



Case No: 12473525

Neutral Citation Number: [2026] EWCOP 23 (T3)

COURT OF PROTECTION
AND IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/05/2026

Before :

THE HONOURABLE MRS JUSTICE LIEVEN

Between :

**NHS KENT & MEDWAY INTEGRATED CARE
BOARD**

Applicant

- and -

OQD

(by his litigation friend, the Official Solicitor)

1st Respondent

- and -

THE ROYAL HOSPITAL FOR NEURO-DISABILITY

2nd Respondent

Eloise Power (instructed by **Capsticks Solicitors**) for the **Applicant**
Sophia Roper KC (instructed by **The Official Solicitor**) for the **First Respondent**
Jake Rylatt (instructed by **Bevan Brittan LLP**) for the **Second Respondent**

Hearing date: 26 March 2026

Approved Judgment

This judgment was handed down remotely at 11:30am on 22nd May 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HONOURABLE MRS JUSTICE LIEVEN

The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven:

1. This is a further judgment in the case of OQD to deal with the issue of delay in properly considering OQD's best interests and in making an application to the Court of Protection. As I explained in the first judgment [2026] EWCOP 16 I wished to produce the substantive decision speedily, given that OQD's family were in the UK over Easter, and so that judgment could focus solely on OQD's best interests. The Second Respondent (the Royal Hospital for Neuro-Disability "RHND") wished for more time to put in a further witness statement on the delay issues. For all those reasons I have produced this judgment separately from that concerned with the substantive issue.
2. I am dealing with the delay in bringing the application to withdraw Clinically Assisted Nutrition and Hydration (CANH) both because of the Court's own concerns about the issue and because the Official Solicitor, who acts on behalf of OQD, has raised considerable concern about the failure of both the Applicant (the ICB) and the RHND to consider OQD's best interests in a timely and effective manner.
3. It is necessary and appropriate to set these concerns out in a further judgment because this is now the fifth case in the Court of Protection at Tier Three (High Court) level raising very similar concerns around the RHND and its approach to the withdrawal of CANH for patients in Prolonged Disorder of Consciousness (PDOC). The evidence suggests that there are systemic issues at the RHND both as to the timeliness of addressing best interests, but also the way the task is being undertaken. I should make clear at the outset that there is no doubt, from any of the cases, that patients are receiving excellent day to day care from all the healthcare professionals, and there is no criticism in that respect. Indeed, it must be in part due to the excellent nursing care at RHND that the longevity of some of these cases, including OQD, is so great.
4. The previous cases are;
 - a. North West London Clinical Commissioning Group v GU [2021] EWCOP 59 (Hayden J as Vice President of Court of Protection (CoP));
 - b. North West London Integrated Care Board v AB [2024] EWCOP 62 (Theis J as Vice President of CoP);
 - c. NHS North Central London Integrated Care Board v Royal Hospital for Neuro Disability and XR [2024] COP 66 (Theis J as Vice President of CoP);
 - d. NHS South East London Integrated Care Board v JP and Royal Hospital for Neuro-Disability [2025] EWCOP 8 (Hayden J). The judgment is dated 26 February 2025.
5. The chronology, in broad terms, is that OQD suffered a very serious assault in in late 2013, which resulted in hypoxic brain damage. He was admitted to the RHND in April 2014. He moved from the Brain Injury Service to the Specialist Nursing Home, both within the RHND, in December 2014. In terms of his neurological functioning, he has been in a Prolonged Disorder of Consciousness (PDOC) throughout his time at the RHND and his neurological condition has not in any material sense changed throughout that period of 12 years. This is confirmed by Dr A, a consultant in neurorehabilitation consultant at RHND, who also states that in his view OQD has been in a vegetative state since his brain injury.
6. I set out in the first judgment a summary of OQD's physical and neurological condition. Two things are apparent. Firstly, his level of consciousness has been very low throughout his time at RHND, consistently scoring at the lower end of the Wessex Head Injury Matrix. Secondly, he has suffered incidents of distress or discomfort over a long period of time, including the "storming", as well as numerous infections and discomforts as a consequence of his condition.
7. Although there is some debate about whether, given he is in a vegetative state, OQD can experience pain, there is no doubt he undergoes a number of "burdens", which I described in the

first judgment. He receives highly skilled and continuous care, which has enabled him to live so long at RHND. When he has storming episodes he has high heart rate, high blood pressure, sweating, fever and muscle movements, which are reduced with medication, specifically opiates.

