Neutral Citation Number: [2024] EWCOP 52 (T3)

Case No: 20000664

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 9 September 2024

Before :

The Honourable Mr Justice Cusworth

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Between :

NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	**Applicant**
- and –	
(1) HX (by her litigation friend, the Official Solicitor)	**Respondents**
(2) CX	
(3) SX	

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Benjamin Harrison (instructed by **DAC Beachcroft LLP**) for the **Applicant**
Sophia Roper KC (instructed by **The Official Solicitor**) for the **1st Respondent**
Nicola Kohn (instructed by **Irwin Mitchell LLP**) for the **2nd Respondent**
The **3rd Respondent** appeared in person

Hearing dates: 4 - 6 September 2024

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JUDGMENT

This judgment was handed down in court at 1.15pm on 13 September 2024 by circulation to the parties or their representatives by e-mail and by release to The National Archives.

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This judgment was delivered in public but the Transparency Order of Mrs Justice Theis of 31 July 2024 remains in force. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the parties, and treating clinicians, must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Cusworth J :

1. These proceedings relate to HX who is currently in her late 40s. On 1 July 2024, HX suffered a cardiac arrest. Prior to the arrest, HX had complained of chest pain. Her son CX (the second respondent to these proceedings), reports that this pain progressed and resulted in a seizure and collapse. He gave his mother CPR. Paramedics arrived at 18:22 and resuscitated HX, but she arrived at hospital unconscious at 19:14. She was transferred to the critical care unit on the same day. She has since been diagnosed with severe, global, hypoxic ischemic encephalopathy or brain damage, resulting from the arrest. HX is currently a patient in the critical care unit at the Northumbria Hospital and is the first respondent in these proceedings. Her participation has been secured by the appointment of the Official Solicitor as her litigation friend.

2. Prior to her hospital admission HX lived with CX, in Blyth, in Northumbria. He had moved to HX's home when he was a teenager. He considers them as having a relationship as best friends, and provides a vivid picture of his mother as she was before her hospitalisation: as a creative woman who loved shopping, choosing outfits for other people, and listening to music; someone who took pride in her appearance and enjoyed beauty and spa treatments. He describes her however as *'closed off',* preferring the company of family to strangers, but generous to others and selfless.

3. CX accepts that HX has had a difficult life. She was born when her own mother was a teenager and raised with the help of her grandmother. At the age of 16 she suffered a rape and then began a relationship with someone described as a violent and abusive drug-user who also introduced her to drug use. She has experienced ongoing mental health problems and domestic violence; her two children born after CX were adopted. One met HX later in life but has not gone on to form a close relationship. The other child is yet to meet HX since the adoption. CX himself was looked after by HX's parents in childhood, until he was taken into care, before returning to his mother 3 years later. HX and CX have lived together since then, and although he reports some positive and memorable times, he acknowledges that HX's mental health deteriorated. He describes her as not wanting to leave the house, and isolating herself from other people. Over the last three years, HX's mental

health struggles have increased. She has found it difficult to access medical treatment, either in relation to her mental health or the physical treatment for a known heart condition explained below.

4. CX explained that HX struggled with mood swings and paranoia. He describes repeatedly requesting help which he considers was not forthcoming. Whatever the reason, it was the case that HX did not fully engage in the treatment which she required for diagnosed triple vessel coronary disease, which is highly likely to have been the precipitating factor in the cardiac arrest which precipitated her brain injury. HX has a formal diagnosis of Borderline/Emotionally Unstable Personality Disorder. Her family, however, feel this may be a misdiagnosis and have suggested that she may in fact suffer from Schizophrenia and Agoraphobia. HX's family are also reported to feel that HX's behaviour and mental health symptoms deteriorated precipitously when her prescription for risperidone was discontinued (due to concern about its wider effects on her physical health).

5. Prior to 1 July 2024, HX had been diagnosed amongst other conditions as suffering from:
   (a) Left Ventricular Systolic Dysfunction following a Non ST-Segment Elevation Myocardial Infarction (heart attack) in 2021 - this is explained as a heart failure in which the left side of her heart cannot pump blood to her body as effectively as it should – often resulting in shortness of breath on exertion;
   (b) Triple vessel coronary disease, meaning that the arteries which serve her heart muscle are narrowed;
   (c) Hypertension or high blood pressure; and
   (d) Type 2 diabetes mellitus.

6. Despite her difficulties, CX describes HX as a strong woman, who he believes should be given another chance to benefit from health services which she has been unable to engage with to date. He describes her as a Christian who had a bible and believed life was precious. She is recorded in her medical records previously as a Methodist, but in 2021 as having no religion. In his statement, CX acknowledges that he has not discussed end of life care with his mother. He states that she would have wanted to be resuscitated, and that she would want treatment *'to make her*

better or at least make her comfortable and give herself time to make a recovery'. I will consider the totality of his evidence on this important area below. On 17 July 2024, CX is recorded in the medical records as saying that he would be happy if his mother survived even if she was fully dependent on full time nursing care, but was unclear if that would be her own view.

7. HX's mother, SX, is the third respondent in these proceedings. She is recorded in the medical notes as saying on 10 July 2024 that HX would not want to be alive like this. There is in truth, and despite all of the evidence from her family of the sort of person that she was, very little evidence available as to what HX would want for herself, given her current situation. It is impossible to know whether her wish for resuscitation recounted by CX would continue if she were able to understand her present situation and the consequences for her if she were to receive CPR. Sadly, the medical evidence which I will examine later is very clear that there is no treatment which will significantly improve HX's condition, nor that giving her further time now will enable her to make any significant recovery.

