



**IN THE COURT OF PROTECTION**

**2017 EWCOP 19**

**20 September 2017**

**Before:**

**THE HONOURABLE MR JUSTICE PETER JACKSON**

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**Between:**

**M**  
**(by her litigation friend, Mrs B)**

**Applicant**

**-and-**

**A Hospital**

**Respondent**

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**Victoria Butler-Cole** instructed by Irwin Mitchell for M  
**Parishil Patel** instructed by Capsticks for the Hospital  
**Ms Bridget Dolan QC and Ms Susanna Rickard** provided written submissions on behalf of the  
Official Solicitor at the invitation of the Court

Hearing date: 22 June 2017  
Judgment date: 20 September 2017  
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**JUDGMENT: M (Withdrawal of Treatment: Need for Proceedings)**  
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**IMPORTANT NOTICE**

This judgment was handed down after a hearing in public. It can be reported, provided that the terms of a reporting restriction order made under the transparency protocol on 22 June 2017 are complied with. That order prevents the identification of Mrs M or her family members or the hospital in which she has been treated. Failure to comply with the order may be a contempt of court.

**Mr Justice Peter Jackson:**

## **Introduction**

1. These Court of Protection proceedings, which began on 27 April 2017 and came to a final hearing on 22 June, concerned M, a sufferer from Huntington’s disease. Although they were dressed up as a challenge to a standard deprivation of liberty authorisation, they really amounted to a far more profound request for the court “*if required*” to determine that it would be in M’s best interests not to continue to receive clinically assisted nutrition and hydration (CANH), with the consequence that she would die. The application was supported by M’s family, her clinicians, and an external specialist second opinion.
2. At a public hearing on 22 June, I made the orders requested, giving short reasons and reserving fuller judgment. On 24 July, CANH was withdrawn from M, who then received palliative care, and on 4 August she died. She was 50 years old at the time of her death.
3. I express my sympathy for the great sadness felt by M’s family and carers.
4. This judgment is given:
  - To explain why CANH was withdrawn from M, a person in a minimally conscious state (MCS).
  - In response to the request of the parties for clarification of whether legal proceedings were necessary or not when there was agreement between M’s family and her clinicians that CANH was no longer in her best interests.
  - To explain why the court appointed M’s mother, Mrs B, as her litigation friend, rather than the Official Solicitor.
5. The short answer to these questions is that:
  - CANH was withdrawn because it was not in M’s best interests for it to be continued. The evidence showed that it had not been beneficial for the previous year.
  - In my view, it was not necessary as a matter of law for this case to have been brought to court, but given the terms of Practice Direction 9E and the state of the affairs before the very recent decision of the Court of Appeal on 31 July in the case of *Briggs* [2017] EWCA Civ 1169, it is understandable that the application was made.

- Mrs B was appointed as litigation friend because she was a proper person to act in that role: the fact that she supported the withdrawal of her daughter's treatment did not show that she had an adverse interest to her.

### The history

6. As a child, M was, according to her mother, Mrs B, "full of life". Her husband, who she met as a teenager in 1984, recalls her as "bright, energetic and youthful". Sadly, M soon began to show the symptoms of her condition, but she and her husband went on to have two children, now adults. Their younger child, a son, is also afflicted by Huntington's disease and is cared for at home by his father.
7. Huntington's disease is an inherited neurological condition that is progressive, incurable and ultimately fatal. In 1994, M became permanently resident in the respondent hospital, though she was still able to go out for short periods. By 2003, she was no longer able to go out at all and from then on, she was dependent on CANH by PEG tube. For her last 10 years, she was bedridden, apart from occasional times when she was hoisted into a wheelchair for short periods.
8. Both before and after she became a permanent hospital patient, M received the most devoted care from her carers and from her family, who witnessed her inexorable decline over a period of more than 25 years. While she was living at home, her husband was her main carer. When she went into hospital, her mother, Mrs B, visited her several times a week, and her other family members visited very regularly.
9. By the time of the hearing, M's mother Mrs B described her in this way:

*"M is rarely awake and all I can describe as is 'a body on a bed'. She is unconscious for the majority of the time. Even when she is awake, M makes no sign of recognition and does not look at me or engage with me. I find it really distressing because even when she goes to sleep, her eyes do not fully close and she looks so uncomfortable. You can see the whites of her eyes but her eyelids do not shut.*

