely understandable that a lay person would interpret these as evidence of conscious interaction, but sadly there is nothing in [the videos] that indicates any clear interaction above the level of vegetative state'*.

28. It is right to note that permission was given for X's father to seek a second opinion in the field of neurorehabilitation, neurology or intensive care. That has not been possible and no application is made to further adjourn this hearing.

29. The statements from the Trust set out the discussions the medical team have had with X's family, on at least six occasions between February and May 2023, to discuss with them the options for X's future care. X's family, understandably, could not agree with the medical team's assessment of what they considered was in X's best interests.

The family

30. X's father has provided a statement that has attached to it statements from his three sisters and a brother, X's aunts and uncles. In addition, he has attached photos of X, showing him with his children and with the wider family. The picture painted of X by his father is someone who embraced life and went out of his way to make friends from a very early age. He was devoted to his children, in the words of his father he was a *'fantastic father',* he was a proud father and committed to his partner who he had known since they were at school. He was a hard working son, partner and father and an integral part of the wider family. Tragically his mother, who was devoted to him as he was to her, passed away earlier this year.

31. X's father states *'I know that [X] would not want to give up on life. He is not the sort of person to let go. Why I say that is because he would say he wants to live for his family, and especially for his children'*.

32. He continues that there is evidence of this fighting spirit in X from the videos he has produced. There are four videos of X in the ICU where the father says X moves his

head, following requests to do so from his father, and is able to open his eyes. These videos were taken between the end of May to end of June. He confirms that although X was not a practising Christian he was brought up in the Christian faith, which is important to his wider family and that faith does not support the Trust's application as they believe people should go naturally.

33. He comments on the high quality of nursing care being given to X, although would like there to be more time spent with him as he is concerned about the amount of time X is on his own. The family visits twice a week and spend time talking to and caring for X.

34. He expresses concern about no up to date scans, no evidence of pain levels and refers to the reactions X has to voices – most recently his grandmother's during a recent visit when the father says X opened his eyes when he heard his grandmother's voice. He believes X has some level of consciousness and disagrees with the assessment that X's pupils are fixed and dilated, he has observed X look at him.

35. In his statement he says *'All I am asking is for [X] to be given more time.'* He gave oral evidence with enormous care and obvious devotion to X. His close and loving relationship with his son was clear. He thinks that X would say 'don't let me go'; he would want to be with his family.

36. The statements from X's aunts and uncle paint a picture of X as a larger than life character, adored by his family, a gentle, loving, caring and family orientated person.

37. The final piece of evidence is the statement the court has from the Official Solicitor's representative who went to see X on 27 July 2023. He was able to spend time with X and discuss his care with the treating team.

Submissions

38. On behalf of the Trust, Ms Butler Cole submits the medical evidence is clear. X is in a persistent vegetive state, very sadly any further treatment is futile and he has no prospect of returning to a recovered state, either physically or any level of consciousness due to the extent of his injuries. She submits, put simply, there is no evidence that continuing the interventions will bring about any benefit to X. She submits, the sad reality is that he will remain in ICU until he dies either from an infection or heart failure. Is it in his best interests to continue providing the treatment to him in those circumstances? She recognises the family believe X may recover, and if that is right withdrawing treatment would not be the right thing to do, but the medical evidence is clear, there is no realistic prospect of his medical condition changing.

39. Ms Butler Cole has referred the court to the RCP Guidelines regarding responses to stimuli. The evidence from Professor TS, she submits, is clear that what is observed on the videos and by the family is reflexive, which is consistent with a vegetative state. The movements are not purposeful or discriminating behaviour.

40. As regards the evidence of burdens, she submits the court needs to be careful about the evidence regarding pain. The fact that it is not observed does not necessarily mean

it is not present and some features of the treatment X is receiving carries with it a burden.

41. Ms Kirkbride, on behalf of X's father, stresses the importance for the court to weigh in the balance the Christian faith within the family, the way X was loved and involved within his family. All the evidence points towards X being a person with a determined and resilient nature, and the court can infer from that that he would want more time. She submits there is limited, if any, evidence of pain which the court must properly weigh in the balance together with the interventions in this particular case. This is not a case where there are repeated significant interventions as part of X's day to day care. She described it as being relatively 'light touch', compared to other cases and, as a consequence, would support ongoing treatment, as it is not overly burdensome or painful.