8. The medical evidence: The hospital performed neuro-prognostication, described as the scientific process of predicting the severity of any brain injury, after 72 hours following HX's cardiac arrest. HX was assessed on the standard Glasgow Coma Scale assessment to have a motor (or 'M') score of 2 after 72 hours. The scale ranges from 1 (no response to pain) to 6 (normal movements to verbal command). Dr X (a critical care consultant, who gave evidence to me by video link from DAC Beachcroft's Offices) explained in his statement of 9 August 2024 that: *'A score of 2 after 72 hours post event represents a highly abnormal response to pain indicative of widespread brain injury and predicts poor prognosis'*.

9. An EEG (brain wave electricity and activity monitor) was performed on two occasions, on 3 July 2024 and 8 July 2024. Both tests, Dr X explains, were '*indicative of severe, global anoxic brain injury but also demonstrate a relative deterioration of the malignant patterns over the time period between the 2 tests'*. Dr Z, one of HX's treating clinicians who gave evidence to me in person explains that: '*A 'malignant pattern' or Malignant EEG Pattern (MEP) is a technical term for an EEG which meets certain grading criteria and which predicts a poor neurological outcome. The*

strength of this prediction is particularly strong when accompanied by true un-responsiveness to pain – a lack of both physical and electro-physiological responses'.

10. Radiological imaging of the brain was undertaken via a CT scan on 1 July 2024 and an MRI scan on 5 July 2024. Dr X has explained that: '*The initial CT scan performed on admission was to exclude other causes of cardiac arrest and/or coma. We would not expect any changes to appear on this relating to anoxic injury at this early stage. Indeed, the scan was reported as "normal." However, the MRI, a more sensitive test looking at the brain tissue, performed at a time where we would expect to see anoxic damage if it had occurred, demonstrated "diffuse, ischaemic, hypoxic brain injury*."' Dr Z explains that: '*In essence what this means is that damage is evident throughout all areas of the parts of HX's brain used to think and respond to the world*.'

11. Pupillary reflexes were absent at 72 hours. They returned but were abnormal and sluggish on day 4. To Dr X: '*These reflexes help demonstrate functioning of the unconscious brain. A pupillary reflex is the ability for the pupil of the eye to shrink in response to a bright light. It relies on the eye being able to sense, the brain being able to "compute" the signal, and the nerves and muscles of the eye being able to constrict the pupil. Its absence is highly abnormal and is indicative of severe brain injury*.' Corneal reflexes were also absent at 72 hours. Dr X explains that: '*Like Pupillary reflexes this reflex shuts the eye (blink) when the front of the eye itself is gently "brushed" with a soft material. This is highly stimulating to the eye and it is highly abnormal when absent*.' Nail bed tests, supraorbital pressure and sternum rub tests have all also been conducted on HX. There was no response from HX to pain stimulus on 22 July 2024 and only a slight extensor response (stiffening of arms) on 5 August 2024.

12. In simple terms, as explained by Dr Z, all of this means that while: *'there is evidence of minimal brain function and whilst this may change over time, the evidence does not predict a change that would represent any significant improvement on her current presentation. As such, were HX to physically survive, then her quality of life would be so poor that the clinicians believe it would be unlikely to be acceptable to her.'* I remind myself that before I can make such a judgment, I must carefully consider all available evidence about HX's own views and wishes.

13. There remains a serious concern that HX is unlikely to physically survive her illness or her admission to Critical Care over the coming weeks, even if she were to remain for full medical escalation as she presently is. This is due to the significant risk of complications which are likely to arise and her notable lack of physiological reserve. HX's risk of complications is elevated in light of her pre-existing severe cardiac dysfunction, as well as her diabetes. Complications are likely to include: ventilator acquired pneumonias; venous thromboembolism; ischemic or haemorrhagic stroke; further heart attack; and blood-stream or other infections. The risk of worsening pressure sores seems to have been a major concern at the time when the Hospital Trust first made its application to the Court of Protection, but these have now begun to improve following implementation of two hourly turning for HX.

14. If HX were to physically survive it is expected that she would do so to a catastrophically diminished level of neurological function. It is unlikely that HX would regain use of her higher functions (thoughts, feelings, communication, self-awareness, agency). Dr Danbury, instructed by the Official Solicitor, and who also gave evidence to me in person, considers that no ICU would be willing to provide CPR to HX if she suffered a further cardiac arrest. He also expresses the view that it would be contrary to her best interests to receive it, as (in addition to the traumatic physical consequences) her already severe brain injury would be worse. The Trust clinicians themselves would also be unwilling to provide CPR to HX for the same reasons.

15. HX's current position is therefore that she remains dependent on a life support machine and her physical condition is not likely to improve. She remains largely immobile, does not appear to be able to see or hear despite occasional withdrawal or grimacing as a reaction to painful stimuli. She occasionally coughs and gags on her breathing tube. It is impossible to say whether HX is currently feeling any pain since standard pain assessment tools are now ineffective given the extent of HX's neurological injury. HX is administered analgesics as and when her critical care nurse concludes that she is in pain or discomfort. All nutrition and hydration is provided via a naso-gastric tube. Even with this intervention HX has still lost 5kg in

weight and her muscles appear wasted. She is dependent on machines to breathe and to monitor her blood pressure.

16. HX's neurological progress is summed up by Dr X as follows: *'Clinical manifestations of neurological injuries like [HX]'s do change over time. In [HX's] case, in the month following her injury, her pupillary reflexes returned (but remain abnormal) and her Motor Coma score has improved from 2 to 4 (but this is intermittent and inconsistent). There is clinical agreement that these slight improvements do not amount to a clinical trajectory that will result in a recovery. In the rare and unlikely event of recovery, the clinicians believe it would be to a level of function that [HX] would find unacceptably poor.'* There are no specific treatments to address or cure the brain damage that has already occurred; rather the focus for the clinicians is on prevention of secondary brain injury by optimising blood flow and oxygenation to the brain and avoiding or treating any swelling of the brain tissue; and prevention of and treatment for any complications arising from HX's co-morbidities.