*The nurses and carers at the hospital try their best to provide M with the routine of care. They put the TV on and radio on, and sometimes she is put in a wheelchair and sat out in her wheelchair in a communal area. However, she never exhibits any signs of awareness, and it is no longer apparent when she is content or enjoys doing something or not, or whether she has any sense of feeling, smell or hearing whatsoever.*

*When I visit M, I always enter the room cheerfully and say hello to her, I tend to her bedding, or change the TV channel, and I will often put on DVDs that I know she used to really enjoy, such as Dirty Dancing and Billy Elliott. I do this out of a sense of routine, and just in case she has any awareness left. However, for around 18 months now I have seen*

*nothing which makes me think she has any awareness of what is going on whatsoever. She never makes a reaction to a change of TV programme, or when myself or her stepdad look directly at her or lean over her.*

*I continue to visit M at least 4 times a week. I insist that I should do her laundry. As her mother, I want to ensure that she is clean and comfortable and that her clothes smell clean and like home, rather than coming from the hospital launderette. Going to see M and caring for her is a huge part of my life. For years now, I find myself getting up, and instead of going to work like anybody else, I have gone to the hospital to see my daughter."*

10. Mrs B continues:

*"M is showing no signs of being aware of her surroundings at all, she is currently not really 'living' any life at all, and to keep her alive by forced and artificial treatment at this stage seems cruel...*

*I am aware that M's treating clinicians have now come to the same conclusion that it would not be in M's best interests for treatment to continue, and that they agree I am acting in M's best interests by bringing this application. I am extremely grateful to the clinical and care team for all that they have done to support M over the years.*

*It is incredibly difficult, as M's mother, for me to reach the conclusion that it is in her best interests for treatment to stop and palliative care instead to be provided. However, I do not feel that M would decide now, if she was able to, that the current treatment is benefiting her in any way, and her life is being prolonged for no purpose, where she has no quality of life. I have always been incredibly close to M, and in fact many people used to comment how we were so similar in mind-set and temperament. I am of the view that if M was able to make a decision right now, she would not want treatment to continue.*

*This application is hugely distressing and emotional for me. I love M with all my heart and have spent almost my entire life caring for. I have been so close to M and feel that I know her inside and out. She would have hated to be in the position she is in now.... This is not the life she would have wanted to continue living."*

11. M's husband supports the views of Mrs B. He writes:

*"M does not recognise me or the children and her quality of life is virtually non-existent. I feel that the PEG feed is keeping her alive, with no possibility of change or cure – it is simply causing M to suffer. When she was diagnosed, we were told she would live for 18 – 19 years, yet 25 years on she is still living with this terrible condition.*

*When M was diagnosed, I recall her telling me that she would not want to live with Huntington's for years and years, and although we did not talk about her end-of-life care, I*

*also believe that she would not have wanted to live in this way, considering the type of person she was. She was vivacious and full of life before the onset of her illness, and in my view, she would not have wanted to be kept alive with no hope of recovery or improvement.”*

12. M’s adult daughter, a healthcare professional herself, supports the views of her grandmother. She writes:

*“Currently, my mother can’t do anything for herself and I don’t think she even knows we are there when we visit her any more. I continue to visit her weekly but she can’t make any eye contact with me anymore and doesn’t seem to recognise me at all. My mum used to always enjoy seeing her family, but that enjoyment has now been taken away from her and she doesn’t seem to have any quality of life at all.*

*My mother never mentioned her views or wishes as to her end of life to me. I was very young at the initial stage of the disease and I don’t think she wanted to upset me. We always stay positive around her, even when she became more unwell.*

*However, I believe that my mother would not have wanted to suffer in this way and that it is not in her best interests to be kept alive when she’s just suffering and no longer seems to have any awareness. She isn’t able to enjoy activities, or even recognise people in the room. I feel that it would have really distressed her if she knew that she would be left living in this way.”*