8. The overall chronology can be split into two parts, before and after the judgment of Hayden J (Vice President of the Court of Protection) in *North West London Clinical Commissioning Group v GU* [2021] EWCOP 59. GU had been admitted to RHND in September 2014 and certainly by August 2018 there was a unanimous view he was in PDOC with no prospect of future change [4]. However, no formal best interest decision had ever been taken [5].

9. Hayden J considered the relevant caselaw and international legal material around the issue of the end of life-supporting treatment and human dignity and withdrawal of CANH in considerable detail. Importantly at [92] under the sub-heading of “Lessons to be learned” Hayden J said;

“Because it was contended by the Official Solicitor that GU's dignity had been so seriously compromised, I invited a response from RHND. I wanted to ensure that delays of this magnitude were not repeated in cases of this kind, or indeed, at all. I also wanted better to understand how the failure to identify GU's best interests had occurred.”

10. I note that in GU’s case the period in which he was at RHND before the matter came to court for a best interests decision was September 2014-November 2021 (7 years). In OQD’s case it is 12 years.

11. It is apparent that in GU’s case the only reason that GU’s best interests were finally addressed was because his brother (E) did not support the continuation of CANH and he ultimately insisted on a best interests meeting [99]. Hayden J was extremely clear about the need for the RHND to focus on the best interests of the patient, and not what is best for the family members;

“The guidance emphasises that the central point to keep in mind is that the decision-making process is about the best interests of the individual patient not what is best for those who are close to, or around them. I was told by the CEO of RHND that the discontinuance of life sustaining treatment in the kind of circumstances arising here causes distress to staff, other patients and their families. It was clearly intended to signal that this was, in some way, a reason to delay the best interests decision-making process. I have no doubt that these cases cause deep distress to others in the hospital. Indeed, it would be concerning if they did not. I have equally no doubt that these considerations have no place at all in evaluating GU's best interests. Factoring these matters into the decision process is both poor practice and ethically misconceived.”

12. Finally, he said at [105];

“This latter point is an important one. The Royal College has issued guidelines, they are to be treated as such and not regarded as set in stone. Consideration of a patient's best interests arises in response to clinically identified need. The need for an assessment is driven by what the patient requires and not confined to the structure of annual review. In simple terms, it requires to be kept in constant and unswerving focus. (see e.g.; Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious Medical Treatment) [2021] EWCOP 51). Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed quite suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance.”

13. I note that judgment was now four and a half years ago. Since *GU* there have been three subsequent judgments on very similar facts exposing very similar problems continuing to arise at RHND and a continuing failure to focus on the patient’s best interests. In *NHS North West*

London Integrated Care Board v AB [2024] EWCOP 62 Theis J (Vice President Court of Protection) was considering an application to withdraw CANH for a woman who had been at the hospital for 9 years in PDOC throughout. Theis J records that Dr Luttrell, the medical director at RHND, said in his witness statement that the Hospital had fully engaged with the criticisms in GU and had undertaken a wholesale systemic review, see [9]. She says, somewhat optimistically, at [13];

“The framework now outlined in Dr Luttrell's statements is a welcome and long overdue development that will ensure the delays in best interest decisions being made for those in PDOC will not occur in the future in the way they did for AB and her family. This includes, importantly, where there is no agreement or the decision is finely balanced for an application to be made to the Court of Protection to be determined.”

14. At [60] –[73] Theis J sets out the various steps that Dr Luttrell explained had been taken, including the Action Plan [64] and the CANH policy [66]. At [67] and [70] she said;

“67. Following the implementation of the RHN CANH Policy the RHN set up the CANH Implementation Group, which both Dr Luttrell and Dr D are members of. This group met fortnightly from its inception in March 2022 until January 2024 and now meets monthly, providing oversight and review to the implementation of the RHN CANH Policy.”

68. To support this work the CANH Clinical Forum was set up to support the clinical teams making these decisions. It meets fortnightly to discuss cases and review the ongoing operation of the processes and systems that are in place which can be fed back to the CANH Implementation Group.”

“70. The work with the ICBs who commission care at the RHN is continuing with the aim of agreeing a protocol which sets out the process for making an application to the Court of Protection in these cases, including timeframes and responsibilities for various actions.”