17. Other consultants have been called in to assess HX. First, Dr S (consultant in anaesthesia and intensive care medicine at a different Trust) assessed her in person on 9 July 2024, and reviewed all of the assessments completed since 1 July 2024. I have read his statement. In his view, no further scans or investigations are indicated or necessary. He concludes: '*…it is my professional opinion that end of life care should be commenced for [HX] to alleviate the suffering that [she] exhibits. This would be in the form of removing [her] from the ventilator and removing the endotracheal tube and allowing [her] to breathe room air. If [HX] demonstrated ongoing distress, then morphine and midazolam should be administered as per critical care's usual practice, in the expectation that [she] was dying. If no distress was exhibited, [HX] should be discharged from critical care and ultimately to a nursing home, where ongoing nursing care could be performed. I would recommend that [HX] should not be resuscitated if a cardiac arrest occurred. If [she] were to deteriorate at any point, palliative care should be commenced. [HX] should not be for escalation of care to critical care. If [she] were to develop any infections, I would recommend not starting antibiotic therapy'*.

18. Second, Dr WA (a consultant neurologist at a different Trust) assessed HX in person on 5 July 2024 and 2 August 2024, and was able to review the MRI images that had been taken on 5 July 2024. Dr WA prepared a statement and gave evidence to me by video link. She does not feel that any further investigations would assist the court to

resolve this case. She concludes that: '*In my professional opinion, [HX's] prognosis is very poor, with no prospects of recovery and I do not believe any further investigations would aid prognosis or trajectory. This is due to a combination of her poor clinical recovery, EEG and MRI brain result. I do not consider she will ever regain consciousness and return to a state where she is able to meaningfully respond to her surroundings or the outside world... On review of the MRI scan, the Neuroradiologist agreed that the scan demonstrated that [HX] had severe widespread brain injury affecting both whole cortex (surface of the brain) and basal ganglia (deep structures that coordinate movement and alertness). There was no significant swelling'*.

19. Third, Dr Y (consultant neurologist at Northumbria Healthcare NHS Foundation Trust) assessed HX in person on 22 July 2024 and 5 August 2024 and has reviewed HX's clinical notes and the EEG reports. I have also read his statement. Dr Y is not aware of any further investigations or scans that may assist the court to resolve this case. He explains that '*all correct and appropriate scans and assessments have been completed and, tragically, are all consistent with a very poor prognostic outcome and further scans or testing will not result in a different prognosis*'. He concludes that: *'...this patient will not make any significant recovery from her current state. Significant neurological damage is present, as evidenced by MRI changes on day 5 and horrendous EEG patterns on day 8, and this is verified by her clinical status nearly one month down the line. Unfortunately in my opinion no meaningful recovery will ensue.*'

20. Meetings have been undertaken regularly between HX's treating clinicians and her family. Following a best interests meeting on 19 July 2024, CX continued to oppose the Trust's recommendation that life sustaining treatment was no longer in HX's best interests and that palliative care should commence. Consequently, on 22 July 2024, in the absence of agreement being reached, the Trust placed the Official Solicitor on notice of its intention to make this application. They then proceeded to file the COP1 application on 24 July 2024. Quite understandably, CX felt that notwithstanding the fairly clear medical picture which was emerging, it was right to give his mother more time to show some signs of recovery. He has pointed to other cases where decisions have not been taken finally for many months or even years.

21. The Trust has defended its decision by reference to the *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] EWCOP 21, which provides, at [8]-

[9] that: '*8. If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is: ... (c) a lack of agreement as to a proposed course of action from those with an interest in the person's welfare,…Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required. 9. Where any of the matters at paragraph 8 above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection must be made…For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration.'*

22. I have also been referred to the decision in *GUP v EUP* [2024] EWCOP 3, where Hayden J at [50] described the guidance as something '*rarely departed from in cases of this gravity*'. He continued: '*Where there is conflict in these serious medical treatment cases, it is in everybody's best interests, but most importantly P's, to bring an application to court. That will be most efficiently achieved where it is driven by the Trust's application.*' Whilst this application has been brought on speedily, I am satisfied that the issue between CX and the Trust is one which was rightly perceived to be incapable of resolution without the involvement of this Court, and the Trust therefore acted entirely appropriately in bringing the application when it did. This would be the case, regardless of the outcome of their application.

23. The matter came before Theis V-P, on the papers, on 25 July 2024. Case management directions were made and the matter was listed for a further attended hearing on 31 July 2024, when Theis V-P heard from the parties and made further directions. She granted the Official Solicitor permission to instruct an independent expert in a number of possible fields. In the end, only Dr Danbury, who is a consultant in neurointensive care, was instructed, and the clinicians who had provided the Trust with second opinions formalised their views by the preparation of their witness statements. This final hearing was listed before me, and I have heard the application over 3 days between 4 and 6 September 2024, just over 2 months following HX's admission to hospital following her cardiac arrest.