### **Medical opinion**

13. This came in the form of psychiatric opinions from M’s previous and current responsible clinicians and an external second opinion from Dr Edward Wild, a specialist in the clinical care of patients with Huntington’s disease at UCL Institute of Neurology, Queen Square, London. Their description of M’s condition was consistent with the observations of the family.
14. Dr S, the previous responsible clinician, provided a very detailed assessment of M’s disabilities, her treatment and her many medications. She explained that from July 2016, M was placed on a Stage III End of Life Care Plan, when death was expected to be in the next few days or weeks. She described how she felt that M might be experiencing discomfort and possibly pain, because her heart rate went down when she was given pain medication and because she grimaced when her position was changed.
15. Dr S gave the opinion in July 2016 that the case for continued treatment was finely balanced. She considered that M’s family were unquestionably acting in her best interests and that they could be regarded as accurately representing M’s own likely views, had she been able to express them. Taking all matters together, Dr S therefore supported the withdrawal of CANH.

16. Dr Wild confirmed the diagnosis in a report prepared in September 2016 and his view has not changed since. If CANH was continued, M's life expectancy was uncertain, but death as a result of severe pneumonia would in the end be likely. He agreed with Dr S that the determination of best interests was difficult, but overall it was his assessment that withdrawal of CANH would be in M's best interests. He carefully analysed the history, issues of capacity, wishes and feelings, beliefs and values, and the reportage of family members. He concluded:

*"It is impossible to be certain whether and how much M is currently suffering on a day-to-day basis because we cannot assess her awareness of her situation. However, she is not comatose, and it is likely that she does retain some general awareness of the situation as well as an ability to experience discomfort. The situation may be very distressing to her, given her previous views on quality of life and enjoyment. This existential suffering may have been going on for several years and may continue for several more."*

Having discussed all the relevant features, he concluded:

*"Taking all this into account, it is my assessment that M's best interests favour withdrawing artificial nutrition and hydration... I recommend this be done gradually as Dr S has proposed. I recommend nutrition and hydration be withdrawn together, as sustaining hydration without nutrition may prolong M's general suffering and any additional suffering from hunger, without any particular benefit."*

17. In February 2017, Dr L became the responsible clinician. She confirmed the consensus view of Dr S and another previous responsible clinician, of the multidisciplinary team including the clinical nurse leader, and of the social worker and consultant clinical psychologist that on balance it was in M's interests that treatment should be withdrawn.
18. I record the chronology leading to this application being made:

21.7.16      Best interests meeting concludes that CANH no longer in M's best interests

29.7.16      Dr S provides witness statement to this effect

9.16          Dr Wild's report

Then          A number of significant professionals had periods of leave

12.16          Hospital instructs Capsticks

Then          Capsticks seek to discuss issues with the Official Solicitor

- 2.17 Mrs B consults Irwin Mitchell solicitors
  - 1.3.17 Emergency legal aid granted to M for a s.21A DOLS application
  - 24.4.17 Proceedings issued by Mrs B
  - 17.5.17 Directions made on paper by Pauffley J
  - 25.5.17 Directions hearing Peter Jackson J
  - 22.6.17 Final hearing
19. The parties' legal costs are in the region of £30,000. This figure, substantial as it is, is a fraction of what it would be where an application of this kind is contested.

**Best interests**

20. The requirements of the law are set out in the Mental Capacity Act 2005 (the MCA):
- (1) Where a person is unable to make a decision for herself, there is an obligation to act in her best interests: s. 1(5).
  - (2) Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death: s.4(5).
  - (3) When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence her decision if she had capacity, and to the other factors that she would be likely to consider if she were able to do so: s.4(6).
  - (4) Account must be taken of the views of anyone engaged in caring for the person or interested in her welfare: s.4(7).
21. Further, whether or not a person has the capacity to make decisions for herself, she is entitled to the protection of the European Convention on Human Rights. In the present context, the relevant rights are found in Article 2 (the right to life) and Article 3 (protection from inhuman or degrading treatment). Further, it is an aim of the UN Convention on the Rights of Persons with Disabilities to secure the full enjoyment of human rights by disabled people and to ensure they have full equality under the law.