15. Dr Luttrell had explained that the process was ongoing in respect of 17 patients.

16. Theis J then heard a further case in NHS North Central Integrated Care Board v XR [2024] EWCOP 66. Importantly in that case Theis J focused on the role of the ICB and the need for them to ensure that the care package remains in P's best interests and not be a mere bystander. At [92] Theis J said;

*“In my judgment the ICB has an important, critical role to play. As the Clinical Lead for the ICB set out in her statement 'The ICB will undertake as a minimum an annual review of the care commissioned to **ensure that the care package remains appropriate to meet the service user's assessed needs**' (emphasis added). For these reviews to be an effective mechanism they should include active consideration by the ICB at each review to be vigilant that the care package includes an effective system being in place for best interest decisions to be made in these difficult cases so that drift and delay is avoided. The ICB should not just be a bystander at these reviews.”*

17. Depressingly, there was then yet another case concerning the RHND before Hayden J in NHS SE London ICB v JP [2025] EWCOP 8, where the same issues in the RHND arose yet again. The judgment was given in February 2025. Hayden J referred on a number of occasions to the high level of care (particularly nursing care) being provided at RHND and the fact that the professionals involved were highly motivated to do their best in what are immensely challenging circumstances. However, a number of important points can be taken from that judgment;

- a. The ICB has a critical role, [11]. Hayden J refers back to Theis J's judgment in XR and reiterates the importance of the ICB being proactive.

- b. *“The family are not making the best interests decision nor are they being consulted as to what they think is best”* [11]. The family are consulted to illuminate P’s past and present wishes and feelings (where ascertainable), [11] and [18].
 - c. Hayden J acknowledged the *“determined professional commitment [by the RHD] to correct their approach to reviewing continuation of CANH...However, this case and the two others heard by Theis J, signal that the attitudinal sea change required is not yet complete”*. [23].
 - d. In respect of the attempts in that case by RHND to “broker an agreement” between the family members, Hayden J said at [34];

“I would endorse this submission. There is no onus on the ICB or healthcare providers to broker an agreement between family members. Ms Paterson moots that it might be desirable if there were. On that point, I take a stronger view. That approach risks occluding the nature of the enquiry, which as I have been at pains to identify, is directed towards understanding what P’s wishes and feelings might have been in these circumstances. It is difficult to see how a disagreement amongst those consulted is capable of mediation. The question is ultimately a binary one: would P have been likely to prefer to remain artificially nourished and hydrated or would he have preferred it to be discontinued in circumstances where treatment was ascertainably futile. Mediation in these circumstances risks conflating the family’s views of best interests with the authentic views of P himself.”
 - e. In [35] he said *“Perhaps the loudest signal emerging from this troubling raft of cases is a failure to understand the crucial significance of issuing proceedings promptly”*
18. Returning to the facts of the present case, Dr Luttrell says in his first witness statement says at [13];
- “I apologise on behalf of the RHN that between 2014 and November 2021 (when the GU judgment was handed down), whether continuing to receive CANH was in [OQD’s] best interests was not considered.”*
19. It is of great concern that a hospital can have had a patient for 7 years and fail to consider whether the treatment that was being provided was in their best interests. However, this failure was considered in detail in GU and there is little benefit in this Court repeating what was said there.
20. However, there was then a period of four years and three months (November 2021 to January 2026) between the judgment in GU and an application to the CoP in this case. It is important to emphasise that throughout this period, and indeed for many years before, OQD’s neurological condition has not changed and neither has his prognosis. His broader physical condition has also been generally stable, although with some fluctuations. Therefore, the conclusions that Dr A and Professor Wade have now reached, that it is not in his best interests to continue with CANH, as set out in the first judgment, must necessarily have been the case for many years.
21. The reasons for the delays after November 2021 are set out in Dr Luttrell’s two witness statements. He explains that after GU the RHND implemented a process for undertaking best interests’ decisions making for patients in PDOC receiving CANH. The processes are described in detail and Dr Luttrell emphasises the significant amount of time involved given the large number of patients in PDOC at RHND and the importance of getting the process right for every patient. The decisions require very sensitive and difficult conversations with families of patients. He also refers to the consequences of the pandemic having slowed the process in the period after GU.
22. Discussions in respect of CANH were commenced with OQD’s family in summer 2022. However, at that time OQD’s mother was unwell with terminal cancer so it was decided not to

undertake consultation with the family at the time. Sadly, she died in September 2022, and it was decided to give the family a few months to grieve.