24. In his report dated 27 August 2024, Dr Danbury summarises his conclusions about HX's condition as follows:

2.1. HX suffered an Out of Hospital Cardiac Arrest (OHCA), most likely due to her underlying ischaemic heart disease.
2.2. The OHCA caused a very significant primary brain injury.
2.3. The attending paramedics were able to achieve Return of Spontaneous Circulation (ROSC).
2.4. Treatment by the ICU team was, and continues to be, of a high standard.
2.5. From 72 hours post injury onwards, HX falls into a poor prognostic group for recovery following cardiac arrest. This is due to:
2.5.1. Motor component of Glasgow Coma Scale being M3 or less
2.5.2. Highly malignant EEG
2.5.3. Global hypoxic ischaemic damage on MRI
2.6. Her most likely outcome, should life-sustaining treatment continue, is a Glasgow Outcome Score-Extended of 2 or 3. This equates to a Permanent Vegetative State or Minimally Conscious State Minus.
2.7. No further imaging is indicated.
2.8. There are no treatments or rehabilitation that will improve her prognosis.
2.9. Should the Court decide that life-sustaining treatment is in her best interests, then it is likely that she will require to be cared for in a long-term care facility.
2.10. It is my opinion that the decision regarding Cardiopulmonary resuscitation is a medical decision and not a best interest decision. No ICU that I am aware of would be prepared to offer cardiopulmonary resuscitation to HX.
2.11. Although it is for the Court to decide, it is my opinion that continued invasive life-sustaining treatments are not in HX' best interests.

25. In the body of his report he explained as follows:

6.28. Primary brain injury is defined as the injury sustained due to the index insult. Secondary brain injury results from the response of cerebral tissue to that insult, arising from the cellular and microcirculation changes of, and in, the brain…
6.30. Thus, the degree of primary brain injury is related to the duration of cerebral hypoxia during cardiac arrest.
6.31. HX suffered a very significant primary brain injury, which occurred prior to Return of Spontaneous Circulation [ROSC].
6.32. Brain injury is not a distinct state, but a continuum.
6.33. As time progresses the brain injury worsens…
6.40. Brain injury is divided into primary and secondary. Primary injury occurs during the insult, in this case the period of hypoxia that occurred during the cardiac arrest. Secondary injury occurs on ICU after ROSC.
6.41. Primary brain injury is rarely treatable.
6.42. Treatment on ICU following ROSC is aimed at minimising the secondary brain injury, in this case the reperfusion injury. Treatment duration also provides a period for neuroprognostication…
6.45. The ICU treated HX in line with European Resuscitation Council [ERC] guidance and I have no criticism of the ICU management following ROSC…
6.52. She has:
6.52.1. A highly malignant EEG on both occasions that it was performed;
6.52.2. Diffuse and extensive hypoxic, ischaemic damage on MRI brain;

6.52.3. Her Neurone Specific Enolase was elevated at 49.6, but remains less than 60mcg/L.

6.53. Consequently HX falls into the poor prognostic group of patients in whom ROSC has been achieved post cardiac arrest…

6.55. In my opinion, should it be capable of weaning HX from mechanical ventilation, which is by no means certain, then in my opinion her predicted Glasgow Outcome Score-Extended [GOSE] would be 2 or 3.

6.56. Even if she had a level of consciousness, it is my opinion that her GOSE would be no more than 3, and it is more likely than not that she would fall within a Minimally Conscious State minus (MCS-).

6.57. As it is now more than 1 month following the cardiac arrest and ROSC, HX can be diagnosed as being in a Prolonged Disorder of Consciousness (PDOC). According to current guidelines, Vegetative State (VS) or MCS cannot be diagnosed yet…

6.58. Based on her current recovery trajectory, using the Nontraumatic brain injury pathway, she will more likely than not be diagnosed with a chronic VS/MCS- after another 2 months and it is my opinion that this will be a Permanent VS/MCS- at the six month point following her cardiac arrest.

6.59. As the national guidance states, best interests discussions and decisions should not be delayed until the diagnosis of VS/MCS- is chronic or permanent.

26. This element of his careful and detailed report is crucial to understanding why it was that the Trust felt able to bring its application as swiftly as it did, and why HX's family's concern that the application (whether or not it is ultimately granted) has been brought too early is, I am satisfied, misplaced. The medical evidence is clear that the primary injury to HX's brain is both severe and very sadly irreversible. Whilst a delay to addressing the questions which are now before me would enable HX's family more time to come to terms with the desperate injury which she has suffered, it would not serve to enable any treatment which could alleviate her condition. Although it cannot by now be determined whether or not HX will eventually come to be diagnosed as VS or MCS-, it can be said with a very high degree of probability that her recovery trajectory will not enable her to progress beyond these levels.

27. Finally, in his report, Dr Danbury also dealt with the question of how any attempt to wean HX of the mechanical ventilation which is currently sustaining her might be achieved. He said:

6.60. Currently HX is mechanically ventilated on a spontaneous mode of ventilation.

6.61. However, she has had a recent episode of prolonged apnoea on the 31/07/24 requiring a mandatory mode of ventilation.

6.62. This period of apnoea is likely to occur again, albeit at an unpredictable time. Recurrent episodes of apnoea do not have any treatment other than continued, indefinite mechanical ventilation.

6.63. There are a variety of techniques of weaning from mechanical ventilation, most commonly is reducing the pressure support during inspiration and then increasing the periods when the patient is removed from mechanical ventilation.

6.64. This weaning process is independent of a decision to form a tracheostomy.

6.65. However, should HX be weaned off ventilation and another apnoeic episode occur, then it is more likely than not she would suffer cardiac arrest due to hypoxia.

6.66. The RCP PDOC guidelines say, at page 130, "For patients with very severe brain injury, even short periods of hypoxia are likely to lead to further brain damage and a worse clinical outcome. Therefore, ACPR [attempted cardiopulmonary resuscitation] is unlikely to be clinically appropriate in the large majority of patients in PDOC".

28. There is consequently considerable uncertainty about whether in HX's case she could be successfully weaned off mechanical ventilation. It would be very unusual for her to be discharged from intensive case if that were not to have been achieved.

29. I have also read and considered a statement from CX, as well as an email received from HX's step-sister LX, who has explained her position to me but has chosen not to be joined as a party to the proceedings.