22. In a case of this kind, the fundamental starting point is a strong presumption that it is in a person's best interests to stay alive. But this is not an absolute, and there are cases where it will not be in the patient's interests to receive life-sustaining treatment: *Aintree v James* [2013] UKSC 6 at [35].
23. At [23] Baroness Hale noted that the Act gives limited guidance about best interests. Every case is different [36]. At [39] she said this:

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

24. At [44-45] it is said that the purpose of the best interests test is to consider matters from the patient's point of view. Where a patient is suffering from an incurable disability, the question is whether she would regard her future life as worthwhile. As was made clear in *Re J* [1991] Fam 33, it is not for others to say that a life which a patient would regard as worthwhile is not worth living.
25. I approached the assessment of M's best interests in accordance with this framework. It is a universal framework that applies regardless of the diagnosis, and whether the individual is in a vegetative or minimally conscious state, and whether their condition arose as a result of a traumatic event (as with Mr Briggs) or a chronic illness (as with M).
26. In this case, the evidence satisfied me that it was no longer in M's interests for her life to be artificially continued by CANH. I accepted the evidence of the family and the clinicians. They had reached their positions after the most careful thought, placing M at the centre of their concern, and concluding that she would not have wanted to go on living like as she was, nor endure the inevitable continued decline in her terminal condition. I therefore decided that CANH should be discontinued and replaced by palliative care after a meeting of family members and professionals had agreed on a suitable timetable.
27. In reaching this decision, I was mindful that this was in effect an application made by agreement and that there are always more investigations that can be made, questions that can be asked, stones that can be turned. Here, I was satisfied that the court had all the essential information and that further inquiries would not alter the fundamentals. I also noted that the medical opinion on M's overall best interests was to some degree influenced by (and might, in the end, be said to have been tipped by) the views of her family. There is nothing wrong with that. For obvious reasons, it is not found in many of



the reported cases, which often portray doctors and families in opposite camps, but those cases are surely unrepresentative of the much greater number where a common position is reached through people listening to each other. Just as family members will naturally pay regard to the views of carers and doctors, particularly on the medical aspects of the situation, so doctors will naturally listen to the views of the family about their relative's wider best interests. What is important is that those called upon to express a view should do so conscientiously, drawing upon their personal and professional knowledge of the individual concerned.

### **The need for proceedings**

28. This is a topical issue. Practice Direction 9E provides that decisions about the proposed withholding or withdrawal of CANH from a person in a permanent vegetative state (PVS) or MCS should be brought to court. This reflected the dicta of the House of Lords in the 1993 case of Tony Bland that, until such time as a body of experience and practice was built up, good practice required a court application before withdrawal of CANH in cases of PVS. This practice, by then codified in the PD to include MCS, was noted by Baker J in his decision in the MCS case of *W v M* [2011] EWHC 2443 (Fam) at [257], but the issue now before me was not raised before him.
29. Whether this requirement is or should remain a legal obligation has received detailed recent consideration:
  - (i) By the ad hoc Court of Protection Rules Committee, chaired by Charles J as the Vice-President of the court. The Committee, having received a range of views, has published notes in May and July 2017, with a view to changes being introduced at the end of the year. It recommends the removal of the practice direction and the establishment of a multi-disciplinary working group to discuss the underlying issues and to give guidance about the circumstances in which cases should and should not be taken to court.
  - (ii) By the Court of Appeal in *Briggs*, where at [108], Eleanor King LJ stated two propositions, amongst others:
    - a. 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 MCA.<sup>1</sup>*

- b. 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 15-17 MCA.*

These propositions are built upon detailed analysis of the Mental Capacity Act in regard to serious medical treatment cases, along with its accompanying regulations and practice directions: [14-15], [19-22] and [26-27]. However, the question of whether the proceedings had been necessary was not decisive in that case, nor was it the subject of full argument, in particular from the Official Solicitor, acting as litigation friend to Mr Briggs.

30. By contrast, in the present case the question of whether proceedings were necessary was explicitly raised when the application was made. However, the undoubted priority was to decide the question of M's treatment, and this was done at the hearing on 22 June. The prior question of the need for proceedings has been the subject of written submissions only, in the following way:

- (i) At and after the hearing, Ms Butler-Cole filed written submissions on behalf of M.
- (ii) For the hospital, Mr Patel provided brief, largely concurring, written submissions.
- (iii) Given the Official Solicitor's general interest in the issue and his passing involvement in the pre-proceedings stages, I invited observations from him. I am grateful to him for a substantial skeleton argument prepared by Bridget Dolan QC and Susanna Rickard, which (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.
- (iv) This has led to an equally robust response from Ms Butler-Cole.
- (v) I have also seen the Official Solicitor's public response to the notes published by the ad hoc Committee.