42. She submits the benefits to X are that he would have more time, he is a family man who takes pride in his children, is a true fighter and the benefits of there being further time, possibly for further testing, should be properly weighed in the balance in this exceptional case.

43. On behalf of the Official Solicitor, Ms Gollop emphasised how the Official Solicitor considered this case to be finely balanced. She understands how the family must feel when, notwithstanding the extent of his injuries, X was admitted to ICU and that such an admission must have meant the medical team assessed that he would benefit from such care. Six months have now passed and the family are being informed he would not benefit from continuing such care. In those circumstances, it is understandable that they should feel such care should continue. As regards the issue of burdens, she submits there is no compelling evidence that the continuation of the treatment is burdensome. She recognises the evidence about the change in heart rate and the impact of X being administered the treatment, such as the sores in his mouth from the breathing tube, but that on its own would not be enough. Part of care in an ICU involves the burdens of treatment.

44. The Official Solicitor accepts the medical evidence that X has no awareness of himself or of the world around him. For the Official Solicitor she has to consider what is the benefit the continuation of treatment provides, other than a continuation of something that cannot be a benefit to him, due to his lack of awareness. As a consequence, when considering all the evidence and expressing profound sympathy for the family, she considers that she is unable to submit that the continuation of treatment is in X's best interests.

Discussion and decision

45. These cases are the most difficult the court is required to consider, where it is necessary to undertake a careful balancing exercise in order to ascertain what is in X's best interests. The outcome is a binary choice.

46. Due to the extent of his catastrophic injuries, X has no capacity to make decisions himself which is why that decision is required to be made by the court, bearing in mind the considerations in s4 MCA 2005.

47. Very sadly, the medical evidence points in one direction. Consequent on injuries to his brain and spine he is in a persistent vegetative state. I accept the medical evidence. Dr AC and her medical team, including Sister TS, have provided dedicated 24 hour specialist nursing care. They have undertaken extensive investigations, not only within their own hospital team, but also, quite properly, sought external specialist advice from other hospitals. They all speak with one medical voice. From X's perspective that means he has a lack of any awareness of himself or his surroundings. He is wholly dependent on the treatment he is being given regarding ventilation, nutrition and all other aspects of his care.

48. It is very understandable, from a lay perspective, that the movements of his head and the opening of his eyes on the video evidence seen by the court would be considered by the family as a response to stimuli or familiar voices. However, the expert medical evidence, which I accept, is that those are spontaneous and reflexive movement which is compatible with a vegetative state, rather than any level of consciousness by X, and accords with the RCP guidelines.

49. It is right that X has defied predictions, bearing in mind the severity and extent of his injuries. This has understandably given the family hope that he will recover and that these movements are early signs of this. Very regrettably, the medical reality is that is not the case.

50. I recognise that there is a strong presumption of sustaining life. It is not surprising that there is limited evidence about X's wishes if he found himself in this position, due to his young age and positive outlook on life generally as described by his family. He loved his family, as they in turn loved him. He came from a strong supportive family, he clearly adored his children and in all likelihood would want to be with his family. This would accord with the evidence from his wider family and the religious beliefs he had along with the wider family.

51. As regards the burdens of continuing treatment, there is no direct of evidence of pain being experienced by him. By definition there are intrinsic burdens to being cared for on ICU and the interventions that are necessary in such care. In this case there is evidence of relative stability in one sense due to the interventions, but there is equally evidence of considerable instability regarding X's condition as part of his care, such as the frequent drops in heart rate.

52. I agree with the final analysis of the Official Solicitor that in the light of the evidence regarding the X's medical condition, his lack of awareness and factoring in the likely wishes he would have to be with his family, the strong presumption of sustaining life and the limited evidence of pain, there is, in my judgment, overall no benefit to X in continuing the treatment, due to his lack of awareness and the bleak medical prognosis. In those circumstances, his best interests are met by the withdrawal of treatment.

53. I fully accept that this is not the decision his family want but I have to stand back, look at all the evidence and balance all the relevant matters in reaching my decision. It is with profound regret that I have reached the decision that I have.