30. With that evidence in writing, I have heard orally from Dr X, Dr Z, Dr WA and Dr Danbury. HX's son CX, and her mother SX, have both come into the witness box and explained to me their feelings, and how they feel that HX would react if she were aware of what has happened to her. I appreciate that this was a difficult process for each of them, and I was impressed with the bravery and honesty which they showed in seeking to help the court as they did. I have also heard helpful submissions from Mr Harrison for the Trust, Ms Kohn for CX, and Ms Roper KC, instructed by the Official Solicitor, for HX.

31. The first issue which I must decide, which is whether HX does lack capacity to conduct these proceedings and to make decisions about her medical care and treatment is not in issue, as all parties acknowledge sadly that that is the case. The second issue is the difficult one – as to whether orders and declarations pursuant to sections 16 and 15 of the Mental Capacity Act 2005 ('the 2005 Act') should be

made to the effect that it is not in HX's best interests, and therefore not lawful, for her to continue to receive Clinically Assisted Nutrition and Hydration [CANH], and whether it is in HX's best interests, and is lawful, for her to be treated in accordance with the Trust's draft Palliative Care Plan.

32. CX does not support the Trust's application. He considers it inappropriate at the current time. He wishes for HX to be allowed a further period of recovery and recuperation before what Ms Kohn suggests should be an assessment and re-evaluation six months after the injury, and so four months hence. His case is that no final decision should be made before an assessment of HX's exact level of functioning can be determined, although this is overwhelmingly likely to be between VS and MCS-. Ms Kohn suggests that this course would be in keeping with the Guidance and common practice and, she submits, in accordance with both HX's previously expressed wishes and her best interests.

33. Ms Kohn also sought an adjournment at the outset of the final hearing to enable Dr Danbury to assess HX in person. I invited her to remake her application once Dr Danbury had given his oral evidence. He had indicated that he did not consider such a visit was necessary before concluding his report. Having been asked questions about this by Ms Kohn, he reconfirmed his view, but said that he would go if the court thought it appropriate. In those circumstances, I have not deemed it necessary to adjourn the application to enable Dr Danbury to visit HX in person.

The Law

34. There is general agreement between the parties as to the current law which I must apply, which has been set out by Mr Harrison in a 'Legal Framework' document with which the Official Solicitor agrees. Whilst the underlying principles are also accepted by Ms Kohn, she relies on some different authorities to support her case that a further delay before any final decision making would be appropriate. What follows on the law is not therefore contentious.

35. Section 1(5) and (6) of the Mental Capacity Act 2005 provide that a decision made under the 2005 Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests. Further, before the decision is made, regard must be

had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. Section 15(1)(c) of the 2005 Act provides that the court may make declarations as to the lawfulness or otherwise of any act done, or yet to be done, in relation to that person. An '*act*' for these purposes includes an omission and a course of conduct: section 15(2). Section 16(3) provides that the court's powers to make decisions on behalf of those who lack capacity are subject to sections 1 and 4 of the 2005 Act.

36. There is no definition of best interests under the 2005 Act, but section 4 provides so far as is relevant:

> *'(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—*
> *(a) the person's age or appearance, or*
> *(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*
> *(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
> *(3) He must consider—*
> *(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
> *(b) if it appears likely that he will, when that is likely to be.*
> *(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*
> *(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
> *(6) He must consider, so far as is reasonably ascertainable—*
> *(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),*
> *(b) the beliefs and values that would be likely to influence his decision if he had capacity, and*
> *(c) the other factors that he would be likely to consider if he were able to do so.*
> *(7) He must take into account, if it is practicable and appropriate to consult them, the views of—*
> *(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,*
> *(b) anyone engaged in caring for the person or interested in his welfare*
> *….*
> *as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)*
> *…*

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
(11) "Relevant circumstances" are those–
(a) of which the person making the determination is aware, and
(b) which it would be reasonable to regard as relevant.'

37. Baroness Hale in the Supreme Court in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 (at [22]) identified the ambit of the court's inquiry as follows:

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

38. No single element of s.4 has priority. Per Lady Hale in *Aintree v James* at [39]:

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

39. At [45], Lady Hale emphasised the role the patient's own wishes and feelings play in the best interests analysis:

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

40. Sanctity of Life. S.4(5) of the 2005 Act provides that a decision must not be motivated by a desire to bring about a patient's death. Sanctity of life remains a fundamental principle of the law in this jurisdiction. Sir Thomas Bingham MR said in the Court of Appeal in *Airedale Trust v Bland* [1993] AC 789, at 808, that: '*a*

profound respect for the sanctity of human life is embedded in our law and our moral philosophy'. Of course, there is a strong presumption that it is in a person's best interests to stay alive, considering their rights under Article 2 (the right to life), Article 3 (protection from inhuman or degrading treatment) and Article 8 (the right to respect for private and family life) of the European Convention on Human Rights.

41. Lady Black in *An NHS Trust v Y* [2018] UKSC 46 reminded us at [91] that:

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

42. As Keehan J further set out in *University Hospitals Birmingham NHS Foundation Trust v HB* [2018] EWCOP 39 at [20]:

'*There is a very strong presumption in favour of taking all steps which will prolong life. Save in exceptional circumstances or where the patient is dying, best interests of the patient will normally require such steps to be taken. If there is doubt, it is to be resolved in favour of the preservation of life, R (Burke) v General Medical Council, Official Solicitor intervening [2006] QB 273'*.

43. The strong presumption of maintaining life can however be displaced by evidence that it would be contrary to a person's best interests to continue receiving life-sustaining treatment. Lady Hale in *Aintree v James* [2013] UKSC 67 explained at [35-6] that:

35. '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. ...Nevertheless, they are also all agreed that this is not an absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment.

36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts. As Hedley J wisely put it at first instance in Portsmouth Hospitals NHS Trust v Wyatt [2005] 1 FLR 21, "The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests" (para 23). There are cases, such as Bland, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those who life may continue for some time.'