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<sup>1</sup> s.5 has the effect that care or treatment can lawfully be provided to a person lacking capacity if it is treatment to which she could have consented, provided that it is reasonably believed to be in her best interests.

31. It would have been disproportionate to reconvene these proceedings for oral argument. I will summarise the competing written submissions. They are of a high quality and any synopsis inevitably sells them short.
32. For M (prior to the Court of Appeal decision in *Briggs*), it was said that:
- There is no obligation in law or good practice for a declaration or decision of the Court of Protection to be obtained in the circumstances of this case.
  - The MCA does not require proceedings to be brought in such cases.
  - The MCA Code of Practice at [6.18] and [8.18] is unclear and ambiguous on the subject.
  - It is not clear whether PD9E is intended to apply only to cases where the PVS or MCS conditions are due to disorders of consciousness, or to other cases, such as the present one.
  - In *R (Burke) v GMC* [2005] EWCA Civ 1003 at [67-80] it was said that there is no legal requirement to obtain court authorisation before withdrawing CANH.
  - *Aintree* at [47] suggests that proceedings are needed where agreement *cannot* be reached.
33. The hospital endorsed these submissions, but pointed out that clinicians carrying out the withdrawal of CANH need to be sure that they are on solid legal ground.
34. The Official Solicitor submits that:
- He would welcome an authoritative answer to whether there is a continuing requirement to bring all CANH withdrawal decisions to court, absent a valid and applicable advance decision.
  - Unless and until Parliament, or the Supreme Court in a case in which the issue is live and fully argued, say otherwise, the position should remain as stated in PD9E. (It is accepted that legislation is unlikely and a 'live' case may be hard to find.)
  - While there is no statutory requirement to bring these cases to court, the common law requires an application as an essential safeguard for persons who are extremely vulnerable, even where there is agreement. Were it otherwise, the law would not comply with Art. 2.

- *Bland* should still be followed. The position has not become clearer since it was decided. The law and medical science are still evolving.
- The possibility of incorrect diagnosis and incorrect prognosis must be guarded against. There are documented instances of both, which have been picked up and corrected through litigation; the Official Solicitor provides a table of cases in support.
- There are also risks attached to over-ready acceptance of relatives' accounts of patients' likely views.
- The statements in *Briggs* were *obiter*, without hearing argument and without considering the European Convention on Human Rights or the UN Convention on the Rights of Persons with Disabilities.
- The cited passage in *Burke* was *obiter*. The Supreme Court has more recently suggested that the basis for the court's involvement is the seriousness of the issue, not the level of agreement: *N v ACCG* [2017] UKSC 22 at [38].
- In the present case, the issue is academic as an application was in fact made. It can only lead to further *obiter* comments on the subject in a case where there was no full argument and no basis for appeal (the Official Solicitor not having been a party to the proceedings).
- The European Court of Human Rights has considered a PVS case (*Lambert v France* Appn 46043/14). It did not hold that Art. 2 requires court authorisation for CANH withdrawal, but it did require that States should make regulations compelling hospitals to adopt appropriate measures for the protection of patients' lives. The Official Solicitor contends that the existing clinical guidelines in this jurisdiction are insufficiently robust to amount to appropriate measures.
- The solution may be to develop a streamlined application procedure.
- As to this case, the Official Solicitor accepts that he has had limited access to the information available to the parties and the court. However, he identifies eight issues that, had he been her litigation friend, he would have explored in detail. These include a closer scrutiny of the family's account and of the doctors' apparent ready acceptance that the family could accurately present M's wishes, an investigation of why there is no recorded account of her wishes in the medical records, and of the unexplained absence of evidence from her son. He concludes that, on the papers at least, M's case is one where her 'voice' was not heard.

35. In her response, Ms Butler-Cole:

- Comments on the general approach of the Official Solicitor, and in particular his approach to the evidence of family and friends in cases of this kind.
- Observes that what is central is not the diagnosis (PVS or MCS), but the patient's actual experience.
- Notes that the Official Solicitor's submissions are silent in relation to those who are receiving treatment that is not in their best interests and ignore the generality of cases in which major life-and-death decisions are taken without any suggestion that the courts should be involved.
- Challenges the Official Solicitor's analysis of some of the tabulated cases.
- On behalf of M's family, strongly rejects the Official Solicitor's criticisms of the process followed in this case.