23. In February 2023 consultation with the family was reopened. Dr Luttrell says that the family wanted face to face meetings and this was difficult to arrange as various family members were not in the UK. They also suggested speaking to OQD's ex-girlfriend and other friends. The family referred to "journals" in which they said he had set out his views as to treatment (in relation to his mental health condition) and a desire to live. There is no criticism of the family, but I note these journals or notebooks have never been seen.
24. In summer 2024 (over two years after GU) OQD was very unwell with infections, and it was anticipated that he was unlikely to survive. The family were distressed and therefore the decision making was paused again. However, he recovered and returned to his baseline condition by Autumn 2024.
25. On 25 March 2025 there was a face to face meeting with the family. It became apparent that there was no consensus as to what was in OQD's best interests and that an application to the Court of Protection would be required. On 27 March 2025 there was a referral to the ICB and the RHND began preparing documentation.
26. I turn to the evidence of the ICB, and the witness statement of Elizabeth Saji, who is the assistant head of All Age Continuing Care and Specialist Placements (North Kent) at the ICB. She explains that OQD has been subject to NHS Continuing Healthcare funding since December 2014 and therefore the ICB is responsible for ensuring that the patient's care package meets their assessed health needs. This apparently involves annual reviews.
27. The chronology suggests that these reviews have been inadequate. The ICB appears to have simply relied on the RHND's reviews and undertaken no independent scrutiny or decision making, and no questioning by the ICB as to whether after so many years of being in PDOC providing CANH remained in OQD's best interests.
28. In the 2024 review the ICB was informed by a family member that there was a potential dispute between the family and the treating clinicians. Ms Saji says; *"Unfortunately, there are no records to indicate there were further discussions between the RHN and the ICB."*
29. On 26 March 2025 the ICB received formal notification that a dispute had arisen over OQD's best interests. There was then a strikingly slow process of obtaining records and a second opinion from Professor Wade, who was instructed on 18 September 2025. The detail of the chronology at this stage matters little, but there was no sign of any urgency on behalf of the RHND in providing documentation or facilitating relevant information to Professor Wade. The application to the Court was finally made on 22 January 2026.
30. The sequence of events, since GU, is deeply troubling. That the RHND takes a careful and sensitive approach to these emotionally difficult decisions is both understandable and commendable. I also appreciate that they have a large number of patients in PDOC (there were 70 relevant patients in the cohort being considered after GU and new patients will continue to arrive on a very regular basis). However, the striking absence of urgency which is apparent from OQD's chronology indicates a lack of focus on the patient's own best interests. Throughout those 4 and a half years OQD has been suffering burdens which have ultimately led to a unanimous view of professionals and the Court that CANH should be withdrawn. The RHND (and ICB)'s failure to address the issue timeously has led to the prolonging of these burdens, and the undermining of OQD's human dignity, as explained so eloquently by Hayden J.
31. In my view, a significant issue for the RHND is its focus on the views of the family and on reaching consensus with the family on a decision. As Hayden J sets out in both JP and GU, the

views of the family are sought primarily in order to illuminate what the P would have wished, not for their own sakes. There is a degree to which the RHND appears to have put the views of the family concerned above focusing on the best interests of the patient. This is plainly wrong.

32. There was over a year in this case (February 2022 until summer 2023) when OQD's best interests were not being addressed, whilst the RHND sought the family's views in a not very effective manner. This is clear evidence of putting the family's views, and what was perceived to be their interests, before those of OQD.
33. I am also concerned about the lengthy and in my view misguided efforts to establish what OQD would have "wished" if he had been able to express a view. It goes without saying that P's wishes are a very important part of making a best interests decision under the Mental Capacity Act 2006. They must be given great weight and in many cases they will be determinative.
34. However, by the time of GU, OQD had been in a vegetative state for 7 years with no prospect of recovery. There is no evidence, and there has been no suggestion, that he had turned his mind before the injury to the prospect of any such situation. It would be fairly extraordinary for anyone to do so. In those circumstances there is only so far that P's wishes before losing capacity can take the determination of what is now in his best interests. Even if OQD had expressed a wish to be kept alive as long as possible, it is hard to imagine that he would have contemplated the burdens that have been placed upon him by his injuries, (e.g. the storming) and the indubitable evidence of there being no hope of any form of recovery.
35. The lengthy delays, and therefore the prolonging of the burdens upon OQD and the impacts on his human dignity, are not possible to justify on the facts of this case.
36. I am sufficiently concerned both about what has happened here, and by the apparent pattern of similar cases at the RHND, that I intend to send this judgment to the Secretary of State for Health and the Chief Executive of NHS England.