44. The need for precise diagnosis. As explained above, the principal benefit of delay to resolving these proceedings from a medical perspective may be to permit, with the passage of a few more months' time, a detailed determination of whether HX's PDOC can be determined to be one of VS, or possibly MCS-. This has in the past been considered important in the decision-making process. In *NHS Cumbria CCG v Rushton* [2018] EWCOP 41, however, Hayden J set out the then newly issued guidance from the Royal College of Physicians and the BMA, now contained in the PDOC Guidelines, and noted at [30]:

> *'The perceived importance of a definitive diagnosis has reduced over time. As is increasingly recognised by clinicians and the Courts, drawing a firm distinction between vegetative state or a minimally conscious state is often artificial and unnecessary. In practice, when assessing 'best interests' and analysing the information relating to the patient's current condition and prognosis for cognitive recovery, the level of certainty to which these can be assessed is often more important than an actual diagnosis. Many patients would want CANH continued until there is a clear sense of the level of recovery that can be achieved. In these patients the prognosis is important as it allows those concerned to make best interest decisions. For example, they may have refused treatment if the Prolonged Disorder of Consciousness (PDOC) assessment showed that they were likely to be left permanently unconscious, but not if they were likely to regain consciousness.'*

45. CX's case, as put by Ms Kohn, is that a long-term disorder of consciousness cannot and should not properly be construed as permanent until there has been 'no further change in trajectory' for six months. She relies on the Royal College of Physicians Guidance 'Prolonged Disorders of Consciousness following Sudden Onset Brain Injury' ('the PDOC Guidance') at page 37. Insofar as it is necessary to determine whether HX's correct diagnosis would be permanent VS or MCS, then she is right that it is currently too soon to make that judgment. However, the next paragraph in the Guidance is significant:

> *'It is important to note however, that any patient who remains in PDOC for more than a few months without an upward trajectory is likely to have severe permanent disability. Treatment is given in the early stages following severe brain injury in the hope of a good recovery, but must always be in the patient's best interests and in line with their likely wishes. Best interests discussions should not be delayed until the condition is diagnosed as 'chronic' or 'permanent' but should take place whenever a treatment decision is made'*

46. I also note the following passage from the previous page 36 which clarifies the position:

'Inevitably there is a level of uncertainty about such predictions, especially in the early stages post-injury, but as time goes on the extent of likely recovery becomes clearer. Although the need to define a permanent state has become redundant so far as the law is concerned, as noted on page 37 it may still be relevant for other areas of clinical management and treatment planning. It may also help to establish realistic expectations for outcome in discussions with family and friends.
The determination of when a patient reaches the stage where it is unlikely that they will regain consciousness is based on a complex set of factors that can only be judged through careful evaluation over time by an experienced clinician, paying particular attention to the trajectory of change. The definitions provided… should therefore not be taken as fixed points at which to make decisions. They are there to provide a simple 'rule of thumb' guide to inform discussions with family members and other clinicians'.

47. In other words, each case will be different, and in each case the clinicians involved will judge the point when the possible trajectory of change is sufficiently clear that a decision can be safely made about a patient's best interests, with sufficient certainty about what their future prospects might be if life sustaining treatment is to be continued. The medical evidence in HX's case is, the clinicians say, to the effect that that point has now been reached.

48. Ms Kohn goes on to refer me to *Birmingham NHS Foundation Trust v HB* [2018] EWCOP 39 at [33-36] and *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG* [2019] EWCOP 21at [26-30], which are two cases where the court has determined not to sanction any withdrawal of life sustaining treatment. I have considered both of those cases carefully. In the first case, Dr Danbury himself gave evidence. In that case his opinion was recorded in the judgment of Keehan J at [29] that:

'*the prospect of any effective improvement in [P's] neurological condition is… poor, but, importantly, Dr Danbury told me that in his clinical experience it was at this stage too early to determine whether and to what extent HB would make any neurological improvement. He gave the example of two of his patients who suffered similarly as HB. One made no improvement at all. The other, over a period of six months, Dr Danbury met as he was walking through his hospital. Dr Danbury further said in evidence that if ten patients were put before him each suffering from the same brain injury as HB, in this timeframe he would not be able to predict who would make no recovery whatsoever and would die, and which of them would make some recovery from their current condition'*.

49. His evidence is therefore in stark contrast to that which he has given to me in HX's case. Whilst it may be too early to diagnose with precision where along the

spectrum of PDOC HX will eventually rest, it is very clear that no such recovery as that which Dr Danbury thought possible in HB's case is viable here.

50. In TG's case, Cohen J was able to clearly find that the course he was being invited to take by the Trust was '*in the face of…the wishes and feelings of TG'* [26], and further that it was '*possible that TG might make some recovery and be able to return to live at home even if she would be unaware of the fact*' [27], albeit that such possibility was '*faint*' [29]. He also referred to the short amount of time that had elapsed since the index incident (as here, 2 months), and the fact that by the PDOC Guidelines, '*six months is required before a vegetative state is regarded as being permanent'* [27]. In that case, it was TG's own wishes, for herself and her family, coupled with what Cohen J found to be a sufficient hope of some recovery, which appear to have persuaded him to refuse the Trust's application. He did conclude by saying that '*It may be that if the position were to remain the same in six months' time… different considerations might apply'* [30].