36. I accept that it would be inappropriate for the court to comment gratuitously on an issue of this importance. However, in this case the question has been explicitly raised and argued by the parties, both family and doctors, and they are in my view entitled to an answer. It is not good enough for the court to say that, because proceedings have in fact been issued and determined, the question of whether they were necessary in the first place has thereby become moot. I nonetheless recognise that I have not heard oral argument and that the Official Solicitor has not been formally involved in the proceedings. What follows should be seen in this light.

37. On the facts of this case, I do not consider it to have been a legal requirement for the decision to withdraw CANH to have been taken by the court, though it is entirely understandable that the parties sought an external decision, given the state of the law. My reasoning on the question is as follows:

- (1) There was no statutory obligation to bring the case to court, and although the cases and materials mentioned in this judgment are of considerable authority, they do not all point in one direction and they are not formally binding upon me. None of them sustains the proposition that a court decision is necessary as a matter of law, as opposed to as a matter of practice. What is however clear is that the court is not the source of lawfulness: it identifies whether treatment is or is not lawful, but it cannot make unlawful treatment lawful, or *vice versa*.
- (2) The essential question is whether the state's Art. 2 duty mandates court oversight as a matter of law. I do not consider that it does, for these reasons:

- (i) The present practice is anomalous. The right to life belongs to everyone, enabled and disabled. Individuals who are in PVS or MCS are at the extremes of vulnerability, but many among us will at some time in our lives come to be in a precarious state. Overwhelmingly, treatment decisions up to and including the withholding and withdrawal of life-support are taken by clinicians and families working together in accordance with recognised good practice. No one suggests that these decisions should all be the subject of external supervision.
  - (ii) The question that therefore needs to be answered is whether it is necessary and proportionate for legal proceedings to be required only in a limited subset of cases. Are these cases so different in kind to other serious medical treatment decisions as to justify a completely different approach? In my view, they are not. The reasons given for requiring all PVS/MCS cases to come before the court could equally apply to a very much larger patient population.
  - (iii) Consideration must also be given to the deterrent effect of costly and time-consuming proceedings, both on the individual case and on the patient population in general. The equality rights of disabled persons require clinicians and carers to take reasonable steps to assure themselves that the treatment and care they are providing is and continues to be beneficial, and that the person's unique point of view is not forgotten because they are unable to express it for themselves. 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. Indeed, the present case stands as an example, in that M received continued CANH that neither her doctors nor her family thought was in her best interests for almost a year until a court decision was eventually sought.
  - (iv) It is not suggested that the court should be involved in PVS/MCS cases where there is a valid and applicable advance decision, yet the grave consequences of the decision and the risk of error are no different in such cases.
- (3) In my judgment, therefore, a decision to withdraw CANH, taken in accordance with the prevailing professional guidance – currently the GMC's Good Medical Practice guidance, the BMA guidance 'Withholding and Withdrawing Life-prolonging Medical Treatment' and 'End of Life Care' and the Royal College of Physicians' Guidance on Prolonged Disorders of Consciousness – will be lawful and the clinicians will benefit from the protection of s.5. The court is always available where there is disagreement, or where it is felt for some other reason that an application should be made, but this will only arise in rare cases, such as *Aintree*.

- (4) This conclusion does not in any way detract from the crucial importance of structured medical assessment in PVS/MCS cases: see Baker J in *W v M* at [258-9] and Newton J in *St George's Healthcare NHS Trust v P & Q* [2015] EWCOP 42 at [46-49]. Nor does it detract from the obvious need for expert second opinions in these cases.
38. Therefore, in agreement with the analysis of the Court of Appeal in *Briggs*, I would hold that notwithstanding PD9E, the decision about what was in M's best interests is one that could lawfully have been taken by her treating doctors, having fully consulted her family and having acted in accordance with the MCA and with recognised medical standards. These standards will doubtless evolve, including through the current initiative taken by the ad hoc Committee, but in my view the approach taken by the clinicians and the family in this case fully respected the Art.2 rights of M in a fashion contemplated by the ECHR in *Lambert*. However, every case is intensely fact-specific, and 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 form of the application**

39. As was the case in *Briggs*, the proceedings were brought as a deprivation of liberty challenge under s.21A. In doing so, Mrs B explicitly acknowledged that the central issue was not M's deprivation of liberty but the withdrawal of CANH. She cannot be blamed for taking this course in the light of the law as it then stood. However, the Court of Appeal decisions in *Ferreira v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 and now in *Briggs* have swept away two fictions. The first was the idea that a person without any real awareness was being deprived of liberty by virtue of receiving life-sustaining treatment: the court will never again be faced with absurd applications for a deprivation of liberty authorisation, such as that made to me at a preliminary stage in the case of the PVS patient Jodie Simpson, subsequently reported as *Cumbria NHS CCG v Ms S* [2016] EWCOP 32 (Hayden J). The second fiction was the use, for reasons of funding, of s.21A applications instead of best interests applications under ss.15-17. Where such serious decisions are concerned, any distortion of the legal framework is surely particularly inappropriate.
40. However, the resolution of these legal issues creates a serious practical concern for those families who do need specialist legal representation to enable serious medical treatment issues to be resolved, either through litigation or as a way of reaching an amicable resolution. Having worked in this area for the past 25 years, I respectfully echo the closing remark of Sir Brian Leveson P in *Briggs*, that in meritorious cases consideration should be given to the justification for adding financial pressures to the many others that the affected families face. I would add this: by making legal aid available in deprivation of liberty cases, the state honours its obligation to defend the right to liberty guaranteed by Article 5; how much more essential such support is where what is at stake is the right to life guaranteed by Article 2. In this regard, I strongly support the observations of Baker J

in *W v M* at [260], where he described the absence of funding for families as ‘alarming’. Whether the state is obliged to provide funding to ensure that a fair hearing is possible in those cases that do have to come to court may need to be determined in a future case.

### **The litigation friend**

41. Rule 140 of the Court of Protection Rules 2007 provides that a person may act as a litigation friend if he (a) can fairly and competently conduct proceedings on behalf of that person, and (b) has no interests adverse to those of that person.

42. The rule does not discriminate between one kind of proceedings or another. Clearly in a case of this kind, the court will look especially closely at the identity of the proposed litigation friend, mindful of the great experience of the Official Solicitor and the need for P’s interests to be fully and expertly represented. The Official Solicitor has always been willing to act in these cases, even where he is not the litigation friend of last resort. There is, however, no rule that the Official Solicitor must always be appointed, and I respectfully agree with the approach of Charles J in *Re NRA and Others* [2015] EWCOP 59 where, at [158-175], he considered this issue, albeit in the context of deprivation of liberty, and concluded as follows:

*[173] So the issue whether a family member or friend should be appointed as a litigation friend is fact and case sensitive and will turn on whether in all the circumstances the family member satisfies the relevant Rules and more generally whether he or she can properly perform the functions of a litigation friend and so in a balanced way consider and properly promote P's best interests.*

*[174] To my mind, this will often be the case because a devoted and responsible family member or friend will be able to perform the tasks to achieve the aims set out in para [164] above.*

*[175] However, I acknowledge that there will be other cases when the history shows that a family member or friend is not an appropriate litigation friend because, for example, (a) he or she has not been taking or is not likely to take that approach or is in dispute with other family members, or (b) the way in which the issue has arisen will mean that the pressures on, or interests of, family members or friends make this inappropriate.*

43. So too, there will be medical treatment cases in which the court will unhesitatingly conclude that the individual requires representation by the Official Solicitor. Often, family members, however well-motivated, will not be capable of discharging the role of litigation friend in relation to such a momentous issue. These situations are harder to define than to recognise. Here, there was no reason to believe that Mrs B’s ability to act on M’s behalf was compromised by her family relationship, or by her considered beliefs about her daughter’s best interests. There was an independent specialist second opinion of the



kind that the Official Solicitor would normally commission. Mrs B also had the ability to conduct the proceedings competently, having the advantage of leading solicitors and counsel in the field – the irony that this came of the application being brought under s.21A not being lost on the parties or the court. In all these circumstances, the fact-specific decision was that Mrs B was a suitable litigation friend, and so she proved.

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