51. I have also been referred to the MCA 2005 Code of Practice, issued pursuant to section 42 of the Mental Capacity Act 2005, which provides guidance in respect of best interests decision-making around life-sustaining treatment. The Code of Practice recognises that there are a limited number of cases in which it may not be in a person's best interests to prolong life. Paragraph 5.31 sets out:

> '*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'*

52. Importantly, on the question of the patient's wishes, the Code continues:

> *'5.32. As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision-maker should consider any*

statements that the person has previously made about their wishes and feelings about life-sustaining treatment…
5.38. In setting out the requirements for working out a person's 'best interests', section 4 of the MCA 2005 puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account – whether expressed in the past or now. But their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests…
5.41. The person may have held strong views in the past which could have a bearing on the decision now to be made. All reasonable efforts must be made to find out whether the person has expressed views in the past that will shape the decision to be made. This could have been through verbal communication, writing, behaviour or habits, or recorded in any other way (for example, home videos or audiotapes).'

53. S.4(6) of the 2005 Act requires consideration of a patient's past and present feelings, beliefs and values and 'other factors' he would be likely to consider if able to do so. This will include any religious or cultural beliefs formerly held. S.4(7)(b) requires the court to take into account so far as is practicable and appropriate, the views of people interested in their welfare. The views of family members are not determinative of their best interests, but I do bear in mind in this case that HX would undoubtedly have wanted her family's views considered, given her close relationship with CX.

54. Best Interests. Whilst Dr Danbury's medical evidence was clear, he fairly accepted that in a case such as this the court might well decide not to grant the Trust's application if it was able to find that HX had expressed clear views in favour of continuing life sustaining treatment, even though the hopes of significant recovery could be medically discounted. Unfortunately, the picture that is presented is far from clear. I will set out in full the detail of CX's written evidence about his perception of his mother's wishes, although first I remind myself that: '*Whilst an individual's wishes and feelings weigh heavily in evaluating their best interests, they are not to be regarded as determinative*' - see Hayden J in *Northern Care Alliance NHS Foundation Trust v KT* [2023] EWCOP 46 at [32] .

55. Firstly, at [16] in his statement, CX said: '*My mum was a Christian and had a bible. She believed that everything would fall into place and believed that life was precious. Before she become mentally unwell my mum was optimistic but as her illness progressed, she came to believe that the world was a bad place, and she became more withdrawn and distant. I did what I could to keep the house clean and caring for her'*.

56. This paragraph does not give any clear evidence that HX might have wanted to be kept alive in her current condition. In the absence of further evidence, it cannot be assumed that as part of her Christian faith HX would, or would not, have any specific views as to whether she would wish for further life sustaining treatment or for a palliative pathway. And further, her later illness may well conceivably have affected any views that she had held earlier in her life.

57. CX continues at [17]: '*Although mum and I never had conversations about end of life care we did have conversations about whether or not she would want to be resuscitated. It was about a year or so ago while we were watching an episode of Casualty. She was very clear with me that she would always want to be resuscitated which is why when the DNAR was put in place, early on in her admission, I strongly advocated for its removal. It was my first priority when I instructed solicitors'*.

58. Whilst this would suggest that HX would not have wanted potentially life-saving treatment to be discontinued, it does not truly address her current circumstances, nor provide evidence of any underlying beliefs which might assist in determining what her views about her current circumstances might be. The passage does not address what HX might have considered was a life of sufficient value to maintain.

59. Next, at [18] CX says: '*Turning to end-of-life care, all I can say is that when a relative, aunty M (my grandmother's brother's wife) was in a hospice she went to see her. M was being given end of life care for lung cancer. My mother thought it was cruel and saw it as clinicians 'helping someone on their way' and did not see it as making someone comfortable. If my mum could see how she is now in a hospital bed she would want to see treatment being given to make her better, or at least make her comfortable and give herself time to make a recovery. I honestly do not believe that my mother would be unhappy being cared for, no matter what her disability and the level of need, as I have said above she loved being cared for. She was not one for going out and doing lots of activities*.'

60. Here, in his oral evidence CX accepted that the situation with Aunt M was quite different from HX's current position. It also took place before CX came to live with his mother, when he was only about 13 or 14. HX's reaction could be interpreted in a number of ways. In HX's current circumstances, the medical evidence is that the treatment which she is receiving will not 'make her better', nor is time likely to allow her to 'make a recovery'. I cannot derive from what CX has told me any clear evidence that HX would wish for continuing life sustaining treatment in her current desperate situation.

61. Finally, at [19] CX concluded: '*I know that my mother would want the decision of whether she lives or dies to be a decision made by God and if and when she has had enough, she will in my words 'declare herself'. By this I mean, should she have, for example, another heart attack and CPR failed then that would be her giving up'*.

62. Again, with enormous sympathy for CX's position, and keeping well in mind the relatively short period of time since HX's cardiac arrest, I am not greatly helped in forming a final view of HX's relevant wishes by this paragraph. I entirely understand CX's feelings, but how HX would feel about an uncertain period in VS or MCS-, in circumstances where any attempt to wean her off mechanical ventilation would be fraught with the difficulties set out by Dr Danbury in his report between [6.60] and [6.66], as set out above, remains unclear.

63. I am reminded that in *Lambert v France* (2016) 62 EHRR 2 the ECtHR approved the establishment of the safeguard in the *Conseil de'Etat* that '*where a patient's wishes were not known, they could not be assumed to consist in a refusal to be kept alive*' (§159). I must accept that if I had clear evidence that HX would favour a continuation of life-sustaining treatment in her current condition, it would be likely to be in her best interests for such treatment to continue. However, when I come to balance the factors for and against continuing the treatment, I am not able to include HX's views as a determinative factor.

64. I do however bear in mind the views expressed by CX, who gave his evidence to me honestly and with conviction. I also have in mind what I was told by SX, which was to the effect that she would want her daughter to be given more time, but that if there was no improvement, she did not tell me that she supported indefinite life sustaining treatment. LX expressed the view in her email that '*if there is any chance of any recovery and progression…I support that my sister should be allowed more time. My sister would also be against any treatment that would help her along her way…*'. Very sadly, I do not have evidence that there is any appreciable chance of recovery or progression for HX.

65. Ms Kohn makes the point that the Trust has presented no evidence that HX is currently experiencing pain or distress as a result of the treatment she is receiving. That, she says, is accepted by Dr Danbury whose evidence at its highest is that HX may suffer nociception from continued ventilation. She points out that he cannot be

clear that HX is experiencing pain. She then cites Hayden J in *M v N and Ors* [2015] EWCOP 76 at [72] where he says:

'There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected.'

66. I acknowledge that there are medical notes which suggest that HX does on occasion react to painful stimuli, just as her mother recounts a squeezing reaction when holding her hand. Dr Danbury is clear that these do not connote feeling or any proximity to consciousness. And whilst that means that HX's present existence, notwithstanding the invasiveness of her necessary treatment, may not be one that is causing her to be aware of suffering, that very lack of pain also demonstrates how far she is from active consciousness. I accept that the life which she currently has is one that some may choose to cling to, even in the absence of any hope of improvement. But I do not have evidence before me that that is HX's position.

67. In *PL v Sutton Clinical Commissioning Group* [2017] EWCOP 22, Cobb J provided a useful list of questions for the court to ask itself in determining a case with issues such as this. Having determined that a patient lacks capacity, he then suggested that the court go on to consider the following, at [9].

a) Her previous stated views on life-support, and on sustaining life artificially, in the event that she is totally dependent on others, and incapable of functioning in many essential domains of her life;
b) The quality of her life at present; whether there is any or any significant enjoyment in her life; whether she experiences pain and/or distress, and if so how that is managed;
c) Her prognosis if CANH were to continue for the foreseeable future; whether there is any real prospect of recovery of any of her functions and improvement in the quality of her life;
d) The prognosis for PL if CANH were to be discontinued: what would the palliative care package include, in the event that the CANH were to be discontinued, and where would her palliative treatment optimally be delivered (i.e. would she need to move from her current residential care home?);
e) The prognosis for PL if I were to authorise the discontinuance of nutrition but not hydration;
f) The views, wishes and feelings of the family and her carers;
g) PL's dignity;
h) The sanctity of life generally

68. I have all of those factors in mind in making my decision. In the absence of clear evidence about HX's views, I have to consider that her life now is one without evidence of enjoyment, and one which, were sensation to return would be one marked principally by the discomfort inherent in being a patient in ICU, which Dr Danbury described as 'torture'; he told me that those who do recover often experience symptoms of PTSD as a result of their awareness of their experiences. It is therefore perhaps fortunate that HX, who has been in ICU for very much longer than the vast majority of patients, is not apparently experiencing what happens to her. There is, of course, no absolute certainty about that.

69. The evidence before me is that there is no real prospect of recovery of any of HX's functions or any substantive improvement in the quality of her life. In HX's case, the removing of mechanical ventilation is quite likely to precipitate a further cardiac arrest in circumstances where there have been episodes of apnoea which have required to be corrected by ventilation, as well as some which have not. The withdrawal of CANH will not necessarily be the eventual cause of HX's death if the palliative pathway is embarked upon. That path would include the removal of HX's invasive treatment devices, and a possible transfer to a palliative care ward or hospice and away from ICU, together with necessary medicine to address any pain or distress.

70. I am asked by Ms Kohn to consider the very difficult life that HX has led, the importance she placed on her relationship with CX, and the very many obstacles she has overcome to enjoy a life with him; I do consider his views and reflect on the evidence that I have about her own attitudes to life. I acknowledge that both HX's, and CX's, Article 8 rights are engaged by this application – as are HX's Article 2 and 3 rights. There is also no question that any assessment of HX's best interests could be coloured in any way by as Ms Kohn puts it, a '*negative assessment of the intrinsic value of the life she lived prior to her cardiac arrest*'. A human life that has been unhappy is just as valuable as one that has been happy, and indeed if anything, HX's positive relationship with CX may have been all the more valuable to her for the difficulties she had encountered in other aspects of her life. She may have wanted to live for his sake. She may also have been less concerned than some about notions of dignity.

71. This is a truly sad case, but one where in the end I am satisfied that the outcome is clear. The principal benefit to HX of continuing with mechanical ventilation, and with CANH, would be the simple preservation of her life. That of course is a matter of fundamental importance, but I also must bear in mind the evidence that there is no prospect that any further time will afford any real prospect that HX may ever again enjoy a positive experience of any description. Her loss would of course be a great sadness for her family, but I must consider HX's best interests, and the treatment which she must continue to undergo which would cause her great pain and distress, if she were able to experience it, is all that lies before her with no real hope of recovery. Weighing all of the evidence that I have about her as a person, and her views as recounted to me by CX, I cannot find that, if she had known of the situation that she would find herself in, she would have chosen to remain in her current condition indefinitely, with no prospect of ever returning to any level of function.

72. I remind myself of the evidence that the likelihood is that even weaning from mechanical ventilation would take time and be fraught with difficulty. Whilst such a course would be likely necessary to enable HX to leave Intensive Care, it may well precipitate a further cardiac arrest. Such an effort may well therefore lead to a traumatic death at a time when her family cannot be with her. By contrast, a palliative pathway would enable HX's body to choose its own time, as part of a peaceful process in which her family can be fully involved. On a careful but clear balance I do consider that the latter outcome is in HX's best interests, in all of the circumstances.

73. Given the overwhelming nature of the medical evidence, I am satisfied that the timing of the Trust's application has been appropriate, and I am satisfied, clearly but reluctantly, that it is not in HX's interests to continue to administer to her life sustaining medical treatment in the form of mechanical ventilation and CANH, but rather that as explained it is in her best interests, with sadness, to begin to implement for her a palliative care regime, the consequence of which (but not the aim) will be the end of her life.

74. That is my judgment.